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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S.**

4:17-cv-05783-HSG

**STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT; STATES' REPLY IN SUPPORT OF STATES' MOTION FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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## INTRODUCTION

Women's access to contraceptive care and the corresponding decision about whether and when to use it are fundamental to her freedom and equality. Before the Patient Protection and Affordable Care Act (ACA), more than half of all American women delayed or avoided care due to costs. With the passage of the Women's Health Amendment to the ACA, women have guaranteed "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, including millions of women in the Plaintiff States.

Defendants' Exemption Rules, if implemented, would steal away the benefits provided by the Women's Health Amendment by allowing nearly any employer, university, or insurer to exempt itself from the contraceptive coverage mandate. These Rules will have short- and long-term consequences for women—and, by extension, for their States. Women will be denied full and equal access to healthcare benefits, and will face financial and logistical obstacles as they struggle to obtain necessary healthcare. As the Defendants explained before the Rules were proposed, "the medical evidence prompting the contraceptive coverage requirement showed that even minor obstacles to obtaining contraception led to more unplanned and risky pregnancies, with attendant adverse effects on women and their families." Resp. Br., *Zubik v. Burwell*, 2016 WL 537623, at *74-75 (Feb. 10, 2016).

The Exemption Rules must be set aside because they violate not only the ACA, but the federal Constitution, as well. As the Supreme Court instructed, this Court should "ensur[e] that women covered by [religious employers'] health plans receive full and equal health coverage, including contraceptive coverage," while protecting the religious beliefs of employers by granting the States' motion and setting aside the Rules. *Zubik v. Burwell*, 136 S. Ct. 1557, 1559-60 (2016). Here, the Court should follow this instruction and set aside the Exemption Rules.

## ARGUMENT

### I. THE STATES HAVE STANDING

Defendants half-heartedly argue that the States lack standing to challenge the Exemption

Rules.[1] As this Court and the Ninth Circuit have already concluded, however, the States have standing because the Rules will inflict economic injury on them. *California v. Azar*, 351 F. Supp. 3d 1267, 1281-82 (N.D. Cal. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018) (concluding that the Rules "will first lead to women losing employer-sponsored contraceptive coverage, which will then result in economic harm to the states").

Defendants have conceded that the Ninth Circuit's decision on this point is "controlling." Defs.' Br. (Dkt. No. 30) at 49, Ninth Circuit (No. 19-15072). And the "law of the case doctrine generally precludes reconsideration of 'an issue that has already been decided by the same court, or a higher court in the identical case.'" *Rocky Mountain Farmers Union v. Corey*, 913 F.3d 940, 951 (9th Cir. 2019).

Despite its concession in the Ninth Circuit, and without offering any analysis of the Ninth Circuit's substantive decision on standing, Defendants now suggest in a footnote that the Ninth Circuit decision is not actually controlling because it was rendered at the preliminary injunction stage. Defs. Opp'n at 13 n.6; *see also* Sisters Opp'n at 13. This, however, does not affect the standing inquiry. The Supreme Court has explained that when a preliminary injunction is sought, a plaintiff's burden to demonstrate standing "will normally be no less than that required on a motion for summary judgment." *Lujan v. Nat'l Wildlife Fed'n,* 497 U.S. 871, 907 n.8 (1990). Accordingly, to establish standing for a preliminary injunction and for a motion for summary judgment, a plaintiff cannot "rest on such 'mere allegations,' [as would be appropriate at the pleading stage] but must 'set forth' by affidavit or other evidence 'specific facts,' which for purposes of the summary judgment motion will be taken to be true." *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 561 (1992). Both this Court and the Ninth Circuit relied not on mere allegations, but on the affidavits setting forth the specific facts as to how the States will be harmed as a result of the Exemption Rules. *California*, 911 F.3d at 572-73 (explaining that the "declarations submitted by the states" demonstrate the states' standing); *California*, 351 F. Supp. 3d at 1282-83. And there is nothing to suggest that the Ninth Circuit's standing analysis was

[1] The States' opposition refers to the Exemption Rules, but to the extent the Court considers the legality of the interim final rules (IFRs), the arguments herein apply to the IFRs as well.

cabined by the preliminary injunction stage of the case. *See also Massachusetts v. U.S. Dep't of Health & Human Servs.*, 923 F.3d 209, 222-228 (1st Cir. 2019) (holding that Massachusetts demonstrated Article III standing to challenge the Exemption Rules at the summary judgment stage).[2]

March for Life seeks to distinguish the Ninth Circuit's holding based on the procedural cause of action that formed the basis for the States' first preliminary injunction. March Opp'n at 12. Such an argument, however, misreads and improperly narrows the Court's opinion. The Court explained that "the record supports the [States'] [] theory" that "the IFRs expanded the number of employers categorically exempt from the ACA's contraceptive coverage requirements, and [the] state will incur significant costs as a result of their resident's reduced access to contraceptive coverage" because "women who lose coverage will seek contraceptive care through state-run programs or programs that the states are responsible for reimbursing." *California*, 911 F.3d at 571. The Court rejected Defendants' argument that there was a "speculative chain of events," and instead explained that "[j]ust because a causal chain links the states to the harm does not foreclose standing." *Id*. at 571-72. By further holding that "[t]here is no requirement that the economic harm be of a certain magnitude," the Court also rejected Defendants' argument that the magnitude of the harm was insufficient. *Id*. at 572; s*ee also Massachusetts*, 923 F.3d at 221-228 (concluding that the State's procedural Administrative Procedure Act (APA) challenge was moot, but nevertheless holding the State had standing to proceed on its substantive claims). As these holdings demonstrate, the Court did not limit its analysis to a procedural injury framework.

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[2] Intervenors also assert that the States lack standing because they have not "identif[ied]" an employer that will utilize the Exemption Rules or a woman who will lose coverage. Sisters Opp'n at 13; March Opp'n at 15. Defendants and Intervenors vigorously pressed this same argument in the Ninth Circuit, and the Ninth Circuit squarely rejected it. *California*, 911 F.3d at 572 ("Appellants fault the states for failing to identify a specific woman likely to lose coverage. Such identification is not necessary to establish standing"); Defs.' Br., 2018 WL 1831303, at *25-41 (9th Cir. Apr. 9, 2018); Sisters' Br., 2018 WL 1831304, at *27-38 (9th Cir. Apr. 9, 2018); March Br., 2018 WL 1831305, at *10-49 (9th Cir. Apr. 9, 2018). Moreover, Sisters themselves moved to intervene on the grounds that it intends to use the Exemption Rules in California. Dkt. No. 38 at 1; *see also Pennsylvania v. United States*, No. 17-3752, Oral Arg. at 27:06-28:00 (3d Cir. May 21, 2019) (Counsel for Sisters explaining how Intervenors would utilize the Exemption Rules), available at https://www.ca3.uscourts.gov/oral-argument-recordings.

Moreover, the States continue to assert procedural injuries and continue to challenge the IFRs. *See infra* at 56-59.

Despite the Ninth Circuit's decision, Intervenors argue that the States lack standing because they have purportedly failed to show any injury. Sisters Opp'n at 13; March Opp'n at 14-15. To demonstrate an "injury in fact," the States must show an invasion of a legally protected interest that is concrete and particularized, and harm that is actual or imminent, not conjectural or hypothetical. *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1548 (2016). Here, as explained more fully below, the States have demonstrated that the Rules will damage the States' fiscs: (1) "through increased reliance on state-funded family-planning programs," (2) "through the state-borne costs of unintended pregnancies," and (3) through the negative affects on "women's educational attainment and ability to participate in the labor force, affecting their contributions as taxpayers." *California*, 351 F. Supp. 3d at 1281 (States demonstrated standing on the first two theories); *California*, 911 F.3d at 571 (the "record supports the first theory" and thus not reaching the alternative standing theories); *Clinton v. New York*, 524 U.S. 417, 432-33 (1998); *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel. Barez*, 458 U.S. 592, 601-602 (1982).

First, the States' declarations confirm that the States will bear increased costs of providing contraceptive services to eligible residents who lose coverage as a result of the Rules. Cantwell Decl. ¶ 16-18; Nelson Decl. ¶ 20; Rattay Decl. ¶ 8; Tosh Decl. ¶¶ 31-33; Maisen Decl. ¶ 11; Nguyen Decl. ¶¶ 15-17; Skinner Decl. ¶¶ 21-24; Meyers Decl. ¶ 21; Tomiyasu Decl. ¶ 3; Lightner Decl. ¶¶ 11-14; Tobias Decl. ¶ 4; Ganim Decl. ¶ 6; Gallagher Decl. ¶¶ 18-19; Zerzan-Thul Decl. ¶¶ 9-10; Harris Decl. ¶ 11; Rimberg Decl. ¶ 7; Charest Decl. ¶ 8; Welch Decl. ¶ 10. This is especially true for States like Virginia and Minnesota (and proposed-intervenor Michigan), where there are no contraceptive equity laws requiring insurance plans to cover contraception. Whorley Decl. ¶ 8; Zimmerman Decl. ¶ 4; Charest Decl. ¶ 5.[3]

[3] Even for those states with contraceptive laws, several state laws are not as comprehensive as the contraceptive mandate, and consequently the Rules will cause women in those states to lose coverage. For instance, North Carolina's contraceptive equity law does not require that all FDA-approved methods of contraceptives be covered and does not require no-cost coverage. N.C. Gen. Stat. § 58-3-178; *see also, e.g.*, Wash Rev. Code § 284-43-5150 (does not prohibit cost

The harm is real; even by Defendants' conservative estimates, tens of thousands of women will be affected by the Rules. 83 Fed. Reg. 57536, 57551 n.26 (Nov. 15, 2018). Of this number, more than two in five are residents of the Plaintiff States.[4] Moreover, given that the numerous employers involved in the *Zubik* litigation are likely to avail themselves of the new Rules—as Defendants predict—Defendants appear to have significantly underestimated the Rules' impact on women and the States.[5] *See* Werberg Decl. ¶¶ 5-8; Chance Decl. ¶¶ 7, 15-19, 20-23, Exhs. A-C; *Massachusetts*, 923 F.3d at 223-225 (holding the State had standing based, in part, on Defendants' estimates, including estimates on which entities would utilize the Exemption Rules).[6]

Second, women who lose no-cost contraceptive coverage are more likely to become pregnant, and the States will suffer financial harm as a result of these unintended and often high-risk pregnancies. Kost Decl. ¶¶ 15-18, 24, 28, 38-43; Lawrence Decl. ¶ 9; Grossman Decl. ¶¶ 8-9; Ikemoto Decl. ¶ 5; Jones Decl. ¶ 15; Tosh Decl. ¶ 33; Nelson Decl. ¶ 30; Rattay Decl. ¶¶ 6, 8; Lytle-Barnaby Decl. ¶ 28; Nguyen Decl. ¶ 22; Peterson Decl. ¶ 5; Lightner Decl. ¶ 15; Ganim Decl. ¶ 6; Rimberg Decl. ¶¶ 7-9. For example, long-acting contraceptives such as intrauterine devices (IUDs) are the most effective but have the highest up-front costs. Kost Decl. ¶ 25. Women who lose their contraceptive access are more likely to use an ineffective or less effective

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sharing); Del. Code. Ann. Tit. 18, §§ 3342A, 3559 (same). Additionally, state insurance regulators do not have authority to enforce contraceptive equity laws to self-insured plans, which are regulated by the U.S. Department of Labor, Employee Benefits Security Administration. Jones Decl. ¶ 12; Taylor Decl. ¶ 13; Navarro Decl. ¶ 11; Peterson Decl. ¶ 3; Lightner Decl. ¶ 4; Ganim Decl. ¶ 5; Gobeille Decl. ¶ 3; Kreidler Decl. ¶¶ 12-14.

[4] *See* 2010 Census Briefs, *Age and Sex Composition: 2010*, at 4, 7 (issued May 2011), *available at* https://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

[5] This impact extends to providing services for state residents who work for out-of-state employers and students at state universities who have out-of-state insurance. Pomales Decl. ¶ 9; Johnson Decl. ¶ 3; Childs-Roshak Decl. ¶ 16.

[6] Intervenor March for Life alleges that the States' harm is self-inflicted (March Opp'n at 15-17), yet the Ninth Circuit rejected this argument. *California*, 911 F.3d at 573-74. Moreover, Defendants explicitly rely on the "multiple Federal, State, and local programs that provide free or subsidized contraceptives for low-income women" to fill the coverage gap created by the Rules. 82 Fed. Reg. 47792, 47803 (Oct. 13, 2017); 83 Fed. Reg. at 57546, 57548, 57574, 57576 (relying on "federal, state, or local governmental programs"); Rabinovitz Decl. ¶¶ 9-12; Cantwell Decl. ¶ 18 (explaining that all Title X clinics screen patients for California's Family PACT program). In any event, leaving women without any coverage would rob Peter to pay Paul; the States would still bear responsibility for covering the costs associated with the even greater rise in unintended pregnancies that would result.

method, or will fail to use any method at all, leading to unintended pregnancies. Hollier Decl. ¶ 6; Wilson Decl. ¶ 5; Nelson Decl. ¶ 30. Whether these pregnancies end in miscarriage or abortion or result in live birth, the States will share the costs imposed by these medical procedures, both during and after pregnancy. Kost ¶ 54; Tosh Decl. ¶ 33; Rattay Decl. ¶¶ 5, 8; Zimmerman Decl. ¶ 5; Novais Decl. ¶ 3; Wilson Decl. ¶ 5; Maisen Decl. ¶ 11.

Third, the outcomes described above cost the States not only in the short-term, but in the long-term. The States are burdened with the social and economic repercussions flowing from lost opportunities for affected women to succeed in the classroom, participate in the workforce, and contribute as taxpayers. Kost Decl. ¶ 45; Lawrence Decl. ¶ 5; Arensmeyer Decl. ¶ 4; Nelson Decl. ¶ 31; Bates Decl. ¶¶ 3, 6; Meyers Decl. ¶ 26; Childs-Roshak Decl. ¶ 27; Gobeille Decl. ¶ 6; Dutton Decl. ¶ 20. These lifelong consequences for women and their families are severe and inflict lasting harm upon the States. *See California*, 911 F.3d at 1283 n.10.

Additionally, the States have "standing to seek judicial review of governmental action that affects the performance of [their] duties." *Cent. Delta Water Agency v. United States*, 306 F.3d 938, 950-51 (9th Cir. 2002). Here, the Rules directly affect the ability of state agencies to carry out their duties. For instance, as the California Department of Fair Employment and Housing (DFEH) explained, the Rules will "impact the analysis that DFEH must engage in to carry-out its required responsibility under the law," when confronted with claims about gender-based workplace classifications filed in response to women losing coverage. Kish Decl. ¶¶ 12-14; *see also* Jones Decl. ¶¶ 23-24 (explaining that the California Department of Insurance has had to field additional consumer complaints and calls in response to the Rules); Kreidler Decl. ¶ 17.

Lastly, the Intervenors challenge the States' standing to bring constitutional claims. March Opp'n at 18; Sisters Opp'n at 12. However, the APA provides the States with a vehicle to raise their constitutional arguments. 5 U.S.C. § 706(2)(B). Because the States have standing to sue under the APA, they do not need to demonstrate an alternative basis for standing to bring constitutional challenges. *See Scanwell Labs., Inc. v. Shaffer*, 424 F.2d 859, 865-66, 872-73 (D.C. Cir. 1970) (adversely affected party has standing under the APA "regardless of a lack of legal right" under provision to be enforced); *Seeger v. U.S. Dep't of Def.*, 306 F. Supp. 3d 265,

276, 279-80 (D. D.C. 2018) (applying *Scanwell Labs.*). Indeed, Intervenors point to no case for the proposition that a different analytical framework for standing applies for plaintiffs asserting constitutional causes of action in the context of APA claims. Sisters Opp'n at 12.[7]

## II. THE EXEMPTION RULES ARE CONTRARY TO LAW

The Exemption Rules 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). Specifically, the Rules are contrary to the Women's Health Amendment. Further, the Religious Exemption Rule is neither required nor permitted by the Religious Freedom Restoration Act (RFRA), and the Moral Exemption Rule is not authorized by any Congressional act. The Rules also create unreasonable barriers to healthcare and impede timely access to care, and violate the ACA's nondiscrimination provision.

### A. The Exemption Rules Are Contrary to the Women's Health Amendment

The Exemption Rules are contrary to the plain text of the Women's Health Amendment, which specifies that women's preventive services "shall" be provided. 42 U.S.C. § 300gg-13(a)(4). Nothing in the Women's Health Amendment explicitly or implicitly permits Defendants to exempt employers from the statutory requirement. Nor does the existence of the church exemption, a narrow exemption for houses of worship that is not at issue in this case, render these Rules lawful. And Defendants' reliance on *Chevron* is misplaced given the text of the Women's Health Amendment.

[7] Moreover, with regard to an Establishment Clause claim, the Supreme Court has consistently held that legislation constituting a governmental endorsement of religion inflicts cognizable injury per se. *McCreary Cnty., Ky. v. Am Civil Liberties Union of Ky.*, 545 U.S. 844, 870 (2005). Plaintiffs have standing "in a wide variety of Establishment Clause cases." *Catholic League for Religious & Civil Rights v. City & Cnty. of San Francisco*, 624 F.3d 1043, 1049-50 (9th Cir. 2010) (en banc) (collecting cases); *see also Washington v. Trump*, 847 F. 3d 1151, 1160 n.4 (9th Cir. 2017) (State asserting Establishment Clause claim); *Hawai'i v. Trump*, 241 F. Supp. 1119, 1131 n.9 (D. Haw. 2017) (same). The very purpose of the Establishment Clause is to "protect[] States, and by extension their citizens, from the imposition of an established religion by the Federal Government." *Zelman v. Simmons-Harris*, 536 U.S. 639, 677 (2002) (Thomas, J., concurring); *Separation of Church & State Comm. v. City of Eugene*, 93 F. 3d 617, 621 (9th Cir. 1996) (O'Scannlain, J., concurring) ("[C]oncerns about federalism … motivated ratification of the Establishment Clause.").

### 1. The Exemption Rules Are Contrary to the Plain Language and Legislative History of the Women's Health Amendment

As this Court concluded, the contraceptive mandate is "in fact a statutory mandate." *California*, 351 F. Supp. 3d at 1285. This statutory command was recognized by the Supreme Court when it explained that the "ACA requires an employer's group health plan or group-health-insurance coverage to furnish 'preventive care and screenings' for women." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 697 (2014). The limited authority delegated to Health Resources and Services Administration (HRSA) was to determine "what types of preventive care must be covered." *Id*. As the Supreme Court explained, "Congress itself . . . did not specify *what types* of preventive care must be covered. Instead, Congress authorized [HRSA], a component of HHS, to make *that* important and sensitive decision." *Id.* (emphasis added); *see also Catholic Health Care System v. Burwell*, 796 F.3d 207, 210 (2d Cir. 2015) ("The ACA does not specify *what types* of preventive care must be covered for female plan participants. Instead, Congress left *that issue* to be determined" by HRSA) (emphasis added). Defendants seek to expand this narrow delegation of authority into the ability to exempt any and all employers from the statutory mandate. The text and legislative history of the statutory scheme forecloses that result, and Defendants' arguments to the contrary are unavailing.

Defendants assert that because HRSA's guidelines regarding preventive services did not exist at the time of the ACA, Congress granted HRSA "broad discretionary authority" to promulgate any and all regulations. Defs. Opp'n at 14. While it is true that the HRSA guidelines were not in existence at the time the ACA was enacted, that does not somehow suggest that Congress *silently* granted HRSA broad authority to re-define the regulated entities, when Congress itself has already answered the question of who must provide preventive services at no cost: "group health plan[s]" and "health insurance issuer[s]." 42 U.S.C. § 300gg-13(a). Nothing suggests that Congress, sub silentio, authorized HRSA to override Congress's explicit determination as to what entities are subject to the preventive services mandate. Moreover, Defendants' atextual reading of the statute would mean that the language of the mandate (*Id*.) has different meanings in different subsections. Under Defendants' reading, regulated entities for

purposes of all other subsections of the mandate are those defined by the statute (group health plans and issuers), but for purposes of the Women's Health Amendment (42 U.S.C. § 300gg-13(a)(4)), the regulated entities are only the subset of plans and issuers selected by HRSA. *See Pennsylvania v. Azar*, 351 F. Supp. 3d 791, 820 (E.D. Pa. 2019) (explaining that Defendants' statutory interpretation is at odds with § 300gg-13(a)); *see also Whitman v. Am. Trucking Assoc.*, 531 U.S. 457, 468 (2001) (It is a basic principle that Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes"). Defendants cite no legal authority or canon of statutory construction to arrive at such an interpretation. And such an interpretation is nonsensical, as there is nothing about the need to develop guidelines regarding specific preventative care and screenings for women that would be relevant to the scope of the entities required to actually provide such care.

The fact that Congress did not explicitly use the word "contraceptives" or the phrase "birth control" in the statute does not change the clear language limiting the scope of the authority that Congress explicitly delegated to HRSA. Defs. Opp'n at 14; Sisters Opp'n at 15. There is no dispute that since the enactment of the Women's Health Amendment, HRSA has always concluded that covered preventive services include contraceptives. This is no surprise given that the federal government itself concluded that improved access to contraception is among the ten great public health achievements of the twentieth century. Ex. 57 (D10 00207323); *see also Priests for Life v. U.S. Dep't of Health & Human Servs.*, 808 F.3d 1, 22-23 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from the denial of rehearing en banc) ("It is commonly accepted that reducing the number of unintended pregnancies would further women's health, advance women's personal and professional opportunities, . . . and help break a cycle of poverty that persists when women who cannot afford or obtain contraception become pregnant unintentionally at a young age."). The regulated entities, as defined by Congress, are bound by this statutory mandate to provide the preventive services included in HRSA's guidelines. Defendants cannot, in the guise of preparing guidelines requiring contraceptive coverage, alter Congress's direction that health plans and issuers "shall" provide that coverage.

Similarly, Defendants claim that because Congress omitted the words "evidence-based" or "evidence-informed" from the Women's Health Amendment, the Court should read into this omission a "positive grant of [delegated] authority" to HRSA "to exempt anyone [it] wish[es] from the contraceptive mandate." Defs. Opp'n at 15; *California*, 351 F. Supp. 3d at 1285. That interpretation goes beyond what such an omission can bear. *See MCI Telecommunications Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218 (1994) (concluding the FCC did not have authority to exempt certain carriers from requirement that all carriers "shall" file tariffs with the FCC, despite a provision allowing the FCC to "modify any requirement"). Congress did not, silently, grant Defendants unfettered authority to create sweeping exemptions from the statute's unqualified mandate that coverage "shall" include preventive services.

Additional statutory text within the ACA confirms that Congress considered what statutory exemptions might be appropriate under the Act because (a) Congress exempted grandfathered plans from the contraceptive mandate, and (b) Congress granted specific religious exemptions to other ACA statutory mandates (aid-in-dying legislation). Defendants concede that the exemption for grandfathered plans is "significant" but assert that this explicit Congressional exemption somehow impliedly translates to greater authority for the Defendants to craft *their own* exemptions. Defs. Opp'n at 16. To the contrary, where Congress creates exceptions in the statute, "additional exceptions are not to be implied." *Hillman v. Maretta*, 569 U.S. 483, 496 (2013). There is no authority—and Defendants cite none—for the notion that because Congress creates specific exceptions, federal agencies have equal authority to carve out their own, additional exceptions to the statute.

Similarly, Defendants argue that "*Congress* has long recognized the need for protecting objections of conscience in the area of health care." Defs. Opp'n at 19. But Congress *did* consider such objections in promulgating the ACA and created such exemptions in aid-in-dying provisions (42 U.S.C. § 18113); Congress did not create an exemption for the preventive services mandate. Defendants fail altogether to address this point, and again, do not cite any authority for their argument that where Congress can—and does—create "conscience exemptions," that express action by Congress silently also grants agencies the authority to carve out their own,

*additional* conscience exceptions from Congressional mandates.[8] Precisely the opposite is true under the law. *Syed v. M-I, LLC*, 853 F.3d 492, 501 (9th Cir. 2017) (concluding that "in light of Congress's express grant" of an exclusion, "the familiar judicial maxim *expressio unius est exclusio alterius* counsels against finding additional, implied exceptions").

Defendants are also incorrect that their Exemption Rules comport with the purpose of the Women's Health Amendment. Defs. Opp'n at 18; *California v. Block*, 663 F.2d 855, 860 (9th Cir. 1981) (the Court's "primary task when testing the statutory authority of a challenged regulation must always be to determine the intent of Congress"); *Syed*, 853 F.3d at 501 ("'an implied exception to an express statute is justifiable only when it comports with the basic purpose of the statute'"). Congress enacted the Women's Health Amendment to promote access to affordable women's healthcare. Specifically, the Women's Health Amendment sought to ensure that "women of America [ ] have the same access to preventive care and screening services as the women of Congress." 155 Cong. Rec. S12026 (Dec. 1, 2009) (Sen. Mikulski). At that time, federal health plans covered contraception. Ex. 9 (D4 000406). More broadly, the Women's Health Amendment was enacted to reduce gender disparities, eliminate charging women more for healthcare than men, improve women's preventative care services and screening, and improve women's access to family planning. *See, e.g.,* 155 Cong. Rec. S12030 (Dec. 1, 2009) (Sen. Dodd). As Defendants acknowledge, "Congress, by amending the Affordable Care Act during the Senate debate to ensure that recommended preventive services for women are covered adequately . . . recognized that women have unique healthcare needs and burdens [and] [s]uch needs include contraceptive services." 77 Fed. Reg. 8725, 8727 (Feb. 15, 2012). Thus, Defendants' purported authority to create exemptions does not comport with the basic purpose of

[8] Defendants' reliance on *Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987) (per curiam), is similarly misplaced. *Rodriguez* dealt with the scope of judicial authority in criminal sentencing matters. That is far afield from the issue here which is whether Defendants had the power to create exceptions to a statutory mandate. *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986) ("an agency literally has no power to act . . . unless and until Congress confers power upon it"); *City & County of San Francisco v. Sessions*, 372 F. Supp. 3d 928, 943 (N.D. Cal. 2019) (same); *City of Los Angeles v. Sessions*, 293 F. Supp. 3d 1087, 1095 (C.D. Cal. 2018) (same).

the statute; "to the contrary," it frustrates Congress's goal of ensuring women have full and equal access to healthcare. *Syed*, 853 F.3d at 501-02.[9]

Subsequent acts of Congress confirm their intent, such that adopting Defendants' interpretation would be tantamount to "giv[ing] a reading to [an] Act that Congress considered and rejected." *Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 220 (1983); *see also Aaron v. Sec. & Exch. Comm'n*, 446 U.S. 680, 694 n.11 (1980) (finding "further support for [the Court's] interpretation" based on "the fact that Congress was expressly informed" on the issue on two occasions "and on each occasion Congress left" the issue undistributed). As this Court recognized, in 2012, the Senate was presented with "the so-called conscience amendment, which would have enabled any employer or insurance provider to deny coverage based on its asserted 'religious beliefs or moral convictions.'" *California*, 351 F. Supp. 3d at 1286 (citing *Hobby Lobby*, 573 U.S. at 744 (Ginsburg, J. dissenting)). While Defendants seek to diminish the relevance of this failed amendment (Defs. Opp'n at 17), it is directly applicable to the analysis here as its supporters conceded that the ACA was "the first time the Federal Government had passed a healthcare law that didn't include" language that would authorize exemptions for religious beliefs or moral convictions. 158 Cong. Rec. S1116 (Feb. 29, 2012) (Sen. Blunt). Further, those supporting the amendment made repeated reference to the Women's Health Amendment, which they further admitted does "not allow purchasers, plan sponsors, and other stakeholders with religious or moral objections to specific items or services to decline providing or obtaining coverage of such items." *Id*. at S539 (Feb. 9, 2012). In rejecting the amendment, "Congress left health care decisions—including the choice among contraceptive methods—in the hands of women, with the aid of their health care providers." *Hobby Lobby*, 573 U.S. at 744 (Ginsburg, J. dissenting).

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[9] Defendants are also incorrect to characterize the Women's Health Amendment as serving only "marginal advances." Defs. Opp'n at 18. Since the contraceptive-coverage requirement took effect, more than 62 million women nationwide have benefited. Ex. 49 (D10 00207142), Ex. 49 (D10 00207145-46), Ex. 28 (D10 00195105), Ex. 64 (D10 00208988), Ex. 24 (D9 668958-59), Ex. 63 (D10 00208945). The cost reductions have been significant, with estimates ranging from $483 million to $1.4 billion in savings related to just one form of contraception (the pill) in one year alone. As noted below, access to contraception advances a compelling government interest as several courts, including a majority of the Supreme Court have concluded.

**2. The Existence of the Church Exemption—an Exemption Not at Issue in this Litigation—Does Not Render These Broad Exemptions Lawful**

Defendants rely on the existence of the "church exemption" to support their position that the Women's Health Amendment authorizes the broad Exemption Rules here. Defs. Opp'n at 14-16 & n.8; *see also* Sisters Opp'n at 14. As explained in the States' Motion at 8-9, in 2011, Defendants exempted houses of worship from the contraceptive mandate, with the understanding that line-level employees of these entities share their employer's religious objection to contraception. 76 Fed. Reg. 46621, 46623 (Aug. 3, 2011). This "church exemption" imported a long-standing and narrowly tailored category of employers defined in the Internal Revenue Code. *Hobby Lobby*, 573 U.S. at 698 (citing 26 U.S.C. § 6033(a)(3)(A)). Defendants recognized that a broader exemption would sweep in employers "more likely to employ individuals who have no religious objection to the use of contraceptive services," and thereby risk "subject[ing] [such] employees to the religious views of [their] employer." 77 Fed. Reg. at 8728. To date, no one has challenged the "church exemption" or Defendants' authority to implement it. Defendants' argument that the "church exemption" authorizes these broader exemptions is without merit.

As this Court already recognized, "the legality of that exemption is not before the Court." *California*, 351 F. Supp. 3d at 1286. And even if it were, whatever authority Defendants might have had to create the church exemption, does not emanate from the Women's Health Amendment. In enacting the exemption, the regulation does not itself reference the Women's Health Amendment. *See* 76 Fed. Reg. at 46625 (The Departments "provide HRSA the discretion to exempt" houses of worship); *id*. at 46624 (same); *id*. at 46623 (same). Thus, by Defendants' own account, the Women's Health Amendment did not grant HRSA the authority to create the church exemption.

This is not to say that the church exemption (or accommodation) is necessarily unlawful: as noted above, that question is not at issue here. It does, however, mean that any authority to promulgate the church exemption is separate from the Women's Health Amendment. *See also* 80 Fed. Reg. 41318, 41325 (July 14, 2015) (recognizing the longstanding governmental recognition of particular sphere of autonomy for houses of worship, such as special treatment in the Internal

Revenue Code); *Zubik* Resp. Br., 2016 WL 537623, at *28, 67-69 (discussing basis for the church exemption); *Geneva Coll. v. Sec'y U.S. Dep't of Health & Human Servs.*, 778 F.3d 422, 443 (3d Cir. 2015) (same), *vacated sub. nom. Zubik*, 136 S. Ct. at 1561; *Little Sisters of the Poor Home for the Ages, Denver, Colo. v. Burwell*, 794 F.3d 1151, 1202 (10th Cir. 2015) (same), *vacated sub. nom. Zubik*, 136 S. Ct. at 1561. Therefore Defendants' effort to characterize the church exemption as an exception to the Women's Health Amendment—and thereby to justify the Exemption Rules—is erroneous.[10]

**3. *Chevron* Deference Is Not Warranted**

Defendants ask this Court to defer to HRSA's interpretation of the Women's Health Amendment using the analytical framework adopted in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). Defs. Opp'n at 16. But no deference is warranted in this case. *Chevron* cautions that the first step in determining whether an agency's interpretation of the law is entitled to deference is to consider "'whether Congress has directly spoken to the precise question at issue.'" *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132 (2000); *cf. Baldwin v. United States*, 921 F.3d 836, 842 (9th Cir. 2019) (finding *Chevron* step one satisfied where the statute was "conspicuously silent" on the issue presented). Here, as discussed above, Congress *has* spoken on the issue of *who* must cover preventive services, and therefore, "the inquiry is at an end; the court must give effect to the unambiguously expressed intent of Congress." *Brown & Williamson*, 529 U.S. at 132. In *Brown & Williamson*, the Court explained that no *Chevron* deference would be afforded to the agency based on the Court's review of the plain text of the specific statute, contextual indications, subsequent acts of Congress, and "common sense." *Id*. at 133.

"With these principles in mind," it is clear that Defendants are not entitled to deference. *Id*. Congress itself spoke directly as to which entities were subject to the "preventive services"

[10] As the federal government previously argued, "[i]t would be perverse and profoundly at odds with our Nation's traditions to hold" "that the provision of an exemption for houses of worship" "effectively mandate[es], through RFRA, the extension of the same exemption" "to all religious objectors, a result that could extinguish the statutory rights of millions of people." *Zubik* Resp. Br., 2016 WL 537623, at *68; *see also Zubik*, Oral Arg. at 30 (now-current Solicitor General Noel Francisco: "I am not suggesting that whenever you give an exemption to churches, that exemption has to apply to all other religious organizations").

mandate, and explicitly defined HRSA's limited authority. Similarly, for the same reason, Defendants would not be entitled to any deference if they promulgated a regulation allowing cost sharing for certain preventive services because Congress already foreclosed that possibility when it said that plans and issuers "shall not impose any cost sharing requirements." § 300gg-13(a).

**B. The Religious Exemption Rule Is Not Required by RFRA[11]**

Congress enacted RFRA "to restore the compelling interest test" after the Supreme Court eliminated it in *Employment Division v. Smith*, 494 U.S. 872 (1990). 42 U.S.C. § 2000bb. RFRA provides that the federal government cannot substantially burden a person's exercise of religion. 42 U.S.C. § 2000bb-1(a). Where federal action is a substantial burden on a person's exercise of religion, RFRA requires that action to be in furtherance of a compelling government interest and the least restrictive means of furthering that compelling government interest. 42 U.S.C. § 2000bb-1(b). Defendants assert that the Religious Exemption Rule is required by RFRA. Given the availability of the current accommodation process, Defendants are incorrect. *See also* States' Mot. at 9-10.

Under the existing accommodation, a nonprofit employer certifies its religious objection to the federal government or to the insurer, and the insurer becomes responsible for providing separate contraceptive coverage for female beneficiaries. 45 C.F.R. § 147.131(c)(2). Upon notification, the government works with the insurer to guarantee that women receive coverage. This process ensures a seamless, automatic mechanism for female employees and dependents to receive contraceptives to which they are statutorily entitled outside of their employer-sponsored health plan. 45 C.F.R. § 147.131.

Defendants assert that the Exemption Rules are required because the existing accommodation violates RFRA. This is erroneous inasmuch as the accommodation: (1) does not substantially burden the exercise of religion because it allows religious objectors to opt out of providing, paying for, referring, contracting, or arranging for contraceptive coverage; (2) furthers the compelling governmental interest in ensuring that women have full and equal access to

[11] RFRA does not apply to the Moral Exemption Rule because RFRA does not extend to moral convictions.

preventive care, including contraceptives, and (3) is the least restrictive means of achieving that compelling government interest. *See* States' Mot. at 21-34.

**1. The Accommodation Does Not Substantially Burden the Exercise of Religion**

Defendants and Sisters offer three arguments for why the accommodation, in their view, substantially burdens the exercise of religion. First, they claim that the accommodation imposes a substantial burden as a matter of law because to conclude otherwise would be to impermissibly question the beliefs of religious employers. Defs. Opp'n at 23; Sisters Opp'n at 26. Second, they assert that the financial penalty imposed on employers who decline to provide contraceptive coverage or avail themselves of the accommodation constitutes a substantial burden. Defs. Opp'n at 24; Sisters Opp'n at 25-26. Third, they argue that even under the accommodation, the objecting employer's insurer or third party administrator (TPA)[12] uses the employer's "plan" or "contracts" to provide separate contraceptive coverage, and that this alleged "use" of the plan itself imposes a substantial burden. Defs. Opp'n at 25; Sisters Opp'n at 26. All of these contentions are incorrect, and each is addressed in turn.

**a. Whether the accommodation substantially burdens the exercise of religion is a legal question for the courts to decide**

Defendants and Sisters continue to conflate the *factual* question of whether a religious belief is sincerely held (which is not in dispute here) with the *legal* question of whether a governmental action substantially burdens a person's exercise of religion. *See* Defs. Opp'n at 23; Sisters Opp'n at 26. It is simply untrue to suggest that the States are questioning the sincerity or correctness of religious employers' beliefs. Rather, the point is that—as a matter of law—the way that the accommodation operates does not substantially burden the exercise of religion. That is a quintessentially legal question that courts must decide in all RFRA cases. *See Guam v. Guerrero*, 290 F.3d 1210, 1222 n.20 (9th Cir. 2002) (whether a governmental action "substantially burdens one's religion is a legal question for courts to decide."); *see also Geneva Coll.*, 778 F.3d at 436 ("We may consider the nature of the action required of the appellees, the

[12] A third-party administrator (TPA) is an entity that processes insurance claims or handles certain aspects of employee benefit plans.

connection between that action and the appellees' beliefs, and the extent to which that action interferes with or otherwise affects the appellees' exercise of religion—all without delving into the appellees' beliefs").

Defendants and Sisters' contention, in effect, is that courts must completely defer to litigants on the substantial burden question. But that position cannot be reconciled with the text, legislative history, or case law interpreting RFRA. Their argument would erase the statutory requirement that only *substantial* burdens must pass strict scrutiny. *United States v. Menasche*, 348 U.S. 528, 538-39 (1955) (It is the duty of the Court "to give effect, if possible, to every clause and word of a statute"). By its plain terms, RFRA "accommodates religion" but it does not "wholly exempt religion from the reach of the law." *Little Sisters of the Poor*, 794 F.3d at 1172 (accommodation "may be more burdensome than the [religious objectors] would prefer, and may sometimes subordinate their interests to other policies not of their choosing"); *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 257-267 (D.C. Cir. 2014) ("In our cosmopolitan nation with its people of diverse convictions, freedom of religious exercise is protected yet not absolute."), *vacated sub. nom. Zubik*, 136 S. Ct. at 1561; *United States v. Lee*, 455 U.S. 252, 257 (1982) ("[n]ot all burdens on religion are unconstitutional"). As the Supreme Court explained, "activities of individuals, even when religiously based, are often subject to regulation" by the government in its exercise of its "undoubted power to promote health, safety, and general welfare." *Wisconsin v. Yoder*, 406 U.S. 205, 220 (1972). RFRA confirms this by providing that only "substantial" burdens must pass strict scrutiny.

The legislative history of RFRA provides a further basis for rejecting Defendants' proffered statutory interpretation. *Abramski v. United States*, 573 U.S. 169, 179 (2014) (court must interpret relevant words of a statute not in a vacuum, but with reference to the statutory history). As the Supreme Court explained, "the word 'substantially' was inserted [into RFRA] pursuant to a clarifying amendment offered by Senators Kennedy and Hatch. In proposing the amendment, Senator Kennedy stated that RFRA, in accord with the Court's pre-*Smith* case law, 'does not require the Government to justify every action that has some effect on religious exercise.'" *Hobby Lobby*, 573 U.S. at 758 (citing 139 Cong. Rec. 26,180 (Oct. 26, 1993)); *see also Priests*

*for Life*, 772 F.3d at 248 (recognizing the import of the same legislative history); *see also* S. Rep. No. 103-111 (1993) (courts should look to pre-*Smith* cases to interpret "whether the exercise of religion has been substantially burdened"). Congress did not intend for every conceivable burden—no matter how slight—to be justified using a strict scrutiny standard.

Beyond the statutory text and legislative history, an extensive body of case law has developed in the quarter century since RFRA's passage. And it is telling that neither Defendants nor Intervenors have cited a single case, with the arguable exception of *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927 (8th Cir. 2015) (addressed below), where a court has concluded that a substantial burden on the exercise of religion existed solely because a litigant sincerely believed that it was so. On the contrary, courts have consistently required litigants to demonstrate both the existence of sincerely held religious beliefs, *and* that the governmental action substantially burdened the exercise of those religious beliefs. *See Holt v. Hobbs*, 135 S. Ct. 853, 862 (2015) ("In addition to showing that the relevant exercise of religion is grounded in a sincerely held religious belief, petitioner bore the burden of proving that the Department's grooming policy substantially burdened that exercise of religion."); *Catholic Health Care Sys.*, 796 F.3d at 218 ("the fact that a RFRA plaintiff *considers* a regulatory burden substantial does not make it a substantial burden. Were it otherwise, no burden would be insubstantial").

If sincerely held religious beliefs, by themselves, established a substantial burden as a matter of law, there would be a broad range of governmental and third party conduct that religious adherents could effectively preclude. For example, in *Zubik*, the Baptist Joint Committee for Religious Liberty pointed out that if employers could prevent their insurers from providing separate contraceptive coverage to their employees, "others might say that they cannot do business with any insurer that provides contraception to anyone."[13] As Defendants previously

[13] *See* Baptist Joint Committee for Religious Liberty as Amicus Curiae in Support of Respondents Br., 2016 WL 692850, at *2 (Feb. 17, 2016); *see also* Ninth Circuit Oral Arg. at 13:25-14:46; 29:56-30:23, available at https://www.ca9.uscourts.gov/media/view_video.php?pk_vid=0000015818 (asking whether employers could refuse to provide any physician-based healthcare, or to cover blood transfusions, based on sincerely held religious beliefs).

explained, the religious claims here "assert a right not only to be relieved from the obligation to provide contraceptive coverage themselves, but also to prevent the government from arranging for third parties to fill the resulting gap." *Zubik* Resp. Br., 2016 WL 537623, at *5. The concept of substantial burden is not so far-reaching that it permits private individuals and entities to dictate how the government conducts its affairs with third parties. *See, e.g.*, *Bowen v. Roy*, 476 U.S. 693, 699 (1986) ("The Free Exercise Clause simply cannot be understood to require the Government to conduct its own internal affairs in ways that comport with the religious beliefs of particular citizens.").

**b. The financial penalty is irrelevant if the accommodation does not impose a substantial burden**

Defendants and Intervenors assert that the financial penalty for not complying with the accommodation substantially burdens the exercise of religion. *See* Defs. Opp'n at 24; Sisters Opp'n at 25; *see* 26 U.S.C. § 4980D(a)-(b) ($100/day tax for non-compliance with the ACA). But if option A (complying with the accommodation process) does not impose a substantial burden, then it is irrelevant if option B (a financial penalty in the alternative) does so. In other words, if complying with the accommodation does not substantially burden the exercise of religion, that is the end of the matter. *Hobby Lobby* itself proves this point. In that case, the Court concluded that complying with the contraceptive mandate or paying the fine substantially burdened the exercise of religion. *Hobby Lobby*, 573 U.S. at 726. But the Court also concluded that complying with the accommodation or paying the fine did *not* substantially burden the exercise of religion in that case. *Id*. at 731 (holding that the accommodation "does not impinge on the plaintiffs' religious belief that providing insurance coverage for the contraceptives at issue here violates their religion"). Yet the monetary fine was identical in both cases. If the financial penalty alone substantially burdened the exercise of religion, the Court could not have reached the result that it did. *Id.*; *see also Catholic Health Care Sys.*, 796 F.3d at 221 (explaining that "this argument is a non sequitur. An objectively insubstantial burden does not become substantial simply because a RFRA plaintiff faces substantial burdens in the alternative"); *Eternal Word Television Network, Inc. v. Sec'y of U.S. Dep't of Health & Human Servs.*, 818 F.3d 1122, 1146

(11th Cir. 2016) (this "view is flawed because any burden (even an objectively insubstantial one) becomes a substantial burden if the penalty is heavy enough"), *vacated* 2016 WL 11503064 (11th Cir. May 31, 2016).

In *Sharpe*, the Eighth Circuit erred by focusing solely on the monetary penalties without considering whether plaintiff's compliance with the accommodation was a substantial burden. The Court simply held that as long as plaintiff's beliefs that complying with the accommodation violated its religion were sincerely held, then participating in the accommodation "is a burden too heavy to bear." 801 F.3d at 937, 941. That holding, however, departs from longstanding RFRA precedent requiring the Court "to examine the acts [plaintiff] must perform—not the effect of the act—to see if it burdens substantially the [plaintiff's] religious exercise." *Geneva Coll.*, 778 F.3d at 440; *Little Sisters of the Poor*, 794 F.3d at 1177 (court must "consider how the law or policy being challenged actually operates and affects religious exercise"); *Navajo Nation v. U.S. Forest Serv.*, 535 F.3d 1058, 1068 (9th Cir. 2008) (en banc); *see also Zubik*, 136 S. Ct. at 1561 (Sotomayor, J., concurring) (explaining that *Sharpe* improperly "ignored" the Court's prior instructions that it expressed no view on the merits, and wrongly interpreted those decisions as signals of where the Court stands).

**c. The accommodation does not use the employer's health plan to provide contraceptive coverage**

Defendants and Sisters argue that the accommodation substantially burdens the exercise of religion because the objecting employer's insurer or TPA uses the employer's "own contracts" or "plan" to provide the separate contraceptive coverage. Defs. Opp'n at 25; Sisters Opp'n at 26. Defendants' argument is factually incorrect. Under the accommodation, the employer's group health plan—the "contract" between the employer and his insurer—does not provide, pay for, or contract for contraceptive coverage. 45 C.F.R. § 147.131(d)-(e). By law, the insurer "must *expressly exclude* contraceptive coverage from the group health insurance coverage provided in connection with the group health plan and provide *separate* payments for any contraceptive services required to be covered." 45 C.F.R. § 147.131(d)(2)(i) (emphases added). Defendants'

and Intervenors' argument is directly refuted by the plain language of the accommodation regulation. They do not—and cannot—provide any evidence to the contrary.

Nor does the separate contraceptive coverage utilize any "plan infrastructure" associated with the employer's group health plan in any way, including the plan's "network." Sisters Opp'n at 26-28; *see* Borzi Decl. ¶ 16. An "insurance coverage network" is a set of doctors, hospitals, and other providers with which an insurer carrier or TPA has pre-negotiated payment rates. The accommodation ensures that female employees and covered dependents receive contraceptive services from healthcare providers in their existing "insurance coverage networks"—i.e., from their regular doctor. Borzi Decl. ¶ 16. And because those providers already have relationships with the women's insurers and TPAs, they also have the "coverage administration infrastructure" to verify the women's coverage for benefits and bill the insurers and TPAs for contraceptive services. *Id*. But the "networks" and "infrastructure" through which the insurers or TPAs provide contraceptive coverage are not owned or controlled by objecting employers—they are relationships among third-party insurers, TPAs, and healthcare providers. *Id*.; *cf*. *Catholic Health Care Sys.*, 796 F.3d at 224 (RFRA does not give objector "a blanket religious veto over the government's interactions with others"); *E. Texas Baptist Univ. v. Burwell*, 793 F.3d 449, 461 (5th Cir. 2015) ("The acts that violate [plaintiffs'] faith are the acts of the government, insurers, and [TPAs], but RFRA does not entitle them to block third parties from engaging in conduct with which they disagree"), *vacated sub. nom*. *Zubik*, 136 S. Ct. at 1561; *Little Sisters of the Poor*, 794 F.3d at 1193 (religious objector "cannot hamstring government efforts to ensure" that women "receive the coverage to which they are entitled under the ACA"); *Geneva Coll.*, 778 F.3d at 441 ("RFRA does not permit person to impose restraints on another's actions because action is religiously abhorrent.").

The result is no different for self-funded plans. When a TPA administering a group health plan receives notification that an eligible employer opts out of providing coverage, the accommodation requires the TPA to arrange for separate contraceptive coverage. *See* Borzi Decl. ¶ 19 (citing 26 C.F.R. § 54.9815–2713AT(b)(2); 29 C.F.R. § 2590.715–2713A(b)(2)); *see also* Volk Decl. Ex. 1 (information on the accommodation sent by a TPA to a plan participant, stating

that the employer does not "contract, arrange, pay, or refer for contraceptive coverage."). The TPA's obligations are enforceable under the Employee Retirement Income Security Act (ERISA). *Id*. (citing 78 Fed. Reg. 39870, 39879-80 (July 2, 2013)). But the fact that ERISA provides the legal authority to require the TPA to provide separate contraceptive coverage does not mean that the separate contraceptive coverage is part of the employer's group health plan coverage. Borzi Decl. ¶ 20. The employer's group health plan coverage remains completely separate from the TPA-provided contraceptive coverage. *Id*. ¶ 19.

Notably, the manner in which the accommodation functions "is typical of religious objection accommodations that shift responsibility to non-objecting entities only after an objector declines to perform a task on religious grounds." *Little Sisters of the Poor*, 794 F.3d at 1183. Quite often, "an affirmative opt out" is required "before another person is required to step in and assume responsibility." *Id*. at n.31 (comparing Utah laws that allow county clerks to opt out of issuing same sex marriage licenses but ensuring that another clerk is able and willing to step in, and pharmacies being allowed to opt out of providing contraceptives so long as they refer patients to other providers, among other examples). The accommodation is consistent with such practices.

Sisters urge this Court to reach a different conclusion based on purported concessions made by the federal defendants in *Zubik* that for self-insured plans, the accommodation uses the employer's health plan. Sisters Opp'n at 27-28. But the federal defendants in *Zubik* squarely rejected the notion that the separate contraceptive coverage was part of the "same plan" or used employers' "plan infrastructure." For example, the federal government stated that "[i]n all cases, the regulations mandate strict separation between the contraceptive coverage provided by an insurer or TPA and other coverage provided on behalf of the employer." *Zubik* Resp. Br., 2016 WL 537623, at *18. Separate payments for that contraceptive coverage "occur entirely outside the employers' plans." *Zubik* Resp. Supplemental Reply Br., 2016 WL 1593410, at *2. "Nor does the government, in fact, provide contraceptive coverage using any 'plan infrastructure' belonging to petitioners." *Zubik* Resp. Br., 2016 WL 537623, at *38. The government acknowledged that if an objecting employer has a self-insured plan subject to ERISA, "the [Defendants'] authority to require the TPA to provide contraceptive coverage derives from

ERISA," and thus "the coverage provided by the TPA is, as a formal ERISA matter, part of the same plan as the coverage provided by the employer." *Id*. But the fact that ERISA provides the legal authority for the government to require the TPA to provide separate contraceptive coverage does not mean that the separate contraceptive coverage is part of the *employer's* group health plan coverage—it is not.[14] *Id.*; *see also* Borzi Decl. ¶ 20; Volk Decl. Ex. 1 (information sent to plan participant that "contraceptive benefits are paid for" by the TPA), Ex. 2 ("Contraceptives Card" provided to plan participant noting that the TPA "will provide separate payments for [] contraceptive services").

Moreover, an "ERISA plan is not a tangible thing. It is simply a set of rules that defines the rights of a beneficiary." Borzi Decl. ¶ 21. In any event, as Defendants previously argued, objecting entities "could avoid any objectionable features of the regulations applicable to such plans by switching to insured plans." *Zubik* Resp. Br., 2016 WL 537623, at *39 n.16. Neither Defendants nor objecting entities have "suggested that the alternative of switching to an insured plan would constitute a substantial burden." *Id*.

**2. The Accommodation Furthers a Compelling Government Interest in Providing Women with Full and Equal Access to Preventive Care**

If the Court reaches the question whether the accommodation furthers a compelling government interest—the second prong in the RFRA analysis—it should conclude that it does because maintaining women's seamless access to contraceptives is a compelling government interest. As discussed previously, the text, structure, purpose, and legislative history of the Women's Health Amendment demonstrate that Congress viewed women's full and equal access to preventive healthcare—including contraceptive services—as a compelling government interest. *See supra* at 8-13. A majority of Justices on the Supreme Court have endorsed this conclusion, which was also the position of the federal government until recently. *See Hobby Lobby*, 573 U.S.

[14] Solicitor General Verilli's "one fair understanding" comment at oral argument—responding to an ambiguous question about "one insurance package"—does not fatally undermine these statements either. During the same oral argument, General Verrilli also said that separate contraceptive coverage "isn't through that [employer] plan. It's in parallel to that plan." *See* Oral Arg., at 66:16-21, https://www.supremecourt.gov/oral_arguments/argument_transcripts/2015/14-1418_j4ek.pdf; *see also id.* at 77:2-12.

at 761 (Ginsburg, J., dissenting); *id*. at 739 (Kennedy, J., concurring); *see also Priests for Life*, 808 F.3d at 15 (Kavanaugh, J., dissenting from the denial of rehearing en banc) ("*Hobby Lobby* strongly suggests that the Government has a compelling interest in facilitating access to contraception for the employees of these religious organizations."); *Zubik* Resp. Br., 2016 WL 537623 at *58 ("Contraceptive coverage also furthers the compelling interest in ensuring that women have *equal* health coverage."); *see also* 78 Fed. Reg. at 39887 (the contraceptive coverage requirement furthers the government's compelling interest "in safeguarding public health by expanding access to and utilization of recommended preventive services for women" and "assuring that women have equal access to health care services"). Several courts of appeals have correctly reached the same conclusion. *See Univ. of Notre Dame v. Burwell*, 786 F.3d 606, 624 (7th Cir. 2015), *vacated*, 136 S. Ct. 2007 (2016); *Eternal Word*, 818 F.3d at 1151; *Priests for Life*, 772 F.3d at 257-267.

**a. The compelling interest in full and equal access to contraception applies with equal force to the female employees of organizations holding religious beliefs**

Defendants seek to reframe the interest at stake, by asserting that there is "no compelling government interest in forcing employers with religious objections to provide contraceptive coverage." Defs. Opp'n at 25. As discussed previously, the accommodation expressly *excludes* objecting employers from the provision of contraceptive coverage. But setting aside Defendants' factually erroneous premise, the compelling interest in ensuring access to contraception applies with equal force to the female employees of organizations holding religious beliefs. The Eleventh Circuit found that applying the accommodation to the religious employers in that case furthered the government's compelling interest because "the accommodation ensures that the plaintiffs' female plan participants and beneficiaries—who may or may not share the same religious beliefs as their employer—have access to contraception without cost sharing or additional administrative burdens as the ACA requires." *Eternal Word*, 818 F.3d at 1155. As the Court noted, "poor health outcomes related to unintended or poorly timed pregnancies apply to the plaintiffs' female plan participants or beneficiaries and their children just as they do to the general population." *Id.*; *see also Kaemmerling v. Lappin*, 553 F.3d 669, 683 (D.C. Cir. 2008) (the compelling interests served

by the DNA Act were not diminished when applied to first time, non-violent felons such as the plaintiff). In other words, none of the important benefits associated with access to contraceptives are diminished by the status of the *employer* for whom female employees (and female dependents of male employees) happen to work.

Preventing gender discrimination independently qualifies as a compelling government interest as well. *See Roberts v. United States Jaycees*, 468 U.S. 609, 626 (1984) ("Assuring women equal access to such goods, privileges, and advantages clearly furthers compelling state interests."). Defendants concede that up to 126,400 women will lose contraceptive coverage under the Religious Exemption Rule. 83 Fed. Reg. at 57551 n.26, 57578. Those women will be forced to pay out of pocket for preventive care like contraception, or seek less costly, less effective alternatives due to high costs. Ex. 57 (D10 00207393-00207404). Congress sought to remedy that longstanding inequity when it passed the Women's Health Amendment. *See, e.g.*, States' Mot. at 19. Remediating such longstanding and deeply entrenched gender discrimination and preventing it from reoccurring are compelling interests in their own right that applies with equal force.

Defendants and Sisters further argue that there is no compelling government interest in providing "seamless" contraceptive coverage. Defs. Opp'n at 26; Sisters Opp'n at 29. But they offer no alternative that would further the interests at stake "equally well." *Hobby Lobby*, 573 U.S. at 731. There is no dispute that the Religious Exemption Rule will cause—at a minimum—tens of thousands of women to lose their existing coverage. Even assuming that they qualify to receive contraceptive coverage elsewhere, those women would need to "take steps to learn about, and to sign up for, a new health benefit." *Eternal Word*, 818 F.3d at 1160. That would reimpose the very barriers to contraceptive access that Congress sought to eradicate, and would be less effective at preventing the harms that Congress sought to remedy. *See*, *e.g.*, States' Mot. at 4. "Seamlessness" is therefore an integral part of furthering Congress's goal of ensuring that women have broad and comprehensive access to affordable contraceptives. As Defendants concluded, every added burden or barrier increases the likelihood that some women will experience an unintended pregnancy, which in turn increases the health risks to those women and their children.

*Zubik* Resp. Br., 2016 WL 537623, at *57. There is a compelling interest in maintaining contraceptive access for tens of millions of women at risk of experiencing an unintended pregnancy in the most effective way possible. *See* 83 Fed. Reg. at 57579 (estimating that in 2017, "49 million women under 65 years of age received primary health insurance coverage from private sector, third party employment-based, non-grandfathered plans.").[15]

**b. The exceptions to the contraceptive mandate do not undermine the compelling interest at stake**

Defendants and Intervenors also claim that because there are exceptions to the contraceptive mandate (for houses of worship and grandfathered plans), the interest at stake cannot be "compelling." Defs. Opp'n at 26; Sisters Opp'n at 29. But as discussed previously, those exceptions are narrowly drawn (the "church" exemption) or were transitional measures (grandfathered plans) designed to ease the transition to ACA-compliant plans. States' Mot. at 28-29. Moreover, nearly all laws contain exceptions, including the tax code, the draft, and Title VII prohibitions on employment discrimination. *Zubik* Resp. Br., 2016 WL 537623, at *27. Yet there is little dispute that these laws further compelling interests. Defendants provide no authority for the notion that any exceptions to a generally applicable law necessarily doom any claim that the underlying interest is compelling. The exceptions to the mandate do not undermine the compelling interest that those requirements further.

Defendants also argue that there cannot be a compelling interest where the government "has not asserted such an interest." Defs. Opp'n at 27. As a preliminary matter, Defendants overlook the fact that until recently, their formal position was that the accommodation "furthers a compelling interest in securing for women the full and equal health coverage the Affordable Care

[15] As explained herein at 31-32, RFRA requires that the compelling interest test be "satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened." *Hobby Lobby*, 573 U.S. at 726. Instead of the case-by-case adjudication that RFRA contemplates, the Rule allows any employer to self-exempt without the Government's knowledge, and without any individualized consideration of what that employer's religious beliefs are, whether they are sincerely held, whether they are substantially burdened by utilizing the accommodation, and whether there is a compelling interest in applying the accommodation to that specific employer. The Court cannot even assess whether there is a compelling interest in exempting a particular employer from complying with the accommodation because the Religious Exemption Rule automatically exempts nearly any employer who wishes to be exempt.

Act provides. . . ." *Zubik* Resp. Br., 2016 WL 537623, at *54-55. In any event, the Women's Health Amendment was adopted by Congress—not the federal agencies before this Court. It is the statutory text and Congress's stated aims that form the basis for determining whether the contraceptive mandate serves a compelling government interest. *See, e.g.*, *Priests for Life*, 772 F.3d at 263 ("When Congress added the Women's Health Amendment to the ACA, which requires group health plans to include preventive healthcare services for women without cost sharing, it did so precisely to end 'the punitive practices of the private insurance companies in their gender discrimination'" (citing 155 Cong. Rec. 28,842 (Dec. 1, 2009) (Sen. Mikulski)). This Court should determine the compelling interest question by looking to the text, structure, purpose, and legislative history behind the Women's Health Amendment. The recently-adopted litigation position of Defendants should have no bearing on that analysis.

**c. Courts must take third party harm into account when considering exemptions under RFRA**

Defendants claim that this Court can ignore the third-party harm that will occur if the Religious Exemption Rule goes into effect. Defs. Opp'n at 28 ("RFRA contains no separate limitation on avoiding exemptions that may affect third parties."). That is incorrect as a matter of law; even the Little Sisters acknowledge that "[p]er *Hobby Lobby*, the burdens on third parties are properly considered under the compelling interest test. . . ." Sisters Opp'n at 31. *Hobby Lobby* directly refutes the notion that third party harm is irrelevant under RFRA. The Court explained that "[i]t is *certainly true* that in applying RFRA, 'courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.'" *Hobby Lobby*, 573 U.S. at 730 n.37) (emphasis added). The Court also emphasized that "we *certainly* do not hold or suggest that 'RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on . . . thousands of women employed by Hobby Lobby.'" *Id.* at 693 (emphasis added).

Defendants suggest that because the Court in *Hobby Lobby* was relying on cases that pre-date RFRA, this part of the Court's opinion has less force. Defs. Opp'n at 28 n.12 (citing *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703 (1985)). But that merely underscores the Supreme

Court's consistent practice of evaluating third-party harm over decades of Free Exercise, Establishment Clause, *and* RFRA jurisprudence. The Court has traditionally ruled in favor of religious adherents when the effects of the religious accommodation on third parties (if any) were limited and borne by the government or society as a whole. *See, e.g.*, *Sherbert v. Verner*, 374 U.S. 398, 400 (1963) (holding that South Carolina could not deny unemployment benefits to a claimant who was discharged for refusing to work on the Sabbath); *Yoder*, 406 U.S. at 231, 234 (Wisconsin could not compel Amish parents to comply with the compulsory school-attendance law when the parents and children wished to be exempt in accordance with their religious beliefs). As noted, Congress enacted RFRA "to restore the compelling interest test established" in *Sherbert* and *Yoder*. 42 U.S.C. § 2000bb.

Conversely, the Court has rejected religious accommodations or exemptions when discrete groups of citizens are singled out to bear the costs of another's religious exercise. For example, the Court rejected religious claims that would "impose the employer's religious faith on the employees." *Lee*, 455 U.S. at 261 (refusing to exempt Amish employer and his employees from social security taxes). The Court similarly invalidated accommodations which "would require the imposition of significant burdens on other employees." *Caldor,* 472 U.S. at 710 (invalidating Connecticut statute which gave Sabbath observers an absolute and unqualified right not to work on their chosen day of Sabbath). In a similar vein, the Court struck down a Texas statute exempting only religious periodicals from sales and use taxes (in part) because it "burdens nonbeneficiaries markedly" (i.e., non-religious periodicals). *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 15 (1989) (plurality op.). In all of these instances, third parties would carry the burden of another's religious exercise, and that fact played an important role in the ultimate outcome.

Here, the Religious Exemption Rule requires no less than tens of thousands of women to lose contraceptive coverage because of their employers' religious views about contraceptives. That heavy impact on third parties sets this case apart from both traditional Free Exercise Clause cases and every other contraceptive mandate case that has come before the Supreme Court. The common thread in *Hobby Lobby*, *Wheaton College*, and *Zubik* was the Supreme Court's insistence that no woman would lose access to the full range of FDA-approved contraceptives

because of the accommodation—a result that is no longer the case under the Religious Exemption Rule. *See Hobby Lobby*, 573 U.S. at 693 ("under that accommodation, these women would still be entitled to all FDA-approved contraceptives without cost sharing"); *Wheaton Coll. v. Burwell*, 134 S. Ct. 2806, 2807 (2014) ("Nothing in this interim order affects the ability of the applicant's employees and students to obtain, without cost, the full range of FDA approved contraceptives"); *Zubik*, 136 S. Ct. at 1560-61 ("Nothing in this opinion . . . is to affect the ability of the Government to ensure that women covered by petitioners' health plans 'obtain, without cost, the full range of FDA approved contraceptives.'").

**3. The Accommodation Is the Least Restrictive Means of Furthering the Government's Compelling Government Interest**

As a final matter, the accommodation meets the "least restrictive means" prong of RFRA because there is no other alternative means of providing full and equal access to healthcare that would work "equally well." *Hobby Lobby*, 573 U.S. at 731; *see also Sherbert*, 374 U.S. at 409 (rejecting alternatives that would be "unworkable"); *Kaemmerling,* 553 F.3d at 684 (rejecting alternative methods of identification that would be "less effective"). In fact, as Defendants admit, they could not develop another approach that would ensure women affected by the rules received full and equal healthcare coverage. 83 Fed. Reg. 57592, 57604 (Nov. 15, 2018); *see also* States' Mot. at 14, 31-32.

Defendants do not respond to any of these arguments. Instead, they claim that because the contraceptive mandate does not further a compelling government interest, "the least-restrictive-means analysis is not relevant." Defs. Opp'n at 32 n.14. Defendants have thus waived any argument that the accommodation is *not* the least restrictive means of furthering the compelling interests at stake, including their suggestion that women take additional steps—outside of their employer-sponsored coverage—and seek out contraceptive coverage through the federal Title X family planning clinics. 83 Fed. Reg. at 57548, 57551; 83 Fed. Reg. at 57605, 57608. The Intervenors essentially concede that Title X, a safety-net program designed for low-income patients, is not "a perfect substitute," but argue that *any* available alternative is sufficient to demonstrate that the mandate and accommodation are not the least restrictive means of ensuring

access to contraceptives. Sisters Opp'n at 31.[16] But the standard is whether an alternative serves the "stated interests equally well." *Hobby Lobby*, 573 U.S. at 731; *see also Eternal Word*, 818 F.3d at 1158-60 (evaluating several contraceptive coverage proposals and concluding that "these proposals are not less restrictive alternatives because they would not serve the government's interests 'equally well.'").

In sum, the Religious Exemption Rule is not required by RFRA.

### C. The Religious Exemption Rule Is Not Permitted by RFRA

Defendants assert that even if the Religious Exemption Rule is not required under RFRA, RFRA permits the agencies to promulgate the Rule. This broad interpretation of RFRA suffers from several fatal defects, including that (1) it is contrary to the plain language of RFRA, (2) it would violate the nondelegation doctrine, and (3) it would allow the agencies to pick religious winners and losers. To the extent RFRA grants agencies some authority, that authority must be cabined to only those situations where authorized to do so by RFRA, namely where there is a "substantial burden." And that authority is further limited by Defendants' obligation to abide by and harmonize with other statutes and to obey the limitations imposed by the Establishment Clause.

#### 1. RFRA Does Not Give Agencies Unchecked Leeway to Create Exemptions to Statutory Mandates

Defendants claim that under RFRA all federal agencies have unlimited authority and unchecked "leeway" to craft any religious exemptions to any Congressional mandate, without

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[16] As the record demonstrates, the Title X program is ill-equipped to replicate or replace the seamless contraceptive-coverage requirement. *See* States' Mot. at 14 (citing Ex. 57 (D10 00207405-08), Ex. 44 (D10 00207048-49), Ex. 44 (D10 00207048) ("[A] recent study published in the American Journal of Public Health confirms that reductions in funding for Title X limit the number of patients Title X-funded providers are able to serve, concluding that Congress would have to increase federal funding for Title X by over $450 million to adequately address the existing need for publicly funded family planning services."), Ex. 28 (D10 00195115-18), Ex. 30 (D10 00195141-42), Ex. 64 (D10 00208990-94), Ex. 60 (D10 00207662-66), Ex. 55 (D10 00207247-52), Ex. 57 (D10 00207405-06) ("With its current resources, Title X is only able to serve one-fifth of the nationwide need for publicly funded contraceptive care."), Ex. 82 (D12 00651932-33) (Congressional leaders noting current efforts to undermine and dismantle Title X), Ex. 57 (D10 00207347), Ex. 74 (D11 00373535-39)).

regard to the third party harms that might result, without regard to the purpose of the underlying statute, and with limited judicial oversight. Such an interpretation of RFRA fails for several reasons.

First, RFRA itself contemplates individualized exemptions that would require a legal determination as to whether the government-imposed action is a substantial burden on the individual claimant. 42 U.S.C. § 2000bb-1(a) (discussing "a person's exercise of religion"); *Id*. at (b) (same); *Id*. at (c) (providing judicial relief for "a person"). Congress expressly provided that the "purpose of this chapter" is to (1) "restore the compelling interest test as set forth in *Sherbert v. Verner*, 374 U.S. 398 (1963) and *Wisconsin v. Yoder*, 406 U.S. 205 (1972) and to guarantee its application in all cases where free exercise *is substantially burdened*," and (2) "to provide a claim or defense to persons whose religious exercise *is substantially burdened*." 42 U.S.C. § 2000bb; *Molzof v. United States*, 502 U.S. 301, 307 (2012) (when Congress employs a term of art, "'it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken'"); *Sekhar v. United States*, 570 U.S. 729, 733 (2013) ("'if a word is obviously transplanted from another legal source, whether the common law or other legislation, it brings the old soil with it'"). These "cardinal rule[s] of statutory construction" apply with even more force here where Congress cited two Supreme Court cases and explained its legal purpose in enacting RFRA. *Molzof*, 502 U.S. at 301. And, under that established precedent, to determine whether there has been a substantial burden necessarily requires an individualized, legal determination as to whether that person holds a sincerely held religious belief and whether the government's action constitutes a "substantial burden."

Nothing in the plain language of the statute suggests that Congress granted federal agencies the sweeping authority that they now claim to have under RFRA. To the contrary, Congress expressly provided the purpose of RFRA and while it includes judicial relief to individuals—it does not grant any further relief to a person aggrieved or additional, separate authority to the agencies. 42 U.S.C. § 2000bb. Tellingly, Defendants cite no authority that supports their expansive exclusionary interpretation.

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Defendants contend that the States' interpretation of RFRA will force agencies to "await a lawsuit." Defs. Opp'n at 29. This argument is a red herring, unsupported by evidentiary support. "In construing the provisions of a statute, [the court] first analyze[s] its language to determine whether its meaning is plain." *In re HP Inkjet Printer Litigation*, 716 F.3d 1173, 1180 (9th Cir. 2013). The inquiry "begins with the statutory text, and ends there as well if the text is unambiguous." *Id*. Here, the plain language of RFRA requires a determination as to whether a government action constitutes a "substantial burden," which, as explained, is a legal determination for the courts. If there is a substantial burden, the government must "demonstrate,"—which is defined as "meet[ing] the burdens of going forward with the evidence and of persuasion" (§§ 2000bb-2(3))—its action is in furtherance of a compelling government interest and is the least restrictive means. Finally, RFRA provides a specific form of relief for a person who believes that the government violated this statute: judicial relief. §§ 2000bb-1, 2. This overwhelming textual evidence shows that, far from granting Defendants the unconstrained authority that they seek, RFRA simply, "restore[s] the compelling interest test" and "provide[s] a claim or defense to a person." § 2000bb(b). Defendants may find it cumbersome to undertake an individualized analysis, but it is not for the Court to rewrite RFRA's stated purpose or expressly provided form of relief. *Puerto Rico v. Franklin California TaxFree Trust*, 136 S. Ct. 1938, 1949 (2016) ("[O]ur constitutional structure does not permit this Court to 'rewrite the statutes that Congress has enacted,'" even if that means that the aggrieved parties "have to wait for possible congressional action to avert the consequences").[17]

Second, Defendants' argument that RFRA permits the agencies to promulgate broad exemptions to any statute runs afoul of the nondelegation doctrine. Legislative power is vested in

[17] Furthermore, Defendants fail to show that Congress "intended to delegate … decision[s]" of far-reaching "economic and political significance to an agency" in a "cryptic … fashion." *Brown & Williamson*, 529 U.S. at 160 (Congress did not implicitly delegate to the FDA authority to regulate tobacco, "an industry constituting a significant portion of the American economy"); *see also, e.g., Whitman*, 531 U.S. at 468 (Congress did not implicitly give EPA authority to consider costs in setting air-quality standards, which "are the engine that drives nearly all of Title I of the [Clean Air Act]"); *Gonzales v. Oregon*, 546 U.S. 243, 267 (2006) (Congress did not implicitly give the Attorney General "broad and unusual" authority to determine whether physician-assisted suicide is a "legitimate medical purpose" for a drug prescription).

Congress, and that authority may not be delegated to another branch or entity with "unfettered discretion to make whatever laws" it sees fit. *A.L.A. Scherer Poultry Corp. v. United States*, 295 U.S. 495, 537-38 (1935); *Mistretta v. United States*, 488 U.S. 361, 371-72 (1989) ("'Congress generally cannot delegate its legislative power to another Branch.'"); *see also* States' Mot. at 20. This is so because "[i]n the framework of our Constitution, the President's power to see that the laws are faithfully executed refutes the idea that he is to be a lawmaker." *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 587 (1952); *Mistretta*, 488 U.S. at 371 (nondelegation doctrine is "rooted in the principle of separation of powers" (citing U.S. Const., Art. 1, § 1)). Therefore, agencies may only act to the extent Congress has articulated an "intelligible principle" to which the agencies are "directed to conform." *J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 409 (1928). To demonstrate that they are acting within their authority, agencies must demonstrate, among other things, that Congress "clearly delineate[d] the general policy" they are acting under "and the boundaries of this [asserted] delegated authority." *Mistretta*, 488 U.S. at 372-73; *Loving v. United States*, 517 U.S. 748, 772 (1996).

Here, Defendants' argument is that under RFRA they have open-ended discretion to waive otherwise applicable laws and that they can utilize this discretion with "leeway" such that it is essentially unreviewable by the Court. Defs. Opp'n at 28-31. Stated differently, Defendants claim that under RFRA (1) the agencies can determine whether a federal statute imposes a "substantial burden;" (2) if they so conclude, they can grant a broad exemption to that statute; (3) without regard to third party harm; (4) without requiring notification to either the government or the affected third parties; and, (5) when agencies do grant broad exemptions, the Court must give them "leeway" and only reverse their action in the narrow circumstance where the action is "arbitrary and capricious." This interpretation would convert RFRA into the most far-reaching delegation of legislative authority, doing great harm to the separation of powers principles that undergird the American system of government and violate the nondelegation doctrine. *See Panama Ref. Co. v. Ryan*, 293 U.S. 388 (1935) (unlimited delegation to President to prohibit interstate and foreign commerce in petroleum, with no requirement for factual findings or conditions for prohibition violated nondelegation doctrine); *Cf. Whitman*, 531 U.S. at 473 (no

violation of the nondelegation doctrine because Congress set concrete limits on the EPA's discretion, providing the requisite "intelligible principles" to guide agency action); *Gundy v. United States*, 2019 WL 2527473, at *4 (U.S. June 20, 2019). As discussed below, this interpretation would also have far-reaching consequences beyond this case.[18]

Third, adopting Defendants' theory will mean that federal agencies will have the ability to pick and choose religious winners and losers. They alone will select which religious exemptions to laws of general applicability that they want to grant—without consequence and with limited judicial review—thereby allowing the government to recognize some religious objections, while ignoring others. *Clark v. Martinez*, 543 U.S. 371, 380-81 (2005) (court should not adopt a statutory construction that would "raise a multitude of constitutional problems"). For example, in the healthcare context alone, Americans across the country have sincerely held religious beliefs and moral objections to several modern medical services and practices. *See, e.g., Robinson v. Children's Hospital Boston*, 2016 WL 1337255 (D. Mass. Apr. 5, 2016) (religious objections to influenza vaccination).[19] This Court should not accept Defendants' invitation to construe RFRA so broadly as to allow the executive to make unchecked decisions about which religions to prefer.[20]

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[18] Moreover, Congress did not delegate to Defendants the right to solely determine whether the government substantially burdens a person's exercise of religion. *Gundy*, 2019 WL 2527473, at *4 (explaining the "nondelegation inquiry always begins (and often almost always ends) with statutory interpretation," including evaluation of the "context, purpose, and history"). As noted, RFRA states that it seeks to restore the compelling interest test, as set forth in *Sherbert* and *Yoder*. 42 U.S.C. § 2000bb. In both of these cases, determination of whether a government action was a substantial burden was a *question of law*. *Sherbert*, 374 U.S. at 403; *Yoder*, 406 U.S. at 218.

[19] *See, e.g.*, *Haines v. N.H. Dep't of Health & Human Servs.*, 2009 WL 1307203 (D.N.H. Apr. 28, 2009) (religious objections to mental health screening); *Children's Healthcare Is a Legal Duty, Inc. v. Min De Parle*, 212 F.3d 1084, 1088 (8th Cir. 2000) (Christian Scientists and other religious groups object to all medical care and consider religion to be the "sole means of healing").

[20] To be clear, the States do not challenge RFRA. Rather, the States challenge Defendants' interpretation of RFRA to justify the broad Religious Exemption Rule at issue in this case. *See I.N.S. v. St. Cyr*, 533 U.S. 289, 299-300 (2001) ("if an otherwise acceptable construction of a statute would raise serious constitutional problems, and where an alternative interpretation of the statute is 'fairly possible,' . . . we are obligated to construe the statue to avoid such problems"); *Kent v. Dulles*, 357 U.S. 116, 130 (1958) (absent explicit terms, the Court will assume that Congress did not intend to raise constitutional questions).

**2. To the Extent that RFRA Grants Agencies Some Authority, That Authority May Only Be Invoked Where Required Under the "Substantial Burden" Framework And Still Subject to Separate Limitations**

The Exemption Rules exceed the scope of RFRA because the exemptions are not required by RFRA. *See supra* at 15-30. In addition, any exemptions created to comply with RFRA must necessarily be limited by Defendants' obligation to abide by other statutes, including the Women's Health Amendment and Sections 1554 and 1557 of the ACA and limitations imposed by the Establishment Clause. The Exemption Rules fail both of these tests as well.

RFRA itself has limitations. Principally, and as Defendants admit, RFRA is only implicated when there is a "substantial burden" on a person's religious exercise. Defs. Opp'n at 29; 42 U.S.C. § 2000bb(a), (b)(2); *Id*. § 2000bb-1. As this Court and eight courts of appeal have concluded, the accommodation does not impose a substantial burden. *California*, 351 F. Supp. 3d at 1287-88. Further, even if it did, "RFRA does not permit religious exercise to unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling." *Priests for Life*, 772 F.3d at 266; *see also Priests for Life*, 808 F.3d at 26 (Kavanaugh, J.) ("The government may of course continue to require religious organizations' insurers to provide contraceptive coverage to the religious organizations' employers, even if the religious organizations object.").

Defendants' reliance on *Ricci* is equally unavailing. Defs. Opp'n at 31; *Ricci v. DeStefano*, 557 U.S. 557, 582 (2009). As this Court previously concluded, *Ricci* "does not shed light on whether the federal agency has plenary discretion under RFRA to grant any exemption it chooses for laws passed by Congress, including broad exemptions that provide no notice and harms third parties." *California*, 351 F. Supp. 3d at 1293. Indeed, even if this Court were to adopt the *Ricci* standard, which requires the government to show both good faith and "a strong basis in evidence" of statutory liability, Defendants do not even attempt to demonstrate that they have met this standard. *Ricci*, 557 U.S. at 585; *id*. at 582 (agency must act with "extraordinary care"). Nor could they given the numerous courts of appeals that ruled to the contrary on the substantial burden inquiry and given that the Supreme Court itself instructed Defendants to craft a solution

that ensured women receive "full and equal" healthcare coverage. *Zubik*, 136 S. Ct. at 1559-60. Defendants have not provided a "strong basis in evidence" of liability, and have provided no authority that allows them to disregard the Supreme Court's instruction that Defendants ensure that their actions not result in third party harms. *See also Hobby Lobby*, 573 U.S. at 693 ("[W]e certainly do not hold or suggest that RFRA demands accommodation for a for-profit corporation's religious beliefs no matter the impact that accommodation may have on . . . thousands of women").

And, the Supreme Court has repeatedly emphasized that it is ultimately the *courts'* obligation to consider whether religious exemptions are required under RFRA. *See Gonzales v. O Centro*, 546 U.S. 418, 434 (2006) (explaining that "it is the obligation of the courts to consider whether exceptions are required"); *Holt*, 135 S. Ct. at 864 (to the extent that the Court respects agencies' expertise, for instance in running prisons, that "respect does not justify the abdication, conferred by Congress" to determine whether a RFRA exemption is warranted). And, Defendants confirm that they are not "entitled to deference in interpreting RFRA." Defs. Opp'n at 31 n.13.

To be sure, the States' position is not that this Court need come up with a bright-line test for agencies' invocation of RFRA. Rather, the States assert, and the record shows, that the Religious Exemption Rule exceeds the limits of what is lawful, given the Congressional command of the Women's Health Amendment and Sections 1554 and 1557, the requirement that agencies harmonize statutes (to the extent that they conflict), and the harm that these Rules impose on third parties—third parties that the underlying statute itself was designed to aid. *See, e.g., Hosanna-Tabor v. EEOC*, 565 U.S. 171, 190-191 (2012) (declining "to adopt a rigid formula for deciding when an employee qualifies as a minister" under Title VII exemption, and instead concluding that "[i]t is enough" that in the case before the Court, "given all the circumstances," the exception applied). On this record, Defendants' attempt to use any permissive authority under RFRA must fail.

Second, as detailed here, the Women's Health Amendment and Sections 1554 and 1557 place certain mandates on Defendants. *See infra* at 7-14, 39-43. Defendants are not free to disregard the will of Congress expressed in these statutes. *See Texas v. U.S.,* 809 F.3d 134, 183

n.191 (5th Cir. 2015) (concluding that agency had no "leeway" to implement Deferred Action for Parents of American and Lawful Permanent Residents program because "it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'"). Rather, to the extent there is a conflict (which there is not, as noted above) the agencies are obligated to harmonize the statutes. *Watt v. Alaska*, 451 U.S. 259, 267 (1981) ("We must read the statutes to give effect to each if we can do so while preserving their sense and purpose."). Strikingly, Defendants fail to respond to the States' argument that the agencies must harmonize statutes. States' Mot. at 34. Instead, they argue that because "RFRA does not prescribe the precise remedy," the agencies have free rein, absent a judicial determination that their exercise of that purported authority is "arbitrary and capricious," to craft any remedy they want. Defs. Opp'n at 29-31. This argument is incompatible with the requirement that statutes must be harmonized. *Citizens to Save Spencer Cnty. v. U.S. EPA*, 600 F.2d 844, 871 (D.C. Cir. 1979) (explaining that if there are conflicting statutes the agency must seek to "pursue a middle course that vitiates neither provision but implements to the fullest extent possible the directives of each, and it is the task of a reviewing court to ensure that the agency has effected an appropriate harmonization of the conflicting provisions while remaining within the bounds of that agency's statutory authority"). The accommodation that predated the Exemption Rules is the answer to harmonizing any purported conflict because it is consistent with the "underlying goals and purposes of the legislature in enacting" the Women's Health Amendment and RFRA, "avoid[s] unnecessary hardship or surprise on affected parties" (i.e. women who are entitled statutory benefits and religious objectors who are no longer substantially burdened), and "remain[s] within the general statutory bounds prescribed." *Id*.[21]

[21] And to the extent that there is an irreconcilable conflict, the maxim of statutory construction that a more recent specific statute prevails over an earlier and more general statute would apply. *Security Pacific Nat. Bank v. Resolution Trust Corp.*, 63 F.3d 900, 904 (9th Cir. 1995) (explaining that "[g]enerally a more specific provision of an enactment prevails, in the sense of making an exception to, a more general provision"). Here, the later-enacted and more specific Women's Health Amendment would prevail over the older and more general RFRA statute.

Third, to the extent Defendants have exemption-making authority under RFRA, their actions are still limited by the Establishment Clause, including the numerous Supreme Court cases holding unconstitutional religious accommodations that harm third parties. 42 U.S.C. § 2000bb-4; *see infra* at 27-29. In *Texas Monthly*, Texas defended its sales tax exemption for religious periodicals by arguing that there is play in the joints among the Religion Clauses. 489 U.S. at 17-21. Texas further asserted that it feared violating the Free Exercise Clause and the litigation that would ensue as a result, absent the sales tax exemption. *Id*. Despite these arguments, the Court still struck down Texas's religious exemption, in part, because of the burdens the law imposed on nonbeneficiaries. *Id.* at 15 & 18 n.8; *Lee v. Weisman*, 505 U.S. 577, 587 (1992); *Bd. of Educ. of Kiryas Joel Vill. Sch. Dist. v. Grumet*, 512 U.S. 687, 706 (1994) (Religious "accommodation is not a principle without limits."). As the Supreme Court has thus recognized, whatever play in the joints there is between the Free Exercise Clause and the Establishment Clause, it does not authorize third-party harm.

**D. The Moral Exemption Rule Is Not Required or Permitted by Any Law**

Aside from the Women's Health Amendment, the Defendants offer no authority for implementing the broad Moral Exemption Rule. *See* Defs. Opp'n at 21. For the reasons set forth above, the Women's Health Amendment does not authorize Defendants to carve out broad exceptions to the mandate. Without citation to authority, Defendants again assert that because *Congress* enacted a statutory exemption to the ACA, Congress also silently authorized Defendants to fashion whatever broad exemptions they might choose, to any and all ACA statutory mandates. *Id*. This theory holds no water. As the Ninth Circuit has held, "'[w]hen Congress provides exceptions in a statute . . . [t]he proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited that statute to the ones set forth.'" *United States v. Valdez*, 911 F.3d 960, 966 (9th Cir. 2018); *Silvers v. Sony Pictures Entm't, Inc.*, 402 F.3d 881, 885 (9th Cir. 2005) (en banc) ("The doctrine of *expressio unius est exclusio alterius* 'as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.'").

### E. The Exemption Rules Violate Section 1554 By Creating Unreasonable Barriers to Care and Impeding Timely Access to Healthcare

Congress expressly prohibited HHS from promulgating "any regulation" that "creates any unreasonable barriers" to medical care *or* "impedes timely access to health care services." 42 U.S.C. § 18114(1), (2). The Rules here do just that, by permitting employers to deny women access to healthcare that has been guaranteed to them by statute. As Defendants have previously explained, requiring "women—and only women—to take burdensome steps 'to learn about, and to sign up for, a new government funded and administered health benefit' in order to get coverage for an important aspect of their medical care" "thwart[s] the basic purposes of the Women's Health Amendment, which was enacted to ensure that women receive *equal* health coverage and to remove barriers to use of preventive services." *Zubik* Resp. Br., 2016 WL 537623, at *29 (emphasis in original) (quoting *Hobby Lobby*, 573 U.S. at 732). Defendants do not defend the Rules as permissible under the statute, but instead argue that the statute does not apply. These arguments lack merit.

Defendants argue that Section 1554 claims are "not reviewable under the APA" because the statute is too broad to be enforced. Defs. Opp'n at 20. This argument is without merit. Several courts have applied Section 1554, and none have found it to be too "open-ended" to be enforced. *See, e.g.*, *California v. Azar*, 2019 WL 1877392, at *22-26 (N.D. Cal. 2019) ("[t]here is no question" that HHS's Title X rule violated Section 1554 because, among other things, "it obfuscate[s] and obstruct[s] patients from receiving information and treatment for their pressing medical needs."), *stayed on other grounds pending appeal*, 2019 WL 2529259 (9th Cir. June 20, 2019); *Mayor & City Council of Baltimore v. Azar*, 2019 WL 2298808, at *8-9 (D. Md. May 30, 2019); *Oregon v. Azar*, 2019 WL 1897475, at *12 (D. Or. Apr. 29, 2019), *stayed on other grounds pending appeal*, 2019 WL 2529259 (9th Cir. June 20, 2019); *Washington v. Azar*, 2019 WL 1868362, at *7 (E.D. Wash. Apr. 25, 2019), *stayed on other grounds pending appeal*, 2019 WL 2529259 (9th Cir. June 20, 2019). In the Oregon case, the court explicitly rejected HHS's argument that Section 1554 is too "overbroad" or "open-ended" to be enforced. *Oregon*, 2019 WL 1897475, at *12 ("[s]imply because Congress specifically sought to limit the general scope of

HHS's rulemaking abilities, . . ., does not render the limitations invalid") (citing *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority delegated by Congress")); *see also Dep't of Commerce v. New York*, 2019 WL 2619473, at *10 (U.S. June 27, 2019) (statute that constrained Secretary's authority "in a number of ways" was reviewable). Moreover, Defendants' argument is that this Court should simply render Section 1554 entirely meaningless. *United States v. Thomsen*, 830 F.3d 1049, 1057 (9th Cir. 2016) (court is to make "every effort" not to interpret a statute in a manner that renders the statute "inconsistent" or "meaningless").

Here, there is no doubt that the Rules create unreasonable barriers to and impede timely access to care. As a direct result of these Rules and by Defendants' own admissions, over tens of thousands of women will no longer have access to contraceptive coverage. 83 Fed. Reg. 57551 n.26. Without complete coverage, women will need to pay out-of-pocket for their basic care, unless they secure funding from other sources. Ex. 57 (D10 00207394) (without coverage, contraceptives cost $50 per month or upwards of $600 per year); *id*. (cost of IUD exceeds $1000, which equates to a month's salary for a woman working full time at the federal minimum wage of $7.25 an hour); Ex. 57 (D10 00207315, 00207316-17); Ex. 58 (D10 00207500-02). Women who lose coverage will also need to locate and secure a separate qualified medical provider, which may require transferring medical records or re-providing a complete medical history to a new provider to ensure proper care. Ex. 57 (D10 00207368); Ex. 57 (D10 00207390, 00207401) (explaining the importance of seamless holistic coverage to ensure that women's "chosen provider" can "manage all health conditions and needs at the same time"). Women may also need to switch to a less expensive, less effective, contraceptive method given the cost. Ex. 57 (D10 00207395); Ex. 57 (D10 00207316-17). These numerous steps demonstrate that the Rules undeniably create barriers obstructing women's care because this disruption in continuity of care results in delayed or no access to contraception or an unintended pregnancy. Moreover, Defendants' imposition of these obstacles directly conflicts with Congress's intention to remedy these very problems in the first place. *Zubik* Resp. Br., 2016 WL 537623, at *74-75 (relying on

the Institute of Medicine report and explaining that "the medical evidence prompting the contraceptive coverage requirement showed that even minor obstacles to obtaining contraception led to more unplanned and risk pregnancies, with attendant adverse effects on women and their families"); *Priests for Life*, 772 F.3d at 235; *Hobby Lobby*, 573 U.S. at 737-39 (Kennedy, J., concurring).

These harms to women who lose coverage are not justified by the Rules, particularly where (a) there is no "substantial burden" to religious objectors and (b) they contravene the command of the Supreme Court to ensure "that women covered by [objectors'] health plans receive full and equal health coverage, including contraceptive coverage" *Zubik*, 136 S. Ct. at 1560-61. This unreasonableness of the barriers is compounded by the agencies' failure to respond to the numerous significant concerns raised by commenters and their about-face on central questions such as the safety and efficacy of contraception. *See infra* at 50-51. Specifically, Defendants fail to respond to the overwhelming evidence, including their *own* evidence, which demonstrates that the Rules impose unreasonable barriers and harm women; instead, Defendants contend that the Rules do not "impose affirmative barriers on access to contraception." Defs. Opp'n at 20. But nowhere in Section 1554 does the word "affirmative" appear. Congress specifically directed HHS not impede access to healthcare. Undeniably, these Rules will result in women losing coverage—which even Defendants admit (83 Fed. Reg. at 57551 n.26, 57581)—and as a result, women losing coverage will need to seek out that care from somewhere else, a fact that Defendants also admit and that the Ninth Circuit recognized (*id* at 57548, 57551, 57605, 57608; *California*, 911 F.3d at 572-73). Defendants cannot ignore this statutory command of Congress.

**F. The Exemption Rules Violate the Nondiscrimination Provision of the ACA**

The Rules also violate Section 1557 of the ACA because they permit employers to exclude women from full and equal participation in their employer-sponsored health plan, deny women full and equal healthcare benefits, and license employers to discriminate on the basis of sex. 42 U.S.C. § 18116; 20 U.S.C. § 1681(a). *See Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 950 (W.D. Wisc. 2018) (concluding that government exclusion that expressly singled out and barred medically necessary treatments solely on the basis of individual's natal sex was "text-

book discrimination *based on sex*"); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 995-97 (W.D. Wisc. 2018) (exclusion of treatment from insurance coverage for transgender employees violated ACA anti-discrimination provision).

Defendants wholly fail to respond to this argument. Instead, they erroneously equate their obligations under Section 1557 with an Equal Protection analysis, which is not the same as what the statute requires. Defs. Opp'n at 20. Section 1557 incorporates various nondiscrimination statutes, including Title IX of the Education Amendments of 1972, which prohibits discrimination based upon sex. 42 U.S.C. § 18116 (Section 1557); 20 U.S.C. § 1681. It also incorporates the enforcement mechanisms of various antidiscrimination statutes. *Id*. Consequently, numerous courts have held that Section 1557 provides a claim under the ACA that is separate and distinct from a claim for violation of the Equal Protection Clause. *See Flack*, 328 F. Supp. 3d at 951 ("As plaintiffs have already established substantially more than a negligible likelihood of success on their ACA claim, the court need not address plaintiffs' equal protection claim."); *Boyden*, 341 F. Supp. 3d at 998; *Edmo v. Idaho Dep't of Corr.*, 2018 WL 2745898, at *8 (D. Idaho June 7, 2018); *Audia v. Briar Place, Ltd.*, 2018 WL 1920082, at *3 (N.D. Ill. Apr. 24, 2018); *see also Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 256 (2009). Thus, Defendants must independently refute the claim that the Exemption Rules violate Section 1557—something that they failed to do in their opposition brief, thus waiving any argument. *Ramirez v. City of Buena Park*, 560 F.3d 1012, 1026 (9th Cir. 2009) (claim waived where not addressed in opposition to a motion for summary judgment).

Even if Defendants did not waive their opportunity to respond, it is beyond dispute that employer-provided healthcare plans unlawfully discriminate when they exclude healthcare benefits "used only by women." *See Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1269 (W.D. Wash. 2001) ("In light of the fact that prescription contraceptives are used only by women, [defendant's] choice to exclude that particular benefit from its generally applicable benefit plan is discriminatory."). Employer-sponsored benefits, like health insurance, are part of an employee's wages and benefits for purposes of asserting an anti-discrimination claim. *See Ariz. Governing Comm. For Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1081

(1983) (considering differential treatment on the basis of sex in retirement benefits). "When an employer decides to offer a prescription plan covering everything except a few specifically excluded drugs and devices, it has a legal obligation to make sure that the resulting plan does not discriminate based on sex-based characteristics and that it provides equally comprehensive coverage for both sexes." *Erickson*, 141 F. Supp. 2d at 1269.

Moreover, the preventive service mandate— 42 U.S.C. § 300gg-13—contains five subsections outlining the mandated preventive services, but Defendants have selected only the Women's Health Amendment for exceptions. Despite established religious objections to vaccines, including those held by Christian Scientists, Defendants have not created exemptions to the immunizations mandate (42 U.S.C. § 300gg-13((a)(2)); *See Real Alternatives v. Dep't Health &Human Servs*, 867 F.3d 338, 364 (3d Cir. 2017) (listing a range of medical treatments that some might find objectionable on religious grounds). Nor have they created an exemption for Jews or Muslims who object to coverage for medications derived from pigs. Nor have they created exemptions for Jehovah's Witnesses for health plans that provide coverage for blood transfusions.

Defendants' Rules inflict the very exclusion, denial, and discrimination that Section 1557 prohibits. The Rules single out a healthcare service utilized *exclusively* by women and permit employers to unilaterally exempt themselves from providing that service, with Defendants' stamp of approval. That the Rules on their face broadly permit employers to exempt themselves from abiding by a statutory requirement, thereby denying women full and equal participation in the health plan, is a direct violation of the ACA's nondiscrimination statute.

## III. THE EXEMPTION RULES ARE ARBITRARY AND CAPRICIOUS

The Exemption Rules must be set aside because, as the record demonstrates, Defendants (1) failed to provide a reasoned explanation for their policy reversal, including disregarding record evidence about contraceptives, failing to account for the costs of the Rules, and overlooking congressional intent; (2) failed to provide a reasoned justification for the expansive Exemption Rules; and (3) failed to meaningfully respond to comments. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983) (*State Farm*).

### A. Defendants' Unexplained, Unsupported, and Contradictory Findings Render the Rules Arbitrary and Capricious

As a threshold matter, Defendants do not dispute that there are reliance interests at stake. Defs. Opp'n at 33. As such, they must provide a reasoned and detailed explanation and justification for disregarding facts and circumstances that underlay their prior policy. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2127 (2016); *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). Defendants have not done so.

Defendants dismiss the safety, efficacy, and benefits of contraception, but the record supports their prior policy rationale supporting the contraception mandate. Defs. Opp'n at 36; Ex. 24 (D9 668955-70); Ex. 25 (D9 669089-90); Ex. 17 (D9 571363, 69-70); Ex. 23 (D9 668358-68). The record shows that the benefits of contraceptives are well established. *See* States' Mot. at 39-43. Indeed, Defendants themselves previously recognized that the scientific and medical evidence demonstrates the health and other benefits of contraceptive services, and it is for a woman and her provider to consider benefits and risks in selecting treatment. 78 Fed. Reg. at 39872-73, 39887-88. They further acknowledged that "[r]esearchers have shown that access to contraception improves the social and economic status of women." 77 Fed. Reg. at 8728. "Contraceptive coverage, by reducing the number of unintended and potentially unhealthy pregnancies, furthers the goal of eliminating [ ] disparit[ies] by allowing women to achieve equal status as healthy and productive members of the job force." *Id*. That is, "by providing women broad access to preventive services, including contraceptive services," disparities are reduced. *Id*. While the Department may wish to disregard this evidence and these earlier findings, an agency action is arbitrary and capricious where the agency "offer[s] an explanation" "that runs counter to the evidence before the agency." *State Farm*, 463 U.S. at 43.

Defendants' assertion that it is unclear whether the mandate has increased contraceptive use (Defs. Opp'n at 34), is likewise unsupported by the record. Defendants previously took the position that the coverage mandate has the benefit of decreasing costs for women, which will improve access and use of contraceptives. States' Mot. at 42; *See Hobby Lobby*, 573 U.S. at 727. The Ninth Circuit recognized that as recently as January 2017, Defendants declined to change the

accommodation in light of the harms to women's access to full and equal healthcare coverage, and later, "failed to specify what developments necessitated the agencies to change their position" when they proposed the Interim Final Rules. *California*, 911 F.3d at 577 (describing Defendants' position as an "unexplained about-face," not entitled to deference); Ex. 19 (D9 666661-62). Defendants' Exemption Rules do not cure the deficiencies already identified by the Ninth Circuit. Defendants concede that the Exemption Rules are substantially the same as the IFRs. *See* Defs.' Supplemental Br., 2018 WL 6044850, at *1, 4 (9th Cir. Nov. 2018).

Defendants' assertion that it is not clear that the Exemption Rules will have a significant effect (Defs. Opp'n at 34), conflicts with their own determination that over 100,000 women will be impacted and their prior determination that the coverage requirement is necessary to address healthcare inequities and is beneficial to women, their families, and society as a whole. Defendants' "unexplained conflicting findings . . . violate the APA." *Organized Vill. of Kake v. Dep't of Agric*., 795 F.3d 956, 969 (9th Cir. 2015) (en banc) ("[A]n agency may not simply disregard contrary or inconvenient factual determinations that it made in the past"); *see also Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs*., 545 U.S. 967, 981 (2005) (unexplained inconsistency renders an agency interpretation arbitrary and capricious). Defendants' failure to give the reasoned explanation for their reversal required by the APA renders the Rules arbitrary and capricious.

**1. Defendants Are Not Entitled to Deference**

Defendants invoke agency deference in an attempt to salvage their policy reversal. Defs. Opp'n at 35. But an agency merits no deference when it fails to give a reasoned explanation for its actions. *United Techs. Corp. v. Dep't of Def*., 601 F.3d 557, 562 (D.C. Cir. 2010) ("[W]e do not defer to the agency's conclusory or unsupported suppositions."); *Arrington v. Daniels*, 516 F.3d 1106, 1113 n.5 (9th Cir. 2008) ("Although our review is deferential, the [agency] is not immune from its responsibility to articulate a rational connection between the facts found and the choices made."). "Where the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion, [the court] must undo its action." *County of Los Angeles v. Shalala*, 192 F.3d 1005, 1021 (D.C. Cir. 1999).

Nor is deference warranted because Defendants purportedly applied their "scientific and technical expertise." Defs. Opp'n at 33, 35-36; March Opp'n at 37. The record does not demonstrate that Defendants actually applied any scientific or technical expertise in their conclusions regarding the efficacy and health benefits of contraceptives. Instead, Defendants cited to comments on both sides of the issue and then stated that they "do not take a position on the variety of empirical questions discussed above." 83 Fed. Reg. at 57555.

**2. Defendants Fail to Reasonably Account for the Costs of the Exemption Rules**

The Exemption Rules are also arbitrary and capricious because Defendants failed to consider all the relevant factors when considering the costs of the rules. As a general rule, the costs of an agency's action are "a relevant factor that the agency must consider before deciding whether to act," and is "an essential component of reasoned decisionmaking under the Administrative Procedure Act." *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 732-33 (D.C. Cir. 2016); *see also Michigan v. EPA*, 135 S. Ct. 2699, 2707-08 (2015) ("Agencies have long treated costs as a centrally relevant factor when deciding whether to regulate"). In this case, although Defendants estimate "transfer costs" of $68.9 million (Religious Exemption Rule) and $8,760 (Moral Exemption Rule), Defendants admit that they did not calculate the "related costs [women] may incur for contraceptive coverage or the results associated with any unintended pregnancies." 83 Fed. Reg. at 57574, 57626; *see also* 82 Fed. Reg. at 47823 n.95 (explaining that Defendants' estimate "has a tendency toward underestimation"). Nor do they acknowledge several populations likely to be harmed by the Rules (*see* States' Mot. at 49-51) and the impact on the states' public fiscs. Ex. 57 (D10 00207358), Ex. 57 (D10 00207348-49), Ex. 57 (D10 00207409), Ex. 57 (D10 00207374). Defendants are required to consider these relevant costs as part of a reasoned decisionmaking process. *Michigan*, 135 S. Ct. at 2707. An agency may not "entirely fail[] to consider an important aspect of the problem" when deciding whether regulation is appropriate. *State Farm*, 463 U.S. at 43.

In essence, Defendants promulgated two broad exemptions to a statutory mandate that had benefited millions of women across the country, and they failed to take any reasonable steps to

determine the Rules' many impacts. For instance, Defendants did not survey regulated entities to estimate the possible impact of the Rules. Yet, Defendants know that in 2017, for self-insured plans, there were $38.4 million in contraception claims sought, and these claims were for plans covering approximately 1,823,000 plan participants, and for fully insured plans, the Departments have *no* information. 83 Fed. Reg. at 57576; 82 Fed. Reg. at 47796 (explaining that for fully insured plans, the issuer is expected to bear the costs of contraceptive coverage when an employer uses the accommodation, and thus is not eligible for reimbursement); *id*. at 47818 (in 2015, 60 self-insured plans used the contraceptive user fees adjustment). At a minimum, under the APA, a government agency must "deploy its expertise" to consider and determine an important aspect of the problem before it is chiseled into bureaucratic stone. *Vill. of Barrington, Ill. v. Surface Transp. Bd.,* 636 F.3d 650, 660 (D.C. Cir. 2011); *Genuine Parts Co. v. EPA*, 890 F.3d 304, 312 (2018); Defs. Opp'n at 38-39 (conceding that Defendants implemented the Exemption Rules without knowing the extent to which women would lose their statutorily entitled benefits).

Defendants assert that the alternative to the Exemption Rules proposed by the States and several commenters—that women discuss their healthcare needs, including any purported "uncertainty" or "risks" related to contraceptives, with their personal physician (States' Mot. at 41)—"would not satisfy or mitigate the conscience objections to providing contraceptive coverage." Defs. Opp'n at 38.[22] This response confirms that the Exemption Rules were not promulgated in response to any purported uncertainty about contraceptives, but were issued as a desire to end "years of litigation." But the Ninth Circuit has already rejected the "desire to avoid litigation" as a rational basis for rulemaking. *Organized Vill. of Kake*, 795 F.3d at 970 (rejecting the agency's litigation risk-based justification for rulemaking where the agency "traded one lawsuit for another").

[22] Notably, the States' suggestion is the precise suggestion that HHS made in April 2017, less than six months before the IFRs were issued. *See* Ex. 23 (D9 668356-57, 66) ("The type of birth control you use depends on your health . . . Your doctor can help you decide which type is best for you right now."). *See also* Ex. 24 (D 9 668955-56).

### 3. The Exemption Rules Do Not Accord with Congressional Intent

Defendants offer that the Exemption Rules comport with Congressional intent because HRSA is a component of HHS, and HRSA has modified guidelines to account for the Exemption Rules. Defs. Opp'n at 39-40. These arguments fail for two reasons. First, the congressional directive to HRSA was to develop "comprehensive guidelines," to ensure women preventive care and screenings without cost sharing. 42 U.S.C. § 300gg-13(a)(4). The directive was not to determine whether some employers are exempt from providing statutorily mandated preventive care, as Defendants' "guideline" modifications establish. *Id*. And, just because HRSA is a component of HHS, does not mean that HHS can direct HRSA to ignore or override a statutory mandate. *Compare Dep't of Commerce*, 2019 WL 2619473, at *12 (where Congress authorized the Secretary, not the Bureau, to make policy choices under the Census Act). Second and as set forth in the States' motion at pages 4-8, HRSA has, since enactment of the ACA in 2010, carried out this statutory duty by convening nationally recognized medical experts to develop and update the medically-approved women's preventive care guidelines. But in this case, Defendants' recent "guideline" modifications are contrary to the advice of its own experts. Ex. 46 (D10 00207106), Ex. 71 (D11 00328171-72), Ex. 58 (D10 00207496-502). Moreover, HHS has its own set of obligations under Sections 1554 and 1557, which it did not abide by in issuing the Rules. An agency acts arbitrarily and capriciously when it ignores its own experts' advice, as Defendants have done here. *Pac. Coast Fed'n of Fishermen's Ass'ns, Inc. v. Nat'l Marine Fisheries Serv.*, 265 F.3d 1028, 1037-38 (9th Cir. 2001); *see also Idaho Sporting Cong., Inc. v. Rittenhouse*, 305 F.3d 957, 969 (9th Cir. 2002).

## B. The Exemption Rules Are Not Tailored to Address the Purported "Problems" the Rules Identify

Defendants assert that the Exemption Rules are narrowly tailored to the problems they are intended to address: "religious and moral objections to the provision of the contraceptive coverage" and "years of litigation." Defs. Opp'n at 40-41. As noted, a "desire to avoid litigation" is not a rational basis for rulemaking. *Organized Vill. of Kake*, 795 F.3d at 970; *see also California*, 351 F. Supp. 3d at 1293 ("the courts are not concerned, at all, with the Federal

Defendants' desire to 'avoid litigation,' especially where that avoidance means depriving a large number of women of their statutory rights under the ACA").[23]

Furthermore, Defendants concede that there is no evidence justifying the broad scope of the Religious or Moral Exemption Rules because there is no evidence that certain employers need the Rules. Specifically, Defendants again concede that they are not aware of any publicly traded entities that have religious objections to providing contraceptive coverage, but they nevertheless expand the exemption to include such entities. 83 Fed. Reg. at 57562; *see also* Defs. Opp'n at 41-42. Similarly, Defendants cite only three employers to justify the entirety of the Moral Exemption Rule—all of which have permanent injunctions. 83 Fed. Reg. at 57626 & n.74. This is arbitrary and capricious. *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014) (finding arbitrary and capricious an FCC regulation designed to deter fraud where there was "no evidence of fraud to deter"); *see also Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 841 (D.C. Cir. 2006) (Kavanaugh, J.) (vacating FERC order where agency had "provided no evidence of a real problem"); *Ariz. Cattle Growers' Ass'n v. U.S. Fish & Wildlife*, 273 F.3d 1229, 1244 (9th Cir. 2001) (holding agency action to be arbitrary and capricious where the basis of the action is "speculation . . . not supported by the record.").

In *Del. Dep't of Nat. Res. & Envtl. Control v. EPA*, 785 F.3d 1, 17-18 (D.C. Cir. 2015) (*DNREC*), the court set aside Environmental Protection Agency (EPA) rules where the EPA failed to explain the need for a nationwide rule that could harm energy markets, and did not address the potential alternative of a more limited rule that could achieve the same result without harming energy markets. Similarly, in *State v. Bureau of Land Mgmt*., 286 F. Supp. 3d 1054, 1066-67 (N.D. Cal. 2018), this court found that even if the agency had provided factual evidence to support its claim that a new waste reduction rule burdened small operators, a "blanket suspension" of the rule was arbitrary and capricious because the suspension was "not properly tailored" to address the allegedly offending provision. The Exemption Rules must be similarly

[23] Defendants also assert that they now believe "objections to complying with mandate are more *substantial*." Defs. Opp'n at 34. However, whether a government-imposed burden constitutes a substantial burden is a legal question for the court to decide. *See above* at 16-19.

set aside because they are not narrowly tailored to address the purported problems raised by Defendants, particularly where, in light of Defendants' stipulation to injunctions across the country there is serious doubt as to whether these Rules are even needed.[24]

### C. Defendants Failed to Respond to the Comments Outlining the Negative Health Impact and Financial Burdens to Women

As they do in the Exemption Rules, Defendants once again summarily dismiss significant comments addressing the negative health impacts and financial burdens of the Rules. *See* States' Mot. at 46-51. Defendants blithely wash their hands of any accountability for the grave consequences likely to result from their Rules, lumping all concerns under the general descriptor of "societal inequality." Defs. Opp'n at 43 (citing 83 Fed. Reg. at 57548, 57549-50). Under the incorrect premise that the ACA does not require contraceptive care, they conclude that "if some third parties do not receive contraception coverage from private parties" "that result exists in the absence of government action—it is not a result the government has imposed." Defs. Opp'n at 43. But Defendants' affirmatively changing the regulatory scheme can hardly be characterized as government "inaction." Moreover, as explained in the Section 1554 section herein, Defendants' Exemption Rules are the direct cause of thousands of women losing coverage. Before the Rules, these women had the coverage and as a direct consequence of the Rules, they will now lose that coverage. As the numerous commenters explain, this will have short-term and long-term impacts on women, their families, and society. *See* States' Mot. at 46-50 (outlining extensive harms and impacts). Defendants' "wan responses to [the] comments" do not fulfil their "obligations under the APA to respond to 'relevant and significant comments.'" *DNREC*, 785 F.3d at 15. Defendants cannot excuse their inadequate responses by passing off on third parties the entirety of the issues raised by these comments. *Id*. "Administrative law does not permit such a dodge." *Id*.

[24] This issue is compounded by the fact that under the Rules, employers need not give any notice to the government or their employees so neither the public nor the government will ever know the extent to which employers are utilizing the Rules depriving women of their healthcare benefits.

## IV. THE EXEMPTION RULES VIOLATE THE ESTABLISHMENT CLAUSE

As explained in the States' motion, government conduct may not have a primary effect, which advances a particular religious practice. States' Mot. at 51-54; *Catholic League for Religious & Civil Rights*, 624 F.3d at 1054-55 (citing *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971)). Conduct unlawfully advances religion by favoring religion at the expense of the rights, beliefs, and health of others. *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327, 334-35 (1987) ("At some point, accommodation may devolve into 'an unlawful fostering of religion.'"); *Lee*, 505 U.S. at 586–87. The Religious Exemption Rule unlawfully advances religion in two ways.[25]

First, Defendants replaced their prior regulatory system that imposed no cognizable burden on the exercise of religion, *see* Zubik Resp. Br., 2016 WL 537623, at *41, with expanded exemptions that advance religious objections at the expense of women and their families. *See Caldor*, 472 U.S. at 711 (O'Connor, J., concurring) (government accommodation of religious objections that comes at "the detriment of those who do not share [those objections]" unlawfully advances religion in violation of the Establishment Clause); *Texas Monthly*, 489 U.S. at 14–15, 18 n.8 (exemptions that impose burdens on third parties to permit others to act according to their religious beliefs, are unlawful); *Kiryas Joel*, 512 U.S. at 722 (Kennedy, J., concurring in the judgment) ("[A] religious accommodation demands careful scrutiny to ensure that it does not so burden nonadherents . . . as to become an establishment."). Defendants admit that thousands of women will lose their contraceptive coverage, incur millions of dollars in out-of-pocket costs, and encounter substantial obstacles to accessing care. *See, e.g.*, 78 Fed. Reg. at 39888 (the ACA "contemplates providing coverage of recommended preventive services through the existing employer-based system of health coverage so that women face minimal logistical and administrative obstacles"). By re-imposing obstacles, Defendants impose significant burdens on women and their families. Kost Decl. ¶¶ 37-45; Taylor Decl. ¶¶ 13-16; Grossman Decl. ¶ 9.

[25] Defendants do not argue that the exemptions are required by the Free Exercise Clause. And thus, the principle on which they rely, that the government may voluntarily "accommodate the practice of religious beliefs" in certain situations, "does not supersede the fundamental limitations imposed by the Establishment Clause." *Lee*, 505 U.S. at 587.

Given these harms on third parties, it is no surprise that the government has, to date, not cited an Establishment Clause case in which the court approved a sweeping agency-crafted exemption that harms the very individuals the statute itself was designed to benefit.

Second, Defendants elevated the religious beliefs of objectors over the health, welfare, safety, and autonomy of female employees, students, and dependents, in an absolute and unqualified way, without giving due weight to the affected women's interests. Ikemoto Decl. ¶ 4; Russell Decl. ¶ 6; Bates Decl. ¶ 7; Nelson Decl. ¶¶ 12-13. In so doing, Defendants essentially rewrite the Women's Health Amendment, "to conform with a particular religious viewpoint." *Edwards v. Aguillard*, 482 U.S. 578, 593 (1987); *see Caldor*, 472 U.S. at 710 ("'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.'"). Under the Exemption Rules, Defendants have delegated "explicitly religious" control over access to a statutory benefit, thereby advancing and promoting religious objections to contraception. *Larkin v. Grendel's Den, Inc.*, 459 U.S. 116, 125–26 (1982). Compounding this delegation of authority is that the Rule contains no exceptions or "special circumstances," including for women who require contraceptive coverage to preserve their health. *Caldor*, 472 U.S. at 709-10; *Hobby Lobby*, 573 U.S. at 737 (Kennedy, J., concurring) ("There are many medical conditions for which pregnancy is contraindicated."). Whereas there is no "substantial burden" on employers, the Exemption Rules have the unconstitutional effect of "subject[ing] . . . employees to the religious views of the[ir] employer." 77 Fed. Reg. at 8728; *Lee*, 455 U.S. at 261 (accommodating Amish employer would operate to impose employer's faith on employee, and noting that "[e]very person cannot be shielded from all burdens incident to exercise"); *see also Amos*, 483 U.S. at 348 (O'Connor, J., concurring in the judgment) ("In order to perceive the government action as a permissible accommodation of religion, there must in fact be an identifiable burden *on the exercise of religion* that can be said to be lifted by the government action.").

Defendants assert that because they determined that the accommodation violates RFRA, their legal "conclusion precludes any finding that the Religious Exemption Rule exceeds the agencies' authority under RFRA." Defs. Opp'n at 44 (explaining that the agencies concluded that

"the burden" the accommodation imposes "is greater than previously thought"). But religious exemptions created pursuant to statutes like RFRA are still subject to Establishment Clause scrutiny. 42 U.S.C. § 2000bb-4; *Hobby Lobby*, 573 U.S. 729 n.37; *Cutter v. Wilkinson*, 544 U.S. 709, 721-22 (2005) (the Establishment Clause limits accommodations under RLUIPA, RFRA's sister statute). Indeed, on two occasions, the Supreme Court has struck down religious accommodations as unconstitutional based on the harm the accommodations would inflict on nonbeneficiaries—over the government's argument that the statutes were necessary to alleviate burdens on religious adherents. *See Caldor*, 472 U.S. at 709; *Texas Monthly*, 489 U.S. at 18.[26]

Defendants argue that the Religious Exemption Rule is not a "burden" because before the Women's Health Amendment "women had no entitlement to contraceptive coverage." Defs. Opp'n at 44. Defendants provide little support for this theory, and as the Church-State scholars explain in their amicus brief, if this argument were correct, then *Lee* would have been an easy case and the religious objector should have won. 455 U.S. at 260; Dkt. No. 325 at 10-11. In *Lee*, the Amish employer sought an exemption from paying social security taxes. 455 U.S. at 260. The Court refused to grant the exemption because doing so would "operate[] to impose the employer's religious faith on the employees," even though the employees had no entitlement to social security before the law passed. *Id*. at 261; Dkt. No. 325 at 11.

Moreover, Defendants' argument suggests that guaranteeing contraceptive coverage was a matter of administrative grace, rather than a Congressional directive that Defendants are required

[26] Defendants suggest that *Caldor* is distinguishable because (1) the statute "involved government interference with private contracts" and (2) "intruded on private relationships." Defs. Opp'n at 46. Neither purported distinction undermines the Court's holding that the government cannot command that "religious concerns automatically control over all secular interests at the workplace," given the impact on the employer and other employees. *Caldor*, 472 U.S. at 709. Further, several other federal statutes, including those involving discrimination in housing and employment also "involve[] government interference with private contracts" and "intrude[] on private relationships." Such involvement does not make those laws unconstitutional. For instance, under Defendants' own reasoning, Title VII of the Civil Rights Act, which prohibits employers from discriminating against employees on the basis of religion, would also be unconstitutional because it involves government interference with private contracts and intrudes on private relationships. In *Caldor*, the statute was unconstitutional because the government was accommodating religious adherents despite the harms such an accommodation imposed on employers and fellow employees. *Caldor*, 472 U.S. at 709-710.

to implement. *Amos* underscores this point. Defs. Opp'n at 44. In *Amos*, Congress itself created a statutory religious exemption to Title VII. 483 U.S. at 329-31. There, the plaintiff employee was thus not encompassed within the statute and as a result, there were no reliance interests at stake. *Id.*; *see also Kong v. Scully*, 341 F.3d 1132 (9th Cir. 2003) (upholding statutory exception). In contrast, here, Congress passed the Women's Health Amendment and for nearly a decade since then women have benefited from and relied on receiving full and equal healthcare, including contraceptive coverage.[27]

Defendants describe the Exemption Rules as "lifting" a substantial burden on religious believers (Defs. Opp'n at 44), but such a description suffers from two fatal flaws: (1) it assumes a "substantial burden" on employers—which there is not—and (2) it ignores that in "lifting" the purported "substantial burden," Defendants are imposing harms on third parties, without exceptions. *See Cutter*, 544 U.S. at 722 ("[A]n accommodation must be measured so that it does not override other significant interests."). As a result of the Rules, one group of citizens—here women—is being singled out to bear significant costs of another person's religious exercise. Such conduct is unconstitutional. *See Hobby Lobby*, 573 U.S. at 693 ("[W]e certainly do not hold or suggest that 'RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on . . . thousands of women'"); *Sherbert*, 374 U.S. at 409 (providing unemployment benefits to Seventh Day Adventist does not "abridge any other person[ ]"); *Yoder*, 406 U.S. at 205 (accommodating Amish students would not result in harm to the students or the public). "Courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." *Cutter*, 544 U.S. at 720; *Hobby Lobby*, 573 U.S. at 729 n.37. [28]

[27] As Amicus Church-State Scholars and the Religious and Civil Organizations explain, *Amos* is the "exception," not the rule. Church-State Scholars Amicus Br. at 7-8 (Dkt. No. 325) (*Amos* concerned the "institutional autonomy of religious congregations and religious non-profits to control their own leadership and membership"); Religious and Civil Rights Organizations at 6 (Dkt. No. 346).

[28] Defendants seek to minimize the harm to women by stating that the burden women will face is "merely the loss of subsidized coverage." Defs. Opp'n at 44. This is a mischaracterization of the interests at stake in this case. There is a very human cost to the Exemption Rules. Before the Women's Health Amendment, over half of all women delayed or avoided care due to costs. 155

## V. THE EXEMPTION RULES VIOLATE THE EQUAL PROTECTION CLAUSE

The Exemption Rules create inequality in healthcare, by reinstating the fundamental inequities that the ACA was designed to remedy. Prior to the ACA, women and men were paying into the same employer-sponsored health plan and yet women were paying 68% more out-of-pocket for healthcare than men. *See* 77 Fed. Reg. at 8728 (explaining that "women in the workforce were at a disadvantage compared to their male co-workers"); *see also* Rabinovitz Decl. ¶ 4; Grossman Decl. ¶ 9. The ACA sought to cure this inequality by eliminating gender rating, providing maternity coverage, ensuring preventive care, and providing public health programs for women. Now, as a result of these Rules, women will once again be paying into the same employer-sponsored plan as their male colleagues but not receiving equal healthcare benefits. In this way, the Rules create a constitutionally impermissible gender-based classification that can be upheld if only Defendants provide an "exceedingly persuasive justification." *United States v. Virginia*, 518 U.S. 515, 533–34 (1996). They have not.

Rather than arguing that there is an "exceedingly persuasive justification," Defendants take issue with the sex-based classification, by arguing that "any sex-based distinctions flow from the statute," "not from Defendants." Defs. Opp'n at 49. Incorrect. The sex-based distinction flows directly from Defendants' decision to create exemptions exclusively for "women's preventive care and screenings." The Women's Health Amendment is one of five subparts to the preventive services mandate, but the Rules single out only women's healthcare for disadvantageous treatment. Moreover, the sex-based distinction in the Women's Health Amendment is based on an exceedingly persuasive justification (i.e., remedying inequities in healthcare), whereas the sex-based distinction created by the Rules has no such justification and in fact perpetuates those

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Cong. Rec. S12027 (Dec. 1, 2009) (Sen. Gillibrand). Without contraceptives, women are significantly more likely to become pregnant. Indeed, over 40% of all unintended pregnancies are caused by inconsistent access to contraceptives. Ex. 57 (D10 00207344 and 00207391). Approximately 70% of U.S. women of reproductive age, about 43 million women, are at risk of unintended pregnancy if they lose access to reliable contraceptives. Ex. 81 (D11 00804725). If a woman has an unintended pregnancy she must decide whether to carry to term and keep and raise a child or put the child up for adoption, or to obtain an abortion (if such an option is available to her, given her geographic and other circumstances). These are not "marginal" interests. Defs. Opp'n at 18.

inequities. As a result of the Rules, the law burdens women unequally. Kost Decl. ¶¶ 37-45; Ikemoto Decl. ¶ 5; Kish Decl. ¶ 12.

Defendants next argue that "any distinctions in coverage among women are not premised on sex, but on the existence of a religious or moral objection on the part of an employer." Defs. Opp'n at 49. But the *ability* of employers to exclude coverage for women is a result of the Rules. Under the Rules, men continue to enjoy full and equal healthcare, whereas women's access to healthcare is contingent on the religious and moral approval of their employers. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (recognizing that access to contraceptive is necessary for women to fully and equally participate in public life); Kost Decl. ¶¶ 38-39; Ikemoto Decl. ¶ 5; Bates Decl. ¶¶ 4-5. [29]

## VI. THE EXEMPTION RULES ARE PROCEDURALLY DEFICIENT

Defendants argue that, even if the adoption of the IFRs was procedurally deficient, the Exemption Rules were properly promulgated under the APA because they accepted comments after enacting the IFRs and the States have had an opportunity to comment. Defs. Opp'n at 52.[30] While the Ninth Circuit has yet to address the legality of this precise factual scenario, several sister circuits have weighed in and rejected the assertion that post-promulgation comments to an unlawfully promulgated IFR are the same as a properly noticed proposed rule that complies with the APA. *See NRDC v. EPA*, 683 F.2d 752, 767 (3d Cir. 1982); *Sharon Steel Corp. v. EPA*, 597 F.2d 377, 380 (3d Cir. 1979); *Leveque v. Block*, 723 F.2d 175, 188 (1st Cir. 1983).

Defendants' attempt to distinguish *NRDC* is unavailing. Defendants argue that in *NRDC*, the "question on which the public commented, . . , was not the question that would have been

[29] Defendants also assert that there is no authority that "declining to require subsidization of contraception constitutes" sex-based discrimination. Defs. Opp'n at 49. As a threshold matter, the ACA requires that "[a] group health plan" and "a health insurance issuer" include preventive services. 42 U.S.C. § 300gg-13. This includes preventive services for men and women, but Defendants have exempted only women's healthcare from this statutory requirement. Thus, it is not the States that are mandating that women's healthcare coverage be included in employer-sponsored healthcare—it is Congress. As a secondary matter, under the accommodation, contraception is not "subsidized," by the employer. *See infra* at 15, 20-23 (explaining employers do not "pay" for the contraceptive coverage).

[30] Defendants argue that they had statutory authority to issue the IFRs. Defs. Opp'n at 52. As the Ninth Circuit has already determined that Defendants violated the APA, we do not address this argument, other than to affirm our agreement with that ruling. *California*, 911 F.3d 575-581.

asked had the APA been followed." Defs. Opp'n at 53-54. Defendants then assert that, here, the question posed to the public in the unlawful IFRs would have been the same had Defendants complied with the APA and issued a Notice of Proposed Rulemaking (NPRM). *Id*. at 54. Defendants misread *NRDC*. As one court recently explained, "[t]he Third Circuit did not invalidate the EPA action because of the degree of change affected [sic] by the procedurally invalid action. Rather, it held that the subsequent notice-and-comment rulemaking '[could not] replace [a rulemaking] on the question of whether the amendments should be postponed in the first place.'" *Pennsylvania*, 351 F. Supp. 3d at 815. Moreover, Defendants' interpretation of *NRDC* disregards the harm to the public. As several courts have explained, when agencies promulgate rules that take immediate effect and *then* take comments, the public's ability to fairly comment is impacted. *See Leveque*, 723 F.2d at 188 ("'We doubt that persons would bother to submit their views or that the Secretary would seriously consider their suggestions after the regulations are a fait accompli'" and thus, "[i]n view of these 'psychological and bureaucratic realities, . . . Congress specified that notice and an opportunity for comment are to *precede* rule-making'"); States' Mot. at 58. Furthermore, Defendants do not cite any authority to support their incorrect interpretation of *NRDC*. *Cf. United States v. Reynolds*, 710 F.3d 498, 519 (3d Cir. 2013) ("[a]ny suggestion that the postpromulgation comments to the Interim Rule can satisfy the[] purposes [of exposure to diverse public comment and developing evidence in the record] misses the point.").

Defendants also argue that there was no harm to the States because the States had the opportunity to submit comments prior to issuance of the Exemption Rules. Defs. Opp'n at 52. But the Court in *NRDC* already rejected this argument. *NRDC*, 683 F.2d at 768; *see also Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1487 (9th Cir. 1992). Similarly, the First Circuit held that the ability of the public to comment, alone, is insufficient. *Leveque*, 723 F.2d at 188-89. Rather, to overcome the "presumption" that the subsequent rule is unlawful, the "quality" of agencies' response to the comments must demonstrate that the comment period "satisfied the requirements and purposes of section 553." *Id*. As explained above, Defendants

failed to meaningfully respond to comments, and thus cannot overcome this presumption that the Exemption Rules are invalid under the APA.

Moreover, Defendants' promulgation of the IFRs followed by notice and comment prejudiced the States. The purpose of the notice and comment period is to allow interested persons to participate in rule making, to allow the public voice to be heard by unrepresentative agencies, and to educate the agency. 5 U.S.C. § 553(c); *Paulsen v. Daniels*, 413 F.3d 999, 1005 (9th Cir. 2005); *see also Alcaraz v. Block*, 746 F.2d 593, 611 (9th Cir. 1984). Instead, here, the States had to simultaneously seek an injunction against the IFRs *and* draft a comment. Similarly, Defendants were defending the substance of IFRs in court while alleging that they would fairly and properly consider the comments about the IFRs they already made effective. And ultimately, Defendants issued Exemption Rules that were substantially identical to the IFRs. *See* Defs.' Supplemental Br., 2018 WL 6044850, at *1, 4. This put the States precisely in the position that concerned the *NRDC* court: the States had to "run the risk that the decisionmaker is likely to resist change" instead of reading comments with an open mind. *NRDC*, 683 F.2d at 768. Here, the record demonstrates that the States were not afforded a true comment period, and such injury taints the Exemption Rules.[31]

Defendants further argue that there is no remediable procedural injury because the only remedy would be the comment period afforded to the States. Defs. Opp'n at 54. The States disagree. They were never afforded an unbiased comment period before any rules became effective, and that is precisely what the Court could order: that the Rules be set aside and in the event that Defendants want to promulgate the same Rules, they must issue a NPRM, take comments on that proposal, and then issue a final rule. Compliance with the APA is not too much to ask given the import of the issues at stake.

[31] In fact, on numerous substantial issues on which the States commented, Defendants said that they were simply not going to take a position. *See* States' Mot. at 40; *see also* 83 Fed. Reg. at 57552, 57555.

## VII. THE COURT SHOULD SET ASIDE THE EXEMPTION RULES AND ISSUE DECLARATORY RELIEF

Defendants admit that the proper remedy for an APA violation is setting aside the Rules. Defs. Opp'n at 55. Defendants then contend, however, that this Court has no authority to go beyond setting aside the Rules, despite the States' explicit requested relief for a declaratory judgment (Second Am. Compl. at 65)—and the States' showing that a declaratory judgment is warranted (States' Mot. at 60). Notably, Defendants do not dispute that Plaintiffs are entitled to a declaratory judgment under this Circuit's precedent. *See* 28 U.S.C. § 2201(a); *Biodiversity Legal Found. v. Badgley*, 309 F.3d 1166, 1174-75 (9th Cir. 2002); *Alliance for the Wild Rockies v. U.S. Forest Service*, 907 F.3d 1105, 1121 (9th Cir. 2018) (providing that, even in the APA context, courts have the authority to grant injunctive and declaratory relief).

Defendants then proceed to conflate nationwide *injunctions* with the congressional mandate that Rules be set aside under the APA where a violation has been found. Defs. Opp'n at 56-57. There is simply no authority for Defendants' proposition that the Rules be set aside only with respect to named plaintiffs. Indeed, such an assertion runs contrary to the plain language of the APA, which provides that the court shall ". . . hold unlawful and set aside *agency action*, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law; [or] without observance of procedure required by law." 5 U.S.C. § 706(2)(A) & (D). Nothing in the statutory text instructs that the agency action, findings, and conclusions may be set aside only for those plaintiffs who bring suit.

Furthermore, Defendants point to no case to support their distorted statutory interpretation. To the contrary, courts consistently set aside rules where an agency acts contrary to law or agency action is arbitrary and capricious. *See, e.g., Camp v. Pitts*, 411 U.S. 138, 143 (1973) (per curiam); *Alliance for the Wild Rockies*, 907 F.3d at 1121-1122 (holding federal agencies had "not overcome the presumption of vacatur"); *Nat. Res. Def. Council v. EPA*, 489 F.3d 1364, 1374 (D.C. Cir. 2007); *State v. Ross*, 358 F. Supp. 3d 965, 1050-51 (N.D. Cal. 2019); *Klamath-Siskiyou Wildlands Cir. v. Nat'l Oceanic & Atmospheric Admin.*, 109 F. Supp. 3d 1238, 1241 (N.D. Cal. 2015). As one court recently explained, the "'usual' remedy for violation of the APA" is vacatur

and remand. *New York v. U.S. Dep't of Commerce*, 351 F. Supp. 3d 502, 673 (D.D.C. 2019) ("Vacatur is consistent with both the plain language of the APA and the principle that agency action taken in violation of the APA 'cannot be afforded the force and effect of law'" (quoting *Chrysler Corp. v. Brown*, 441 U.S. 281, 313 (1979)), *reversed in part on other grounds*, *Dep't of Commerce*, 2019 WL 2619473. There, like here, Defendants objected to the normal APA remedy based on theories of Article III standing. *New York*, 351 F. Supp. 3d at 674-75. In rejecting that argument, the court explained that once Article III standing is established, the Court has the power to adjudicate the controversy and "the question of what relief it may or must order is a 'merits' question of substantive law that is ultimately for the legislature to decide." *Id*. The Court explained that in the context of the APA, "a court has both the power *and* the duty to order the remedy Congress created." *Id*.

## CONCLUSION

The Court should deny Defendants' and Intervenors' motions to dismiss and motions for summary judgment, and grant the States' motion for summary judgment.

Dated: July 1, 2019

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF JOHN ARENSMEYER IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, John Arensmeyer, declare:

1. 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 interactive communications 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 a thriving and inclusive 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. On March 1, 2018 Small Business Majority released the results of a nationwide survey of women small business owners titled "Access to Reproductive Health Underpins Women Entrepreneurs' Economic Success." A true and correct copy of these results is attached as Exhibit B. Findings from the survey include:

- More than 6 in 10 female entrepreneurs of color (65 percent of African-American and 64 percent of Latina women entrepreneurs) agree that their ability to access birth control and to decide if and when to have children has impacted their bottom line.
- Women of color who own small businesses feel strongly that access to birth control has allowed them to advance their career (71 percent of African-American women and 69 percent of Latinas agree). Fifty-six percent of all respondents agree their ability to access birth control and to decide if and when to have children allowed them to advance in their career and start their business.
- While respondents overall are split on whether access to birth control has impacted their success (46 percent agree and 46 percent disagree), women of color who own small businesses are more likely to say access to birth control to decide if and when to have children has impacted their ability to succeed. Sixty-eight percent of African-American and 66 percent of Latinas agree that this has been important to their success.

6. 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 June 11, 2019, in Sausalito, California.

John Arensmeyer
Founder & CEO
Small Business Majority

# EXHIBIT A

SMALL BUSINESS MAJORITY

# Opinion Poll

## Women Small Business Owners Say Access to Birth Control is Important to their Success, Support Continued Coverage

October 13, 2017

**Small Business Majority**
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## Women Small Business Owners Say Access to Birth Control is Important to their Success, Support Continued Coverage

The Patient Protection and Affordable Care Act (ACA) expanded contraceptive coverage to more than 62 million women by requiring most health insurance plans, including most employer-sponsored plans, to cover birth control. With the recent move by the Trump administration to roll back this requirement, it's important to understand the perspective of one of the most important, and fastest growing, segments of our economy: women small business owners.

A recent scientific opinion poll conducted for Small Business Majority by Lake Research Partners and American Viewpoint found women small business owners support coverage of birth control for employees and cite birth control access as an important factor in their own ability to advance their career and become small business owners. This is critically relevant data, as women small business owners are our nation's job creators. In fact, it is projected that roughly one-third of the 15.3 million total new jobs created between 2010 and 2018 will be created by women-owned small businesses.[1] In 2016, there were nearly 11.3 million women-owned businesses, generating more than $1.6 trillion each year and employing nearly nine million people.[2]

The poll, which surveyed 507 women small business owners nationwide, including oversamples of 100 African-American and 100 Latina small business owners, found reproductive healthcare is especially important to women entrepreneurs. Specifically, the poll found more than 7 in 10 (71%) female entrepreneurs agree that health insurance issuers should be required to include birth control coverage in their health plans, with a majority (54%) in strong agreement. This agreement 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. Further, 69% of female small business owners are supportive of policies that ensure and expand access to birth control. Strong majorities across all demographic and political sub-groups support expanded access, including 63% of Republicans, 84% of Democrats and 57% of independents.

Indeed, according to this survey, the vast majority of female business owners agree (79%, with 59% in strong agreement) that access to reproductive healthcare is basic healthcare and important for women's economic wellbeing and stability. An additional 79% agree (61% of whom strongly agree) we need to ensure all women have access to affordable reproductive healthcare as a basic economic issue for our families. Seven in 10 women business owners across all political and demographic subgroups make this economic link and agree with both of these statements.

Women entrepreneurs believe access to basic healthcare like birth control improves their employees' financial stability, which in turn is important to their business's bottom line. African-American and Latina small business owners are even more likely to feel that access to birth control is important, with 68% and 80% respectively saying such access is important. Strong majorities of small business owners say that having health insurance coverage (87%) and having access to birth control to determine if and when to have children (57%) is important to obtaining financial security.

Female small business owners support access to birth control for their employees and also feel that access to reproductive healthcare has been critical to their ability to start a business. Fifty-six percent of women small business owners agree that their ability to access birth control and to decide if and when to have children allowed them to advance in their career and start their own business, and 52% agree this access impacts their ability to grow their business. What's more, 63% of respondents say that their ability to access birth control impacts their families' economic security and 64% agree that having such access is an important part of their ability to make choices about their career and future. Women small business

[1] Women-Owned Businesses: America's New Job Creation Engine, Forbes, 1/12/2010, https://www.forbes.com/2010/01/12/small-business-job-market-forbes-woman-entrepreneurs-economic-growth.html
[2] 2016 State of Women-Owned Business Report, American Express OPEN, April 2016, http://about.americanexpress.com/news/docs/2016x/2016SWOB.pdf

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owners recognize the importance of healthcare coverage and access to reproductive healthcare for women in planning their careers, families and future.

It's important to note that respondents are politically diverse, and do not view these issues through an ideological lens: 41% identify as Republican or Republican-leaning independents, 39% are Democrat or Democrat-leaning independents and 11% are pure independent.

## Main Findings

- **Women small business owners believe insurance companies should be required to include birth control in their health plans**: 71% of female small business owners agree that insurers should be required to include birth control coverage in their health plans, with 54% of respondents strongly agreeing to this statement. This support held across all demographic sub-groups, with particularly high support among African American and Latina entrepreneurs, who support such requirements by sizable majorities of 79% and 87% respectively.
- **Large majority of women small business owners support policies that ensure and expand access to birth control:** 69% of respondents support policies that would increase women's access to birth control, with 50% of respondents strongly supporting such policies. Strong majorities across all demographic and political sub-groups support expanded access, including 84% of Democrats, 57% of independents and 63% of Republicans.
- **Vast majority of women small business owners feel that access to birth control is important for women's economic empowerment and well-being:** Female small business owners understand that access to birth control is an economic issue for many women—including many small business owners and employees—with 79% of respondents agreeing that access to birth control is important to financial well-being. Fifty-nine percent strongly agree with this statement. The same percentage, 79%, also agree that we need to ensure all women have access to affordable reproductive healthcare as a basic economic issue. Sixty-one percent strongly agree.
- **Women entrepreneurs believe access to birth control was critical to their ability to start a business and make career choices:** 56% of respondents agree that their ability to access to birth control and to decide if and when to have children allowed them to advance in their career and start their business, and 52% agree that such access impacts their ability to grow their business. Additionally, almost two-thirds of female small business owners (63%) say that access to birth control impacts their family's economic security, and 64% agree that this access is an important part of their ability to make choices for their career and their future.
- **Women small business owners are politically diverse:** 41% identify as Republican or Republican-leaning independents, 39% are Democrat or Democrat-leaning independents and 11% are pure independent.

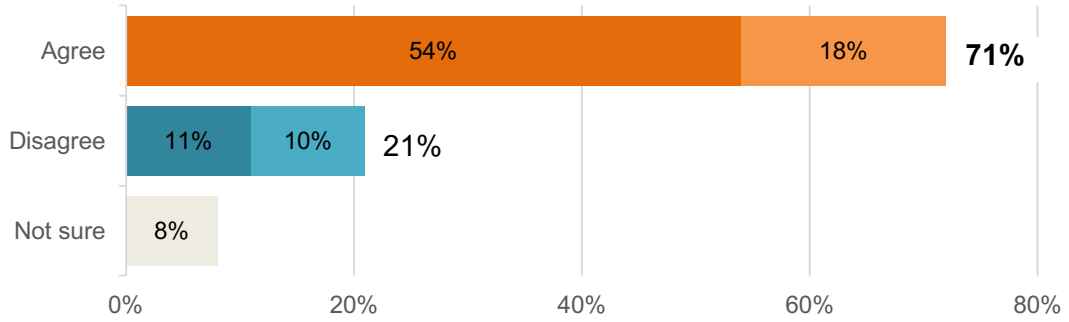
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## Women Small Business Owners Believe Insurance Plans Should Include Contraceptive Coverage and Support Expanding Access to Birth Control

More than 7 in 10 (71%) women small business owners agree that health insurance issuers should be required to include birth control coverage in their health plans, while just 21% disagree. Fifty-four percent of respondents strongly agree that insurance companies should be required to offer such coverage. Women of color who own small businesses support such requirements by even greater majorities—79% of African-American business owners and 87% of Latina business owners feel that insurance companies should be required to include birth control coverage in health plans.

**Figure 1:** ***Female entrepreneurs feel strongly that health coverage should include birth control***

Do you agree or disagree that the health insurance issuers should be required to include birth control coverage in their health plans?

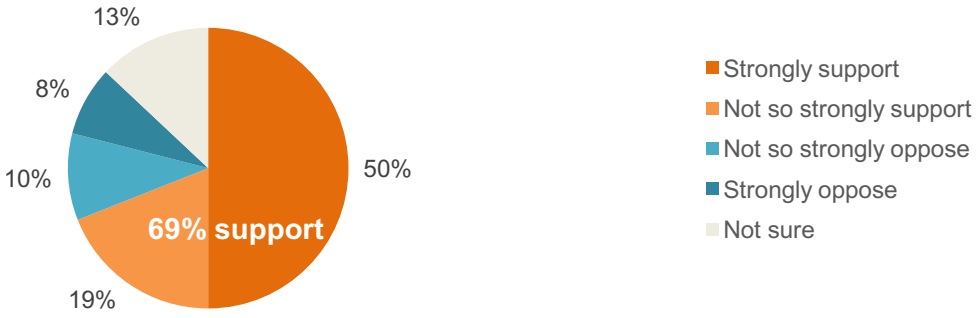



A large majority (69%) of women small business owners support policies that would ensure and expand access to birth control, with 50% of respondents strongly in support of such policies.

Support for such policies held across all major demographic sub-groups polled. For example, 69% of African-American women entrepreneurs and 72% of Latina women entrepreneurs are supportive of policies that would expand access.[3]

**Figure 2:** ***Female small business owners support policies that ensure and expand access to birth control***

Do you support or oppose policies that ensure and expand access to birth control?



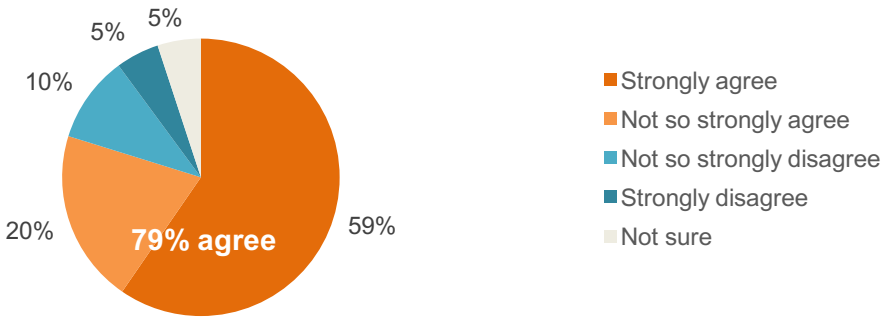

[3] This poll was conducted before the October 6, 2017 rule change announced by the Trump administration that allows more employers to opt out of providing birth control coverage in employer-sponsored health plans.

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## Women Entrepreneurs Believe Health Insurance and Access to Reproductive Health are Vital to Economic Security

Female small business owners understand that access to health insurance and reproductive health is an economic issue for entrepreneurs and their employees. Nearly 8 in 10 respondents (79%) agree that reproductive healthcare is basic healthcare, and that having access to it is important for economic well-being and stability. A large majority (59%) strongly agree with this statement, while just 15% disagree. The same percent, 79%, agree that we need to make sure all women have access to affordable reproductive healthcare as a basic economic issue for families.

**Figure 3:** ***Women entrepreneurs believe access to reproductive healthcare is essential to women's economic security and wellbeing***

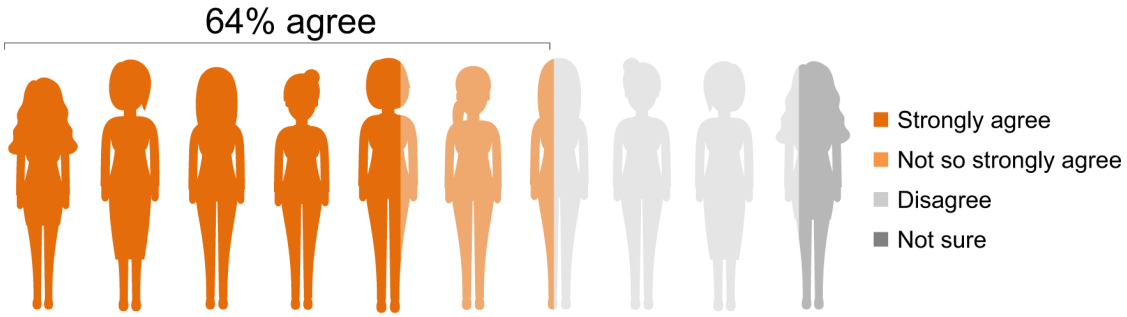



## Women Small Business Owners Say Birth Control Access Critical to their Ability to Start a Business and Pursue their Career

Beyond understanding the importance of birth control access to employees' financial wellbeing, women entrepreneurs see a connection between this access and their ability to pursue their dreams. A majority of women small business owners say having access to birth control allowed them to pursue their education after high school (54% agree). Women of color who own small businesses are even more likely to agree (74% African Americans, 70% Latinas and 50% white women). What's more, 56% of women entrepreneurs agree that the ability to access birth control and to decide if and when to have children allowed them to advance in their career and start their own business. Fifty-two percent say having access to birth control and the ability to decide if and when to have children impacts their ability to grow their business.

Additionally, nearly two-thirds report that their ability to access birth control and decide if and when to have children has been an important part of planning their career and future (64% total agree with 47% who strongly agree).

**Figure 4:** ***Women entrepreneurs say ability to access birth control is important to planning their career and future***




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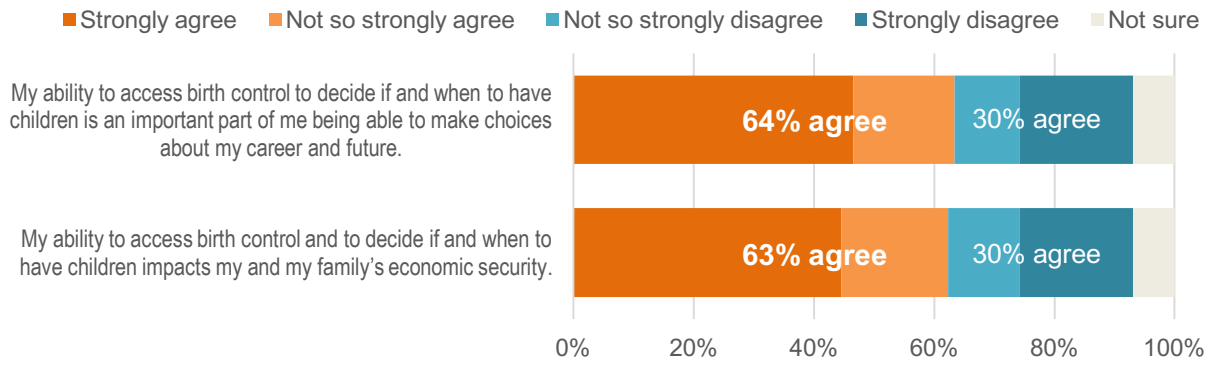
Illustrating the resonance of this sentiment as a core belief among women small business owners is the agreement across various demographic subgroups:

- 64% of non-college (47% strongly) and 63% of college-educated women (46% strongly) agree
- 72% of Latina (45% strongly), 62% of white (46% strongly), and 72% of African American (55% strongly) small business owners agree
- 80% of Democrats (62% strongly), 57% of independents (41% strongly), and 52% of Republicans (35% strongly)

Similarly important for women business owners is how birth control access has not only impacted their career, but also their family's economic security. Sixty-three percent of women business owners agree with this statement and 45% agree strongly. This holds true for women regardless of educational attainment, race or party affiliation:

- 64% of non-college educated (46% strongly) and 62% of college-educated (45% strongly) respondents agree
- 75% of Latina (47% strongly), 62% of white (45% strongly), and 70% of African-American (49% strongly) women small business owners agree
- 76% of Democrats (60% strongly), 56% of independents (44% strongly), and 55% of Republicans (34% strongly).

**Figure 5:** ***Women entrepreneurs believe access to birth control impacts their careers and family's economic security***




## Conclusion

Female entrepreneurs are a vital and growing part of the small business community and the overall economy. Women-owned firms are one of the fastest growing segments of the business community, with a 45% increase in women-owned firms between 2007 and 2016, compared to just a 9% increase for new businesses overall. Women entrepreneurs are significant job creators, with employment in women-owned businesses increasing 18% since the recession compared to a 1% decline in employment across all businesses since 2007.

These numbers show how critical women entrepreneurs are to our economy, and underscore the importance of promoting policies that will help them and their employees thrive. This is why it's 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' financial stability. Access to contraceptive coverage promotes the financial stability of female entrepreneurs and their employees, both of which are ultimately

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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.

## Methodology

This poll reflects an Internet survey of 507 women small business owners nationwide with 1-99 employees, including oversamples of African-American and Latina small business owners (100 of each). The poll was conducted by Lake Research Partners and American Viewpoint for Small Business Majority during August, 2017. The margin of error is +/-4.4%.

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# Toplines

500 women small business owners nationwide, cap 25% self-employed.
Oversamples of 100 African American women, 100 Latinas

| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |
| **Region** | | | | |
| New England | 5 | 7 | 5 | 4 |
| Middle Atlantic | 14 | 14 | 14 | 15 |
| East North Central | 13 | 17 | 11 | 13 |
| West North Central | 7 | 11 | 7 | 5 |
| South Atlantic | 21 | 26 | 18 | 23 |
| East South Central | 4 | 6 | 2 | 5 |
| West South Central | 10 | 9 | 9 | 12 |
| Mountain | 8 | 10 | 9 | 5 |
| Pacific | 17 | 0 | 24 | 19 |
| **Q1**. Please indicate your gender | | | | |
| Female | 100 | 100 | 100 | 100 |
| **Q2**. What is your race or ethnicity? Select all that apply | | | | |
| Hispanic or Latino or Spanish origin | 12 | 2 | 7 | 26 |
| White | 76 | 89 | 85 | 55 |
| Black, African, African American | 9 | 6 | 4 | 20 |
| Asian | 3 | 0 | 4 | 5 |
| Middle Eastern | 1 | 0 | 2 | 0 |
| Native Hawaiian or Other Pacific Islander | 0 | 0 | 0 | 0 |
| Native American, Indigenous, American Indian or Alaska Native | 1 | 1 | 1 | 1 |
| Not listed; Please specify | 1 | 2 | 2 | 0 |
| **Q3**. Just to confirm, are you the owner of a for-profit small business that has 99 or fewer employees? | | | | |
| Yes, owner | 100 | 100 | 100 | 100 |
| **Q4**. Approximately how many people work 30 or more hours per week at your company, including yourself? | | | | |
| 1 | 23 | 100 | 0 | 0 |
| 2-9 | 46 | 0 | 100 | 0 |
| 10-14 | 10 | 0 | 0 | 32 |
| 15-24 | 6 | 0 | 0 | 21 |
| 25-49 | 9 | 0 | 0 | 29 |
| 50-99 | 6 | 0 | 0 | 19 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q5**. What percentage of your employees would you say are women?

| | | | | |
|---|---|---|---|---|
| Mean | 58 | | 59 | 56 |
| Median | 50 | | 50 | 50 |
| 100% | 19 | | 25 | 10 |
| 75 – 99% | 15 | | 12 | 19 |
| 51 – 74% | 12 | | 7 | 20 |
| 50% | 25 | | 30 | 17 |
| 25 – 49% | 15 | | 12 | 20 |
| 11 – 24% | 4 | | 2 | 7 |
| 10% or less | 10 | | 12 | 7 |

**Q6**. What percentage of your employees would you say work part-time?

| | | | | |
|---|---|---|---|---|
| Mean | 32 | | 33 | 32 |
| Median | 20 | | 20 | 20 |
| 100% | 9 | | 12 | 4 |
| 75 – 99% | 8 | | 8 | 8 |
| 51 – 74% | 4 | | 2 | 7 |
| 50% | 15 | | 16 | 13 |
| 25 – 49% | 13 | | 11 | 16 |
| 11 – 24% | 9 | | 4 | 18 |
| 10% or less | 42 | | 47 | 34 |

**Q7**. Do you have any children?

| | | | | |
|---|---|---|---|---|
| Yes, I have children younger than 18 | 29 | 15 | 22 | 49 |
| Yes, I have children 18 or older | 36 | 40 | 43 | 22 |
| Yes, I have children who are both younger and older than 18 | 7 | 6 | 7 | 7 |
| All yes, combined | 71 | 61 | 72 | 78 |
| No, I do not have any children | 29 | 39 | 28 | 22 |

**Q8**. Are you planning to have children in the future, or are you not planning to have children in the future, or are you not sure?

| | | | | |
|---|---|---|---|---|
| Planning on having children | 21 | 10 | 13 | 41 |
| Not planning on having children | 70 | 84 | 79 | 47 |
| Not sure | 9 | 6 | 8 | 12 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q9**. Which of the following categories best describes your business?

| | | | | |
|---|---|---|---|---|
| Professional services including taxes, accounting, IT, legal, finance, media | 23 | 20 | 28 | 19 |
| Retail | 15 | 24 | 11 | 13 |
| Construction and Real Estate | 13 | 5 | 15 | 17 |
| Healthcare and education or social services | 8 | 5 | 8 | 10 |
| Restaurant/food service | 7 | 2 | 7 | 9 |
| Wholesale and distribution of goods | 6 | 4 | 6 | 9 |
| Manufacturing | 6 | 1 | 4 | 11 |
| Leisure and hospitality | 5 | 2 | 6 | 7 |
| Other non-retail services | 13 | 29 | 11 | 3 |
| Not sure | 4 | 9 | 4 | 1 |

**Q10**. How important is it for people to have access to the following items to obtain financial security?

a. Birth control to determine if and when to have children

| | | | | |
|---|---|---|---|---|
| Very important | 39 | 43 | 34 | 42 |
| Somewhat important | 19 | 13 | 16 | 27 |
| A little important | 13 | 16 | 11 | 13 |
| Not important at all | 22 | 21 | 29 | 14 |
| Not sure | 7 | 8 | 10 | 4 |
| Important | 57 | 55 | 51 | 68 |
| Not important | 35 | 37 | 40 | 28 |

b. Health insurance coverage

| | | | | |
|---|---|---|---|---|
| Very important | 67 | 79 | 64 | 63 |
| Somewhat important | 19 | 12 | 18 | 26 |
| A little important | 7 | 3 | 9 | 7 |
| Not important at all | 3 | 2 | 3 | 2 |
| Not sure | 4 | 4 | 5 | 1 |
| Important | 87 | 91 | 82 | 90 |
| Not important | 10 | 5 | 12 | 10 |

**Q11**. Do you agree or disagree that the health insurance issuers should be required to include birth control coverage in their health plans?

| | | | | |
|---|---|---|---|---|
| Strongly agree | 54 | 57 | 51 | 56 |
| Not so strongly agree | 18 | 15 | 17 | 21 |
| Not so strongly disagree | 10 | 5 | 9 | 13 |
| Strongly disagree | 11 | 12 | 13 | 8 |
| Not sure | 8 | 12 | 10 | 3 |
| Agree | 71 | 71 | 68 | 77 |
| Disagree | 21 | 17 | 22 | 21 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q12**. Do you support or oppose policies that ensure and expand access to birth control?

| | | | | |
|---|---|---|---|---|
| Strongly support | 50 | 56 | 51 | 44 |
| Not so strongly support | 19 | 21 | 15 | 24 |
| Not so strongly oppose | 10 | 5 | 10 | 14 |
| Strongly oppose | 8 | 6 | 8 | 8 |
| Not sure | 13 | 11 | 15 | 10 |
| | | | | |
| Support | 69 | 77 | 66 | 68 |
| Oppose | 18 | 12 | 19 | 22 |

**Q13**. Here are some statements some people have made. For each, select if you agree or disagree.

a. Reproductive health care is basic health care, and having access to it is important for economic well-being and stability

| | | | | |
|---|---|---|---|---|
| Strongly agree | 59 | 67 | 61 | 49 |
| Not so strongly agree | 20 | 23 | 16 | 25 |
| Not so strongly disagree | 10 | 5 | 9 | 16 |
| Strongly disagree | 5 | 2 | 7 | 5 |
| Not sure | 5 | 3 | 7 | 5 |
| | | | | |
| Agree | 79 | 91 | 76 | 75 |
| Disagree | 15 | 7 | 16 | 21 |

b. We need to make sure that all women have access to affordable reproductive health care as a basic economic issue for our families

| | | | | |
|---|---|---|---|---|
| Strongly agree | 61 | 66 | 63 | 53 |
| Not so strongly agree | 18 | 19 | 14 | 24 |
| Not so strongly disagree | 9 | 7 | 7 | 14 |
| Strongly disagree | 6 | 4 | 9 | 5 |
| Not sure | 6 | 4 | 8 | 5 |
| | | | | |
| Agree | 79 | 85 | 77 | 77 |
| Disagree | 15 | 11 | 15 | 18 |

**Q14**. Do you agree or disagree with the following statement? My ability to access birth control and to decide if and when to have children allowed me to advance in my career and start my own business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 39 | 35 | 39 | 42 |
| Not so strongly agree | 17 | 13 | 17 | 20 |
| Not so strongly disagree | 12 | 11 | 11 | 14 |
| Strongly disagree | 24 | 33 | 24 | 17 |
| Not sure | 8 | 8 | 10 | 7 |
| | | | | |
| Agree | 56 | 48 | 56 | 62 |
| Disagree | 36 | 44 | 35 | 31 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q15**. Do you agree or disagree with the following statement? My ability to access birth control and to decide if and when to have children impacts my ability to grow my business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 36 | 32 | 35 | 39 |
| Not so strongly agree | 16 | 14 | 16 | 19 |
| Not so strongly disagree | 13 | 14 | 10 | 18 |
| Strongly disagree | 28 | 36 | 31 | 18 |
| Not sure | 7 | 4 | 9 | 6 |
| | | | | |
| Agree | 52 | 46 | 51 | 57 |
| Disagree | 41 | 50 | 40 | 36 |

**Q16**. Do you agree or disagree with the following statement? My ability to access birth control and to decide if and when to have children impacts my and my family's economic security.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 45 | 42 | 47 | 44 |
| Not so strongly agree | 18 | 17 | 18 | 19 |
| Not so strongly disagree | 12 | 9 | 10 | 17 |
| Strongly disagree | 19 | 24 | 19 | 14 |
| Not sure | 7 | 8 | 6 | 6 |
| | | | | |
| Agree | 63 | 59 | 65 | 63 |
| Disagree | 30 | 33 | 29 | 31 |

**Q17**. Do you agree or disagree with the following statement? My ability to access birth control to decide if and when to have children is an important part of me being able to make choices about my career and future.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 47 | 48 | 48 | 43 |
| Not so strongly agree | 17 | 15 | 15 | 22 |
| Not so strongly disagree | 11 | 9 | 9 | 15 |
| Strongly disagree | 19 | 23 | 20 | 14 |
| Not sure | 7 | 6 | 8 | 6 |
| | | | | |
| Agree | 64 | 63 | 63 | 65 |
| Disagree | 30 | 32 | 29 | 29 |

The remaining questions are for statistical purposes only.

**Q18**. What is your religion?

| | | | | |
|---|---|---|---|---|
| Protestant (Baptist, Adventist, Lutheran, Methodist, Presbyterian, Pentecostal, Anglican) | 33 | 35 | 28 | 32 |
| Catholic | 24 | 18 | 20 | 33 |
| Other Christian | 15 | 13 | 13 | 18 |
| Jewish | 6 | 6 | 6 | 5 |
| Muslim | 1 | 2 | 0 | 2 |
| Mormon, Latter Day Saints, LDS | 1 | 2 | 1 | 1 |
| Other (Please write in) | 6 | 7 | 8 | 3 |
| None/Agnostic/Atheist | 15 | 20 | 17 | 9 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q19**. Generally speaking, do you think of yourself as a Republican, a Democrat, an independent, or something else?

| | | | | |
|---|---|---|---|---|
| Strong Democrat | 23 | 20 | 21 | 27 |
| Not strong Democrat | 10 | 8 | 9 | 14 |
| Lean Democrat | 6 | 8 | 6 | 4 |
| Democrat | 39 | 36 | 36 | 45 |
| Indepependent | 11 | 8 | 11 | 14 |
| Republican | 41 | 46 | 40 | 39 |
| Lean Republican | 6 | 6 | 5 | 6 |
| Not strong Republican | 14 | 17 | 13 | 12 |
| Strong Republican | 22 | 23 | 22 | 21 |
| Other | 3 | 4 | 4 | 0 |
| Not sure | 2 | 2 | 3 | 1 |
| Prefer not to answer | 4 | 4 | 6 | 1 |

**Q20.** What is your age?

| | | | | |
|---|---|---|---|---|
| 18-24 | 5 | 1 | 4 | 9 |
| 25-29 | 8 | 7 | 3 | 16 |
| 30-34 | 9 | 5 | 7 | 16 |
| 35-39 | 12 | 12 | 9 | 15 |
| 40-44 | 11 | 11 | 11 | 11 |
| 45-49 | 9 | 7 | 10 | 8 |
| 50-54 | 13 | 11 | 18 | 6 |
| 55-59 | 14 | 14 | 17 | 8 |
| 60-64 | 11 | 16 | 12 | 7 |
| 65-69 | 6 | 12 | 6 | 3 |
| 70-74 | 2 | 3 | 2 | 1 |
| 75 & older | 0 | 1 | 0 | 0 |
| (don't know) | 0 | 0 | 0 | 0 |

**Q21**. What is the last year of schooling that you have completed?

| | | | | |
|---|---|---|---|---|
| 1 - 11th Grade | 0 | 0 | 0 | 1 |
| High School Graduate | 10 | 9 | 12 | 9 |
| Non-College Post H.S. | 2 | 1 | 2 | 2 |
| Some College | 29 | 29 | 32 | 25 |
| Bachelor's degree | 36 | 38 | 35 | 37 |
| Master's degree | 16 | 16 | 13 | 19 |
| Doctoral degree | 6 | 7 | 5 | 7 |

**Q22**. At any point in your life, have you used birth control, like a pill, implant, patch, shot, vaginal ring, or IUD?

| | | | | |
|---|---|---|---|---|
| Yes | 81 | 84 | 82 | 78 |
| No | 15 | 12 | 14 | 19 |
| Prefer not to answer | 3 | 4 | 4 | 3 |
| Not sure | 0 | 0 | 1 | 0 |

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| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q23**. (If have insurance) Does your health insurance cover your birth control?

| | | | | |
|---|---|---|---|---|
| Weighted N= | 438 | 99 | 196 | 143 |
| Unweighted N= | 615 | 117 | 244 | 254 |
| Yes, my insurance pays the full cost of my birth control | 33 | 25 | 26 | 50 |
| Yes, but I pay a copay for my birth control | 13 | 10 | 14 | 15 |
| No, my insurance does not cover my birth control | 13 | 9 | 15 | 14 |
| I do not use prescription birth control | 28 | 39 | 31 | 16 |
| I do not have health insurance | 0 | 0 | 0 | 0 |
| Not sure | 12 | 16 | 14 | 5 |

**Q24**. For statistical purposes only, which of these categories best describes the gross revenue of your business in 2016?

| | | | | |
|---|---|---|---|---|
| Less than $100,000 | 39 | 81 | 37 | 11 |
| $100,000 to under $250,000 | 20 | 10 | 26 | 19 |
| $250,000 to under $500,000 | 15 | 2 | 17 | 23 |
| $500,000 to under $1 million | 10 | 0 | 9 | 19 |
| $1 million to under $2 million | 7 | 0 | 7 | 14 |
| $2 million or more | 4 | 0 | 1 | 12 |
| Not sure | 4 | 6 | 3 | 3 |

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# EXHIBIT B

SMALL BUSINESS MAJORITY

# Opinion Poll

## Access to Reproductive Health Underpins Women Entrepreneurs' Economic Success

March 1, 2018

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## Executive Summary

For decades, women have been breaking the glass ceiling on entrepreneurship. From 1987 to 2007 the number of U.S. women-owned, small businesses increased from 10% to 30%. As of last year, more than 11 million of our nation's business are owned by women, contributing more than $1.6 trillion to our economy. Yet despite this progress, women-owned businesses lag behind their male counterparts in crucial business indicators like revenue and number of employees. This is especially true for female entrepreneurs of color, who are disproportionately affected by a variety of factors that impact the growth of minority entrepreneurship, including inadequate capital, lack of workplace development training and fewer angel investors. This is why it's crucial for women entrepreneurs to have access to the resources and benefits that underpin their success.

New scientific opinion polling conducted for Small Business Majority by Lake Research Partners and American Viewpoint found reproductive healthcare and access to birth control is important to women small business owners' bottom lines, especially for women of color, and has been an important component of their ability to move forward in their careers and launch their businesses.

The poll, which surveyed 507 women small business owners nationwide, including oversamples of 100 African-American and 100 Latina small business owners, found the majority of African-American and Latina women entrepreneurs (65% and 64% respectively) say their ability to access birth control and to decide if and when to have children has impacted their bottom line as a business owner.

Among those who say access and choice of birth control has impacted their bottom line, respondents ranked the top ways this has impacted them as business owners. They indicated access to birth control has given them the opportunity and freedom to focus on their business and has given them the choice of when or if to have children. Additionally, roughly two-thirds of female entrepreneurs of color (68% for African-American entrepreneurs and 66% for Latina entrepreneurs) say their ability to access birth control to decide if and when to have children has impacted their ability to succeed as a business owner.

The poll also found women small business owners believe access to birth control is important to women's financial security. Nearly 8 in 10 respondents (79% agree with 59% who strongly agree) agree that access to reproductive healthcare is basic healthcare and is important to women's financial well-being and stability. Strong majorities say having health insurance coverage (87%) and having access to birth control to determine if and when to have children (57%) is important to obtaining financial security.

Additionally, in a recent report of this same survey set, we found a majority of women entrepreneurs (56%) feel that access to reproductive healthcare has been critical to their ability to advance in their career and start a business.[1] More than half (52%) agree this access impacts their ability to grow their business. A majority of women entrepreneurs also say access to birth control has been an important part of their ability to make decisions about their careers, with 64% of respondents agreeing with this statement. This is particularly important for younger business owners—7 in 10 of respondents under 50 agree this has been true for them in their own careers.

As this survey makes clear, access to reproductive healthcare and birth control is important to women small business owners' ability to plan and move forward with their careers and their businesses. Other research shows this is especially true for women business owners of color, who are more likely to have faced systemic barriers to entrepreneurship, such as lack of access capital to start or grow their business or access to the networks and business development resources that can make or break a fledgling business.[2, 3] It's not surprising then that reproductive healthcare is important to their success, and that access to family planning resources has been a critical component of pursuing financial security through entrepreneurship.

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[1] Women Small Business Owners Say Access to Birth Control is Important to their Success, Support Continued Coverage. Small Business Majority, October 13, 2017, http://www.smallbusinessmajority.org/our-research/healthcare/women-small-business-owners-say-access-birth-control-important-their-success-support-continued-coverage

[2] 21st Century Barriers to Women's Entrepreneurship, U.S. Senate Small Business Committee, July 23, 2104, http://www.gbaforwomen.org/download/21st-century-barriers-to-womens-entrepreneurship/

[3] Competitive and Special Competitive Opportunity Gap Analysis of the 7(a) and 504 Programs, Urban Institute, January 17, 2008, https://www.urban.org/research/publication/competitive-and-special-competitive-opportunity-gap-analysis-7a-and-504-programs

## Main Findings

- **Women entrepreneurs who traditionally face more systematic and institutional barriers to growth say access to birth control is important to their bottom lines**: More than 6 in 10 female entrepreneurs of color (65% of African-American and 64% of Latina women entrepreneurs) agree that their ability to access birth control and to decide if and when to have children has impacted their bottom line. Additionally, 45% of solo entrepreneurs agree that this gave them the opportunity to focus on their business.
- **Women small business owners, especially younger business owners and women of color, believe access to birth control was critical to their ability to start a business and advance their career**: Women of color who own small businesses feel strongly that access to birth control has allowed them to advance their career (71% of African-American women and 69% of Latinas agree). Sixty-two percent of younger business owners and 56% of all respondents agree their ability to access birth control and to decide if and when to have children allowed them to advance in their career and start their business, and 52% agree that such access impacts their ability to grow their business.
- **Women of color who own small businesses say access to contraception has impacted their ability to succeed**: While respondents overall are split on whether access to birth control has impacted their success (46% agree and 46% disagree), women of color who own small businesses are more likely to say access to birth control to decide if and when to have children has impacted their ability to succeed. Indeed, 68% of African-American and 66% of Latinas agree that this has been important to their success. A majority of women owning larger businesses with 10 or more employees (57%) also feel that this access has been critical to their success.
- **Women small business owners believe access to health insurance and reproductive healthcare is important to women's financial security**: 79% of respondents agree access to reproductive healthcare is important to women's financial well-being, and 59% strongly agree with this statement. The same percentage, 79%, also agree that we need to ensure all women have access to affordable reproductive healthcare as a basic economic issue. Strong majorities say having health insurance coverage (87%) and having access to reproductive healthcare to determine if and when to have children (57%) is important to obtaining financial security.
- **Majority of women entrepreneurs say access to birth control has been an important part of their ability to make decisions about their careers**: 64% agree that access to birth control has been an important part of their ability to make choices about their careers. This is particularly important for younger business owners—7 in 10 of respondents under 50 agree this has been true for them in their own careers.
- **Women small business owners do not see these issues through an ideological lens**: 41% identify as Republican or Republican-leaning independents, 39% are Democrat or Democrat-leaning independents and 11% are pure independent.

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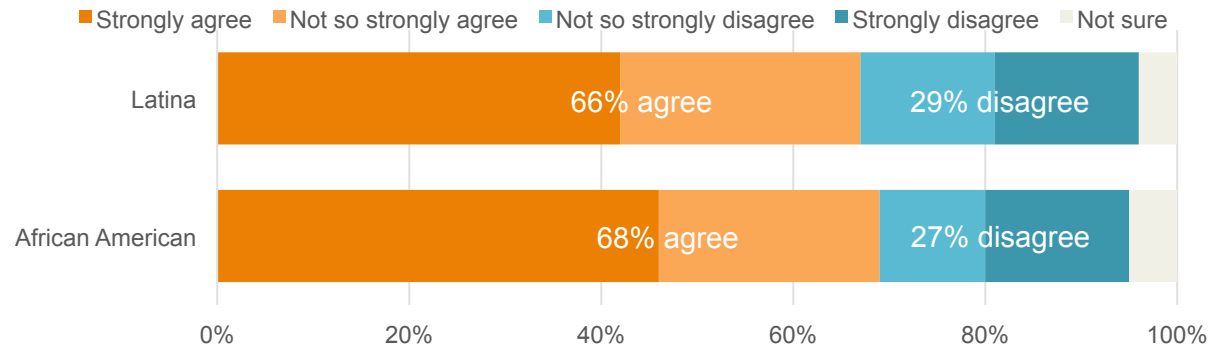
## Women Small Business Owners Say Access to Birth Control is Important to their Bottom Lines

Women entrepreneurs report that access to contraception has been important to their success as business owners, and this is especially true for women of color, who typically face more barriers to launching and growing a business. Sixty-five percent of African-American and 64% of Latina entrepreneurs say their ability to access birth control and to decide if and when to have children has impacted their bottom line. More than 4 in 10 (42%) of all respondents agree with this sentiment, though 48% overall disagree with this statement. A majority (52%) of women owners of larger firms with more than 10 employees agree that access to contraceptives has impacted their bottom line. Birth control is particularly important for solo entrepreneurs, with 45% saying access birth control and to decide if and when to have children gave them the opportunity and freedom to focus on their business.

While respondents overall are split on whether access to birth control has impacted their success (46% agree and 46% disagree), more than two-thirds of African-American (68%) and 66% of Latina entrepreneurs say their ability to access birth control to decide if and when to have children has impacted their ability to succeed as a business owner. This is also especially important for owners of larger small businesses, with 57% of respondents with 10 or more employees saying their ability to access birth control impacted their ability to succeed as a business owner.

**Figure 1:** ***Women of color who own small businesses say access to birth control important to their bottom lines and their ability to succeed as a business owner***

My ability to access birth control to decide if and when to have children has impacted my ability to succeed as a business owner.




Among those who say access and choice of family planning has impacted their bottom, many say this has given them the opportunity and freedom to focus on their business (31%) and given them the choice of when/if to have children (23%). For those who say access and choice has impacted their ability to succeed as business owners, nearly 1 in 4 say it has helped them better focus on their business (23%) and take control of planning their family (22%).

## Women Small Business Owners Say Birth Control Access Critical to their Ability to Pursue their Careers and Launch their Businesses

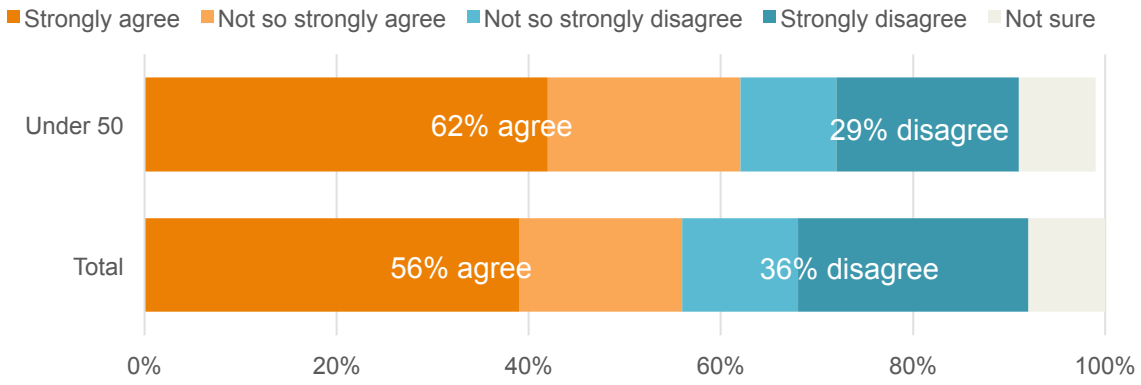
As reported in a recent survey among this same response group, women entrepreneurs see a strong connection between their access to contraception and their ability to pursue their dreams.[4] A majority of women small business owners say having access to birth control allowed them to pursue their education

[4] Women Small Business Owners Say Access to Birth Control is Important to their Success, Support Continued Coverage. Small Business Majority, October 13, 2017, http://www.smallbusinessmajority.org/our-research/healthcare/women-small-business-owners-say-access-birth-control-important-their-success-support-continued-coverage

after high school (54% agree). Women of color who own small businesses are even more likely to agree (74% African Americans and 70% Latinas compared to 50% of white women). What's more, 56% of women entrepreneurs agree that the ability to access birth control and to decide if and when to have children allowed them to advance in their careers and start their own businesses. This is especially true for women under 50, with 62% agreeing this helped them advance in their careers and start a business. Fifty-two percent of all respondents say having access to birth control and the ability to decide if and when to have children impacts their ability to grow their business.

**Figure 2:** ***Women small business owners, especially younger entrepreneurs say access to birth control allowed them to advance in career and start their own businesses***

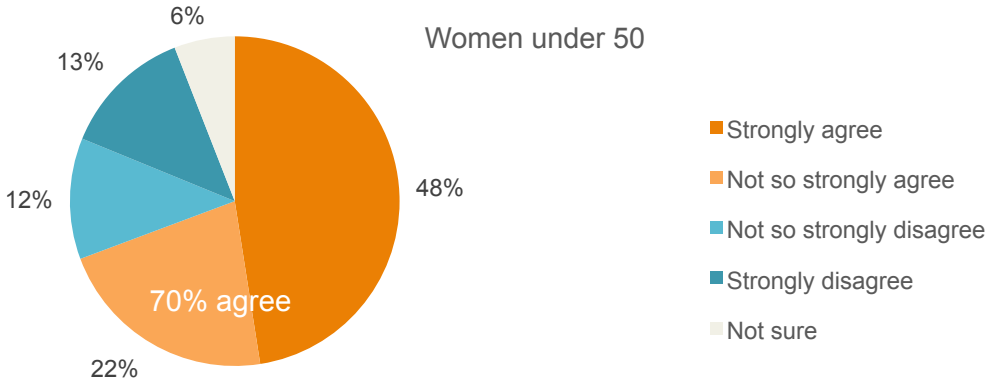
My ability to access birth control to decide if and when to have children allowed me to advance my career and start my own business.




Additionally, nearly two-thirds report that their ability to access birth control and decide if and when to have children has been an important part of planning their career and future (64% total agree, 47% strongly agree). This is especially important for younger business owners—7 in 10 of respondents under 50 agree this has been true for them in their own careers.

**Figure 3:** ***Access to birth control is important to younger women entrepreneurs in planning their career and future***

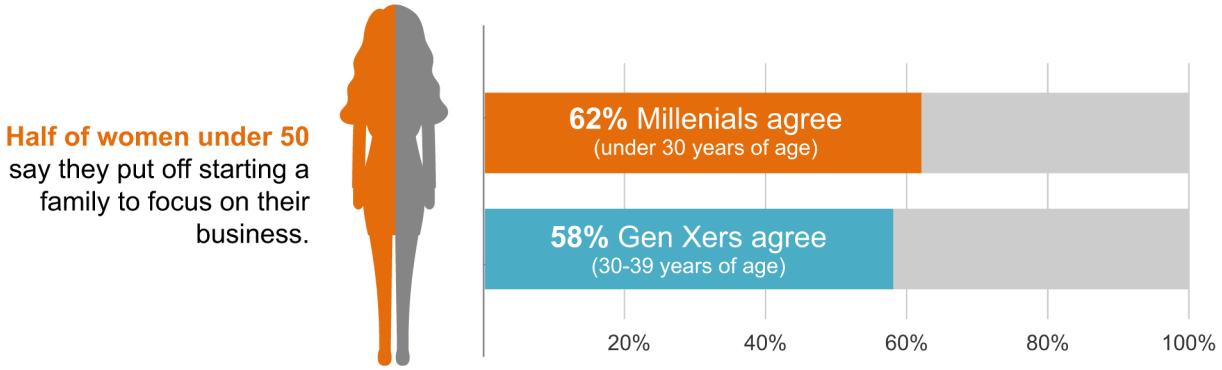
My ability to access birth control to decide if and when to have children is an important part of me being able to make choices about my career and future.




Taking a closer look at how access has impacted their personal career trajectories, women small business owners are relatively split on whether they waited to start their business until they started a family, with half (51%) saying they disagree with that statement. Most women also say they disagree with a statement about putting off starting a family to focus on their business (58%), although a third say they agreed

(34%). While there is little difference across educational attainment among these women, there is significant difference generationally. Half (50%) of women under 50 say they put off starting a family to focus on their business while only 15% of women over 50 say so. This is most true for millennials (62%) and Gen Xers (58%). This indicates reproductive healthcare is particularly important to younger entrepreneurs as they launch a business.

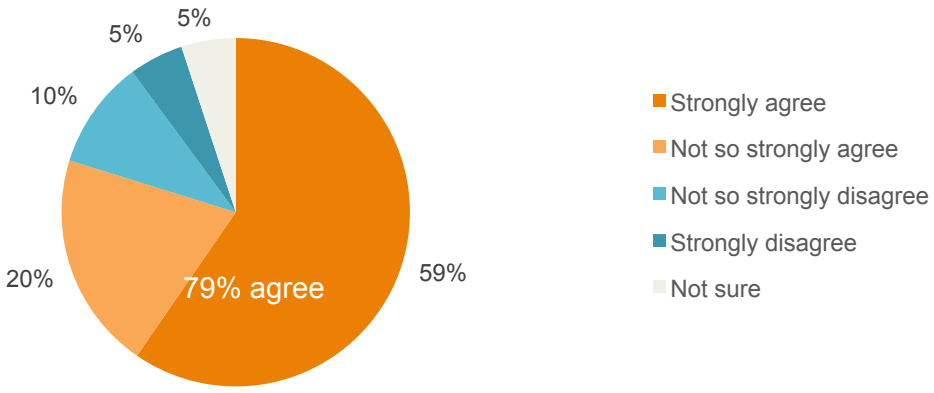
**Figure 4:** ***Women entrepreneurs under 50 say they put off starting a family to focus on their business***




## Women Entrepreneurs Believe Health Insurance and Reproductive Healthcare are Vital to Economic Security

Women small business owners understand that access to health insurance and reproductive healthcare is an economic issue for entrepreneurs and their employees. Nearly 9 in 10 women entrepreneurs (87%) agree that access to health insurance coverage is important for obtaining financial security. More than two-thirds (67%) agree that this access is very important. Additionally, as described in a recent report of this same survey set, nearly 8 in 10 respondents (79%) agree that reproductive healthcare is basic healthcare, and that having access to it is important for economic wellbeing and stability.[5]

**Figure 5:** ***Women entrepreneurs believe access to reproductive healthcare is essential to women's economic security and wellbeing***



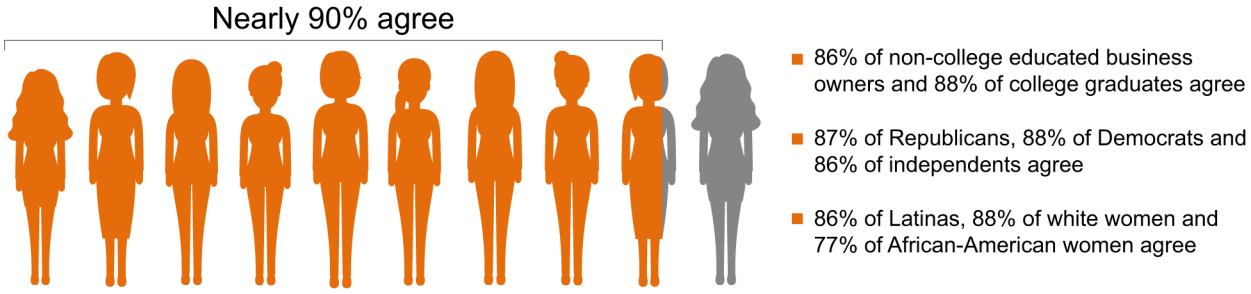

Women entrepreneurs also agree that women should have the freedom to plan if and when to have children (75% strongly agree) and that it is important to ensure that all women have access to affordable reproductive healthcare as a basic economic issue (79% total agree, 61% strongly agree).

[5] Ibid.

Nearly 3 in 4 (74% with 55% who agree strongly) say they support access to birth control, not just as an employer but as someone who cares about their employees. Additionally, the vast majority (78%) say we must ensure access to reproductive healthcare for all women.

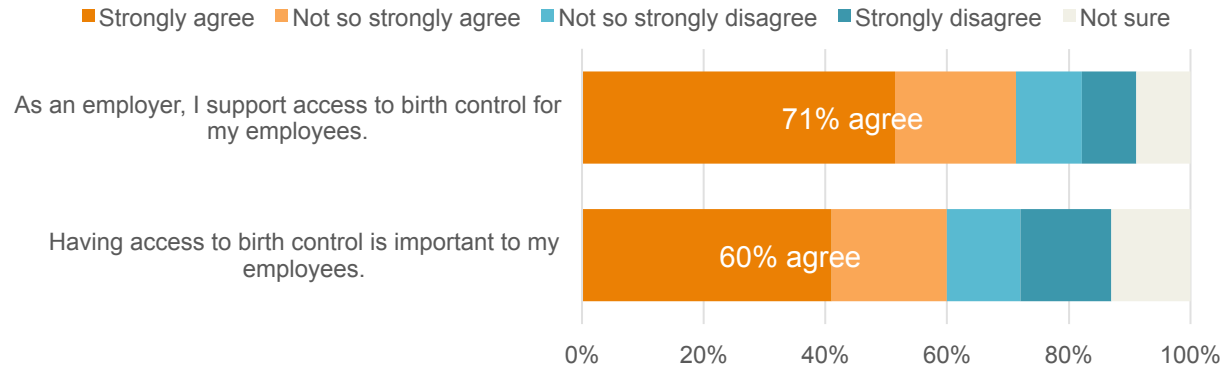
These are values that resonate with women small business owners across demographic subgroups. Majorities of women across varying degrees of educational attainment, party lines and race all agree that women should have the freedom to plan if and when to have children.

**Figure 6:** ***Respondents across demographic sub-groups agree women should have the freedom to plan if and when to have children***




While access to birth control is important for these women personally, a majority of small business owners also believe that access is an important issue for their employees (60% agree, 41% strongly agree) and as employers, they support access to birth control for their employees (71% agree, 52% strongly agree). This view crosses party lines with 83% of Democrats, 67% of independents and 63% of Republicans agreeing that they support access for their employees.

**Figure 7:** ***Women small business owners believe access to birth control important to their employees***




## Women Entrepreneurs Support Family-Friendly Benefits to Promote Financial Security

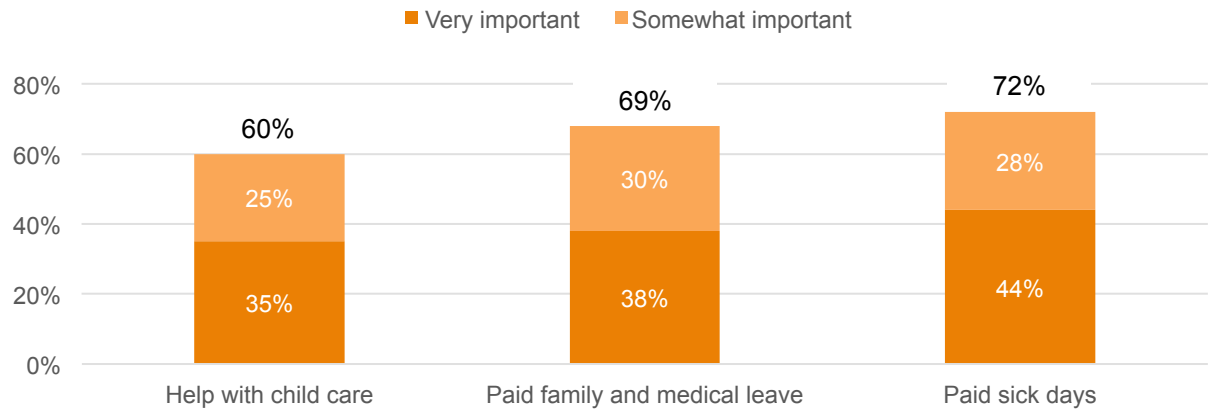
Women entrepreneurs understand that access to healthcare and family-friendly benefits is crucial to retaining a productive workforce and promoting the financial security of employees. Women small business owners see the importance of comprehensive health insurance to their business, and are more likely to offer employer-sponsored healthcare to employees than their male counterparts. Forty-four percent of female small business owners offer health coverage to their employees, according to the polling

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data. Recent polling by Small Business Majority poll conducted in March 2017 found 32% of all small business owners nationwide provide employer-sponsored health coverage to employees.[6]

Polling data show that female small business owners support a variety of other family-friendly benefits that help to ensure financial security for employees. More than 7 in 10 (72%) believe it is important to have access to paid sick days (44% believe this is very important). Sixty-nine percent believe paid family and medical leave is important, with 38% believing this is very important. What's more, 6 in 10 believe help with child care is vital to employees' economic security (35% very important).

**Figure 8:** ***Women small business owners support family-friendly benefits***




## Conclusion

Women small business owners are one of the most important and fastest growing segments of our economy. As this report shows, access to reproductive healthcare and birth control has been important to their ability to plan and make decisions about their careers, their businesses and their families, and this is particularly important to women of color and younger business owners. Efforts to improve the health and financial security for women entrepreneurs of color can help this group overcome traditional barriers to success, and efforts to undermine access to healthcare may disproportionately impact this group. This is why it's critical to promote policies that will support and expand access to birth control and ensure small business owners and employees have access to the reproductive healthcare they need to plan for their futures and ensure their financial security.

## Methodology

This poll reflects an Internet survey of 507 women small business owners nationwide with 1-99 employees, including oversamples of African-American and Latina small business owners (100 of each). The poll was conducted by Lake Research Partners and American Viewpoint for Small Business Majority during August 2017. The margin of error is +/-4.4%.

[6] Small Businesses Support ACA Over Replacement Plan, Small Business Majority, March 23, 2017, http://www.smallbusinessmajority.org/our-research/healthcare/small-businesses-support-aca-over-replacement-plan

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# Toplines

500 women small business owners nationwide, cap 25% self-employed
Oversamples of 100 African-American women, 100 Latinas

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |
| **Region** | | | | |
| New England | 5 | 6 | 2 | 3 |
| Middle Atlantic | 14 | 13 | 11 | 20 |
| East North Central | 13 | 13 | 19 | 8 |
| West North Central | 7 | 9 | 4 | 3 |
| South Atlantic | 21 | 20 | 26 | 26 |
| East South Central | 4 | 4 | 6 | 1 |
| West South Central | 10 | 8 | 23 | 11 |
| Mountain | 8 | 9 | 3 | 8 |
| Pacific | 17 | 18 | 6 | 21 |
| **Q1**. Please indicate your gender | | | | |
| Female | 100 | 100 | 100 | 100 |
| **Q2**. What is your race or ethnicity? Select all that apply | | | | |
| Hispanic or Latino or Spanish origin | 12 | | | |
| White | 76 | | | |
| Black, African, African American | 9 | | | |
| Asian | 3 | | | |
| Middle Eastern | 1 | | | |
| Native Hawaiian or Other Pacific Islander | 0 | | | |
| Native American, Indigenous, American Indian or Alaska Native | 1 | | | |
| Not listed; Please specify | 1 | | | |
| **Q3**. Just to confirm, are you the owner of a for-profit small business that has 99 or fewer employees? | | | | |
| Yes, owner | 100 | 100 | 100 | 100 |
| **Q4**. Approximately how many people work 30 or more hours per week at your company, incl. yourself? | | | | |
| 1 | 23 | 27 | 16 | 5 |
| 2-9 | 46 | 51 | 18 | 28 |
| 10-14 | 10 | 9 | 14 | 12 |
| 15-24 | 6 | 4 | 12 | 16 |
| 25-49 | 9 | 5 | 28 | 24 |
| 50-99 | 6 | 4 | 12 | 15 |
| **Q5**. What percentage of your employees would you say are women? | | | | |
| Mean | 58 | 57 | 60 | 55 |
| Median | 50 | 50 | 60 | 50 |
| 100% | 19 | 21 | 8 | 11 |
| 75 – 99% | 15 | 14 | 23 | 15 |
| 51 – 74% | 12 | 8 | 23 | 21 |
| 50% | 25 | 27 | 19 | 17 |
| 25 – 49% | 15 | 14 | 19 | 24 |
| 11 – 24% | 4 | 4 | 4 | 4 |
| 10% or less | 10 | 12 | 4 | 7 |

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| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q6**. What percentage of your employees would you say work part-time?

| | | | | |
|---|---|---|---|---|
| Mean | 32 | 32 | 34 | 33 |
| Median | 20 | 18 | 27 | 25 |
| 100% | 9 | 10 | 2 | 9 |
| 75 – 99% | 8 | 8 | 8 | 4 |
| 51 – 74% | 4 | 3 | 7 | 7 |
| 50% | 15 | 15 | 18 | 9 |
| 25 – 49% | 13 | 10 | 23 | 21 |
| 11 – 24% | 9 | 6 | 21 | 16 |
| 10% or less | 42 | 47 | 22 | 33 |

**Q7**. Which of the following categories best describes your business?

| | | | | |
|---|---|---|---|---|
| Professional services including taxes, accounting, IT, legal, finance, media | 23 | 23 | 21 | 20 |
| Retail | 15 | 15 | 18 | 11 |
| Construction and Real Estate | 13 | 14 | 5 | 27 |
| Healthcare and education or social services | 8 | 7 | 11 | 10 |
| Restaurant/food service | 7 | 5 | 12 | 7 |
| Wholesale and distribution of goods | 6 | 5 | 11 | 8 |
| Manufacturing | 6 | 5 | 8 | 6 |
| Leisure and hospitality | 5 | 6 | 2 | 3 |
| Other non-retail services | 13 | 15 | 10 | 2 |
| Not sure | 4 | 4 | 2 | 5 |

**Q8**. Do you have any children?

| | | | | |
|---|---|---|---|---|
| Yes, I have children younger than 18 | 29 | 22 | 52 | 62 |
| Yes, I have children 18 or older | 36 | 42 | 19 | 9 |
| Yes, I have children who are both younger and older than 18 | 7 | 7 | 6 | 7 |
| All yes, combined | 71 | 71 | 76 | 79 |
| No, I do not have any children | 29 | 29 | 24 | 21 |

**Q9**. Are you planning to have children in the future, or are you not planning to have children in the future, or are you not sure?

| | | | | |
|---|---|---|---|---|
| Planning on having children | 21 | 13 | 54 | 54 |
| Not planning on having children | 70 | 79 | 39 | 33 |
| Not sure | 9 | 8 | 7 | 13 |

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| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q10**. How important is it for people to have access to the following items to obtain financial security?

a. Birth control to determine if and when to have children

| | | | | |
|---|---|---|---|---|
| Very important | 39 | 38 | 44 | 50 |
| Somewhat important | 19 | 16 | 25 | 30 |
| A little important | 13 | 14 | 16 | 8 |
| Not important at all | 22 | 24 | 14 | 8 |
| Not sure | 7 | 8 | 1 | 4 |
| | | | | |
| Important | 57 | 54 | 68 | 80 |
| Not important | 35 | 38 | 30 | 15 |

b. Health insurance coverage

| | | | | |
|---|---|---|---|---|
| Very important | 67 | 70 | 60 | 66 |
| Somewhat important | 19 | 17 | 22 | 26 |
| A little important | 7 | 6 | 11 | 6 |
| Not important at all | 3 | 3 | 5 | 2 |
| Not sure | 4 | 4 | 2 | 1 |
| | | | | |
| Important | 87 | 87 | 82 | 91 |
| Not important | 10 | 9 | 16 | 8 |

**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 231 | 158 | 33 | 40 |
| Unweighted N= | 373 | 188 | 99 | 105 |

**Q11**. My ability to access birth control to decide if and when to have children has impacted my ability to succeed as a business owner.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 32 | 30 | 46 | 42 |
| Not so strongly agree | 13 | 11 | 23 | 25 |
| Not so strongly disagree | 13 | 13 | 11 | 14 |
| Strongly disagree | 32 | 36 | 15 | 15 |
| Not sure | 9 | 9 | 5 | 5 |
| | | | | |
| Agree | 46 | 41 | 68 | 66 |
| Disagree | 46 | 50 | 27 | 29 |

**Q11b**. (Asked if agree in previous question) In what way has your ability to access birth control and decide if and when to have children impacted your ability to succeed as a business owner?

| | |
|---|---|
| Better focus on business | 23 |
| Control of family plan | 22 |
| Financially stable and/or prepared for children | 12 |
| Enabled career advancement | 7 |
| Impact on employees | 3 |
| Benefits health of woman | 0 |

**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 231 | 158 | 33 | 40 |
| Unweighted N= | 373 | 188 | 99 | 105 |

**Q12**. My ability to access birth control to decide if and when to have children is an important part of me being able to make choices about my career and future.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 47 | 46 | 55 | 45 |
| Not so strongly agree | 17 | 17 | 17 | 27 |
| Not so strongly disagree | 11 | 10 | 16 | 13 |
| Strongly disagree | 19 | 21 | 8 | 11 |
| Not sure | 7 | 7 | 4 | 4 |
| | | | | |
| Agree | 64 | 62 | 72 | 72 |
| Disagree | 30 | 31 | 24 | 23 |

**Q13**. My ability to access birth control and to decide if and when to have children has impacted my bottom line as a business owner.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 26 | 23 | 41 | 34 |
| Not so strongly agree | 16 | 14 | 24 | 30 |
| Not so strongly disagree | 15 | 16 | 14 | 14 |
| Strongly disagree | 34 | 37 | 15 | 18 |
| Not sure | 10 | 10 | 5 | 5 |
| | | | | |
| Agree | 42 | 37 | 65 | 64 |
| Disagree | 48 | 53 | 29 | 32 |

**Q13b.** (Asked if agree in previous question) In what way has your ability to access birth control and to decide if and when to have children helped your bottom line?

| | |
|---|---|
| Gave opportunity and freedom to focus on business | 31 |
| Choice if/when to have children | 23 |
| Increased flexibility and decision making about future | 8 |
| Did not have an impact | 7 |
| No child-related expenses | 5 |
| Has had a positive impact | 3 |
| Employees are more focused | 2 |

**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q14**. Reproductive health care is basic health care, and having access to it is important for economic well-being and stability.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 59 | 61 | 52 | 55 |
| Not so strongly agree | 20 | 20 | 24 | 20 |
| Not so strongly disagree | 10 | 9 | 12 | 18 |
| Strongly disagree | 5 | 5 | 5 | 4 |
| Not sure | 5 | 5 | 6 | 2 |
| | | | | |
| Agree | 79 | 81 | 77 | 75 |
| Disagree | 15 | 14 | 17 | 23 |

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**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q15**. We need to make sure that all women have access to affordable reproductive health care as a basic economic issue for our families.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 61 | 62 | 59 | 55 |
| Not so strongly agree | 18 | 18 | 16 | 25 |
| Not so strongly disagree | 9 | 8 | 13 | 14 |
| Strongly disagree | 6 | 6 | 5 | 5 |
| Not sure | 6 | 6 | 7 | 2 |
| | | | | |
| Agree | 79 | 80 | 75 | 80 |
| Disagree | 15 | 14 | 18 | 18 |

**Q16**. Having access to birth control allowed me to pursue my education after high school.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 35 | 34 | 41 | 40 |
| Not so strongly agree | 19 | 15 | 33 | 30 |
| Not so strongly disagree | 11 | 9 | 13 | 18 |
| Strongly disagree | 25 | 29 | 8 | 8 |
| Not sure | 10 | 12 | 5 | 4 |
| | | | | |
| Agree | 54 | 50 | 74 | 70 |
| Disagree | 36 | 38 | 21 | 26 |

**Q17**. I waited to start or expand my business until I started or raised my family.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 25 | 22 | 43 | 28 |
| Not so strongly agree | 17 | 15 | 20 | 34 |
| Not so strongly disagree | 13 | 14 | 13 | 9 |
| Strongly disagree | 37 | 41 | 22 | 27 |
| Not sure | 7 | 8 | 3 | 1 |
| | | | | |
| Agree | 42 | 37 | 63 | 62 |
| Disagree | 51 | 56 | 35 | 37 |

**Q18**. My ability to access birth control and to decide if and when to have children allowed me to advance in my career and start my own business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 39 | 37 | 47 | 45 |
| Not so strongly agree | 17 | 16 | 24 | 25 |
| Not so strongly disagree | 12 | 12 | 13 | 14 |
| Strongly disagree | 24 | 26 | 12 | 12 |
| Not sure | 8 | 9 | 4 | 4 |
| | | | | |
| Agree | 56 | 53 | 71 | 69 |
| Disagree | 36 | 38 | 25 | 26 |

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**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q19**. My ability to access birth control and to decide if and when to have children impacts my ability to grow my business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 36 | 33 | 48 | 39 |
| Not so strongly agree | 16 | 16 | 19 | 24 |
| Not so strongly disagree | 13 | 13 | 17 | 13 |
| Strongly disagree | 28 | 31 | 14 | 15 |
| Not sure | 7 | 7 | 3 | 8 |
| | | | | |
| Agree | 52 | 49 | 67 | 63 |
| Disagree | 41 | 44 | 30 | 28 |

**Q20**. I put off or am putting off starting a family to focus on or expand my business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 22 | 18 | 43 | 34 |
| Not so strongly agree | 11 | 9 | 17 | 26 |
| Not so strongly disagree | 13 | 11 | 15 | 22 |
| Strongly disagree | 45 | 53 | 20 | 14 |
| Not sure | 8 | 9 | 4 | 5 |
| | | | | |
| Agree | 34 | 27 | 61 | 59 |
| Disagree | 58 | 64 | 35 | 36 |

**Q21**. I should have the freedom to plan if and when to have children.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 75 | 79 | 61 | 56 |
| Not so strongly agree | 11 | 9 | 16 | 30 |
| Not so strongly disagree | 7 | 6 | 14 | 10 |
| Strongly disagree | 2 | 2 | 5 | 2 |
| Not sure | 4 | 4 | 4 | 2 |
| | | | | |
| Agree | 87 | 88 | 77 | 86 |
| Disagree | 9 | 8 | 19 | 12 |

**Q22**. We must ensure access to reproductive health care for all women.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 58 | 60 | 56 | 55 |
| Not so strongly agree | 20 | 19 | 21 | 27 |
| Not so strongly disagree | 9 | 8 | 13 | 14 |
| Strongly disagree | 7 | 7 | 5 | 3 |
| Not sure | 6 | 6 | 5 | 2 |
| | | | | |
| Agree | 78 | 78 | 77 | 81 |
| Disagree | 16 | 16 | 18 | 17 |

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**Asked only of respondents with employees:**
**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 391 | 284 | 40 | 58 |
| Unweighted N= | 391 | 284 | 40 | 58 |

**Q23**. I support access to birth control, not just as an employer but as someone who cares about the people who work for me.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 55 | 55 | 53 | 52 |
| Not so strongly agree | 19 | 18 | 22 | 26 |
| Not so strongly disagree | 10 | 9 | 16 | 13 |
| Strongly disagree | 9 | 10 | 4 | 6 |
| Not sure | 7 | 8 | 5 | 4 |
| | | | | |
| Agree | 74 | 73 | 76 | 78 |
| Disagree | 19 | 19 | 19 | 18 |

**Q24**. Having access to birth control is important to my employees.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 41 | 38 | 55 | 52 |
| | | | | |
| Not so strongly agree | 19 | 18 | 24 | 19 |
| Not so strongly disagree | 12 | 12 | 12 | 14 |
| Strongly disagree | 15 | 17 | 6 | 8 |
| Not sure | 13 | 15 | 3 | 8 |
| | | | | |
| Agree | 60 | 56 | 79 | 70 |
| Disagree | 27 | 29 | 19 | 21 |

**Q25**. As an employer, I support access to birth control for my employees.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 52 | 52 | 50 | 57 |
| Not so strongly agree | 20 | 19 | 25 | 15 |
| Not so strongly disagree | 11 | 10 | 12 | 20 |
| Strongly disagree | 9 | 10 | 8 | 6 |
| Not sure | 9 | 10 | 4 | 2 |
| | | | | |
| Agree | 71 | 71 | 76 | 72 |
| Disagree | 20 | 20 | 20 | 26 |

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**Asked only of respondents with employees:**
**Do you agree or disagree with the following statements?**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 391 | 284 | 40 | 58 |
| Unweighted N= | 391 | 284 | 40 | 58 |

**Q26.** How important is it for people to have access to the following items to obtain financial security?

| | | | | |
|---|---|---|---|---|
| **Paid sick days** | | | | |
| Very important | 44 | 42 | 47 | 56 |
| Somewhat important | 28 | 28 | 25 | 35 |
| A little important | 17 | 18 | 17 | 8 |
| Not important at all | 7 | 7 | 10 | 1 |
| Not sure | 4 | 5 | 1 | 1 |
| Important | 72 | 70 | 72 | 91 |
| Not important | 24 | 25 | 27 | 9 |
| **Paid family and medical leave** | | | | |
| Very important | 38 | 35 | 53 | 59 |
| Somewhat important | 30 | 30 | 25 | 24 |
| A little important | 17 | 19 | 12 | 9 |
| Not important at all | 9 | 9 | 8 | 4 |
| Not sure | 6 | 6 | 2 | 3 |
| Important | 69 | 65 | 78 | 84 |
| Not important | 26 | 29 | 20 | 13 |
| **Help with child care** | | | | |
| Very important | 35 | 33 | 46 | 50 |
| Somewhat important | 25 | 23 | 29 | 31 |
| A little important | 20 | 23 | 14 | 10 |
| Not important at all | 14 | 14 | 8 | 6 |
| Not sure | 6 | 6 | 2 | 3 |
| Important | 60 | 56 | 75 | 81 |
| Not important | 34 | 37 | 23 | 16 |

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**QUESTIONS 11, 12, 13 BY FIRM SIZE**
**Do you agree or disagree with the following statements?**

| | TOTAL | SOLO | 2 - 9 EMPL | 10+ EMPL |
|---|---|---|---|---|
| Weighted N= | 507 | 116 | 233 | 158 |
| Unweighted N= | 718 | 143 | 288 | 287 |

**Q11**. My ability to access birth control to decide if and when to have children has impacted my ability to succeed as a business owner.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 32 | 22 | 33 | 39 |
| Not so strongly agree | 13 | 14 | 9 | 18 |
| Not so strongly disagree | 13 | 12 | 15 | 12 |
| Strongly disagree | 32 | 40 | 34 | 24 |
| Not sure | 9 | 12 | 9 | 6 |
| | | | | |
| Agree | 46 | 36 | 43 | 57 |
| Disagree | 46 | 52 | 48 | 37 |

**Q12**. My ability to access birth control to decide if and when to have children is an important part of me being able to make choices about my career and future.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 47 | 48 | 48 | 43 |
| Not so strongly agree | 17 | 15 | 15 | 22 |
| Not so strongly disagree | 11 | 9 | 9 | 15 |
| Strongly disagree | 19 | 23 | 20 | 14 |
| Not sure | 7 | 6 | 8 | 6 |
| | | | | |
| Agree | 64 | 63 | 63 | 65 |
| Disagree | 30 | 32 | 29 | 29 |

**Q13**. My ability to access birth control and to decide if and when to have children has impacted my bottom line as a business owner.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 26 | 19 | 27 | 29 |
| Not so strongly agree | 16 | 12 | 13 | 23 |
| Not so strongly disagree | 15 | 14 | 14 | 17 |
| Strongly disagree | 34 | 45 | 35 | 23 |
| Not sure | 10 | 10 | 11 | 7 |
| | | | | |
| Agree | 42 | 31 | 41 | 52 |
| Disagree | 48 | 59 | 48 | 41 |

**Q13b**. (Asked if agree in previous question) In what way has your ability to access birth control and to decide if and when to have children helped your bottom line?

| | | | | |
|---|---|---|---|---|
| Weighted N= | 213 | 36 | 95 | 82 |
| Unweighted N= | 345 | 46 | 127 | 172 |
| | | | | |
| Gave opportunity and freedom to focus on business | 31 | 45 | 36 | 20 |
| Choice if/when to have children | 23 | 30 | 29 | 13 |
| Increased flexibility and decision making about future | 8 | 5 | 9 | 9 |
| Did not have an impact | 7 | 8 | 7 | 6 |
| No child-related expenses | 5 | 8 | 7 | 2 |
| Has had a positive impact | 3 | 1 | 2 | 5 |
| Employees are more focused | 2 | 0 | 0 | 4 |

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**QUESTIONS 12, 18, 19, 20 BY AGE**
**Do you agree or disagree with the following statements?**

| | TOTAL | Under 50 | 50 & Over | Under 30 |
|---|---|---|---|---|
| Weighted N= | 507 | 271 | 236 | 65 |
| Unweighted N= | 718 | 445 | 273 | 140 |

**Q12**. My ability to access birth control to decide if and when to have children is an important part of me being able to make choices about my career and future.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 47 | 48 | 45 | 49 |
| Not so strongly agree | 17 | 22 | 11 | 23 |
| Not so strongly disagree | 11 | 12 | 9 | 10 |
| Strongly disagree | 19 | 13 | 26 | 12 |
| Not sure | 7 | 6 | 8 | 6 |
| | | | | |
| Agree | 64 | 70 | 57 | 72 |
| Disagree | 30 | 25 | 35 | 22 |

**Q18**. My ability to access birth control and to decide if and when to have children allowed me to advance my career and start my own business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 39 | 42 | 35 | 50 |
| Not so strongly agree | 17 | 20 | 14 | 19 |
| Not so strongly disagree | 12 | 10 | 14 | 10 |
| Strongly disagree | 24 | 19 | 29 | 13 |
| Not sure | 8 | 8 | 8 | 9 |
| | | | | |
| Agree | 56 | 62 | 49 | 68 |
| Disagree | 36 | 29 | 43 | 22 |

**Q19**. My ability to access birth control and to decide if and when to have children impacts my ability to grow my business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 36 | 42 | 28 | 49 |
| Not so strongly agree | 16 | 20 | 12 | 19 |
| Not so strongly disagree | 13 | 12 | 15 | 14 |
| Strongly disagree | 28 | 20 | 37 | 14 |
| Not sure | 7 | 6 | 8 | 5 |
| | | | | |
| Agree | 52 | 62 | 40 | 68 |
| Disagree | 41 | 31 | 53 | 27 |

**Q20**. I put off or am putting off starting a family to focus on or expand my business.

| | | | | |
|---|---|---|---|---|
| Strongly agree | 22 | 34 | 8 | 46 |
| Not so strongly agree | 11 | 15 | 7 | 15 |
| Not so strongly disagree | 13 | 10 | 15 | 12 |
| Strongly disagree | 45 | 31 | 62 | 20 |
| Not sure | 8 | 9 | 8 | 6 |
| | | | | |
| Agree | 34 | 50 | 15 | 62 |
| Disagree | 58 | 41 | 77 | 32 |

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**The remaining questions are for statistical purposes only.**

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q27**. What is your religion?

| | | | | |
|---|---|---|---|---|
| Protestant (Baptist, Adventist, Lutheran, Methodist, Presbyterian, Pentecostal, Anglican) | 32 | 36 | 32 | 15 |
| Catholic | 24 | 22 | 17 | 47 |
| Other Christian | 15 | 13 | 27 | 14 |
| Jewish | 6 | 7 | 3 | 4 |
| Muslim | 1 | 1 | 4 | 1 |
| Mormon, Latter Day Saints, LDS | 1 | 1 | 0 | 0 |
| Other (Please write in) | 6 | 5 | 5 | 6 |
| None/Agnostic/Atheist | 15 | 16 | 12 | 12 |

**Q28**. Generally speaking, do you think of yourself as a Republican, a Democrat, an independent, or something else?

| | | | | |
|---|---|---|---|---|
| Strong Democrat | 23 | 20 | 46 | 30 |
| Not strong Democrat | 10 | 9 | 14 | 12 |
| Lean Democrat | 6 | 6 | 6 | 9 |
| Democrat | 39 | 35 | 65 | 51 |
| Indepependent | 11 | 11 | 11 | 11 |
| Republican | 41 | 45 | 17 | 32 |
| Lean Republican | 6 | 6 | 2 | 1 |
| Not strong Republican | 14 | 16 | 3 | 8 |
| Strong Republican | 22 | 23 | 11 | 23 |
| Other | 3 | 3 | 1 | 1 |
| Not sure | 2 | 2 | 1 | 3 |
| Prefer not to answer | 4 | 3 | 5 | 2 |

**Q29.** What is your age?

| | | | | |
|---|---|---|---|---|
| 18-24 | 5 | 3 | 18 | 13 |
| 25-29 | 8 | 5 | 19 | 18 |
| 30-34 | 9 | 7 | 16 | 18 |
| 35-39 | 12 | 10 | 20 | 23 |
| 40-44 | 11 | 10 | 13 | 9 |
| 45-49 | 9 | 10 | 5 | 3 |
| 50-54 | 13 | 14 | 5 | 7 |
| 55-59 | 14 | 15 | 2 | 8 |
| 60-64 | 11 | 14 | 2 | 1 |
| 65-69 | 6 | 8 | 0 | 1 |
| 70-74 | 2 | 3 | 0 | 0 |
| 75 & older | 0 | 1 | 0 | 0 |

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| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 507 | 387 | 48 | 61 |
| Unweighted N= | 718 | 433 | 145 | 153 |

**Q30**. For statistical purposes only, which of these categories best describes the gross revenue of your business in 2016?

| | | | | |
|---|---|---|---|---|
| Less than $100,000 | 39 | 43 | 32 | 24 |
| $100,000 to under $250,000 | 20 | 19 | 19 | 21 |
| $250,000 to under $500,000 | 15 | 13 | 24 | 24 |
| $500,000 to under $1 million | 10 | 9 | 15 | 14 |
| $1 million to under $2 million | 7 | 7 | 5 | 13 |
| $2 million or more | 4 | 4 | 4 | 4 |
| Not sure | 4 | 4 | 1 | 1 |

**Q31**. What is the last year of schooling that you have completed?

| | | | | |
|---|---|---|---|---|
| 1 - 11th Grade | 0 | 0 | 0 | 1 |
| High School Graduate | 10 | 11 | 13 | 9 |
| Non-College Post H.S. | 2 | 2 | 2 | 2 |
| Some College | 29 | 31 | 25 | 25 |
| Bachelor's degree | 36 | 37 | 30 | 40 |
| Master's degree | 16 | 13 | 22 | 19 |
| Doctoral degree | 6 | 5 | 8 | 4 |

**Q32**. At any point in your life, have you used birth control, like a pill, implant, patch, shot, vaginal ring, or IUD?

| | | | | |
|---|---|---|---|---|
| Yes | 81 | 84 | 68 | 83 |
| No | 15 | 13 | 27 | 14 |
| Prefer not to answer | 3 | 3 | 5 | 2 |
| Not sure | 0 | 0 | 0 | 0 |

**Q33**. (If have insurance) Does your health insurance cover your birth control?

| | TOTAL | WHITE | AA | LATINA |
|---|---|---|---|---|
| Weighted N= | 438 | 337 | 39 | 53 |
| Unweighted N= | 615 | 380 | 116 | 134 |

| | | | | |
|---|---|---|---|---|
| Yes, my insurance pays the full cost of my birth control | 33 | 29 | 51 | 59 |
| Yes, but I pay a copay for my birth control | 13 | 12 | 22 | 17 |
| No, my insurance does not cover my birth control | 13 | 13 | 12 | 11 |
| I do not use prescription birth control | 28 | 33 | 8 | 9 |
| I do not have health insurance | 0 | 0 | 2 | 0 |
| Not sure | 12 | 13 | 6 | 4 |

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF KEISHA BATES IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Keisha Bates, declare:

1. I am a Maryland resident who is currently residing in Lanham, MD. Since moving to Maryland, I have worked in basic science research at a neuroscience lab at Johns Hopkins and as an admission counselor at the University of Maryland College Park. I am currently working as an inpatient gynecology/perinatal nurse at a large, urban hospital and am a student in the Doctor of Nursing Practice program, Family Nurse Practitioner Specialty, at the University of Maryland School of Nursing.

2. This declaration is about my personal knowledge about the impact of the final rules published by the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and the U.S. Department of Treasury, on November 15, 2018. The final rules will dramatically reduce access to contraceptive coverage for me and my patients.

3. Contraceptive coverage is essential to me. Through my current employer, I have contraceptive 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 contraceptive coverage, regardless of where I work. The current IUD I have will expire in less than a year, 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 complete my doctoral degree to become a nurse practitioner.

4. The final rules personally harm me by limiting my future job choices to employers with contraceptive coverage, thus decreasing my opportunities for career development and advancement. The final rules will increase the number of employers who do not offer insurance with contraceptive 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 final rules also personally harm me because, at any point in my career, my employer could discontinue contraceptive 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.

6. As a nurse, I am concerned about the impact of the final rules on my patients. Pregnancy is a serious medical condition, and it 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 final rules on my patients. If their employers drop contraceptive coverage, they may forgo using contraception and be in a position where their health or life is at risk.

7. 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

Executed on June 17, 2019, in Lanham, Maryland.



Keisha Bates
B.A., M.S., R.N.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF PHYLLIS C. BORZI IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Phyllis C. Borzi, declare:

1. From 2009-2017, I was the Assistant Secretary for the U.S. Department of Labor. In that capacity, I was the official in charge of the Employee Benefits Security Administration. The Employee Benefits Security Administration oversees millions of private-sector pension and welfare benefit plans, including health plans that provide benefits to approximately 142 million Americans.

2. Prior to serving as Assistant Secretary, I was a research professor in the Department of Health Policy at George Washington University's Medical Center's School of Public Health and Health Services. I was also of counsel at O'Donoghue & O'Donoghue LLP, specializing in the Employee Retirement Income Security Act (ERISA) and other legal issues affecting employee benefits plans. From 1979 to 1995, I served as pension and employee benefit counsel for the U.S. House of Representatives, Subcommittee on Labor-Management Relations of the Committee on Education and Labor. Attached hereto as Exhibit 1 is my curriculum vitae.

3. In my time as the Assistant Secretary, I worked extensively on the Affordable Care Act's contraceptive coverage requirement and subsequent religious accommodation.

4. Under the accommodation, an "eligible organization" can opt out of any requirement to "contract, arrange, pay, or refer for contraceptive coverage," by providing notice of its objection in either of two ways: (1) providing a "self-certification" form directly to an issuer or (2) providing notice directly to the Secretary of Health and Human Services (HHS). Under either method of notification, once an employer opts out, it is relieved of any obligation to provide

contraceptive coverage. Instead, the regulation provides for a third party to make separate payments for contraceptive services for employees (and their covered dependents) who choose to use those services.

5. If an employer chooses to opt out using the self-certification form, it must complete a form known as the EBSA Form 700. The form requires the employer to certify that is has a religious objection to providing contraceptive coverage and that it is eligible to opt out. The only other information the form requires is the name and contact information of the person making the certification.

6. If an employer chooses to opt out using the notification process, it must provide written notification of its objection to the Secretary of Health & Human Services. The employer need not use any particular form and need only provide information comparable to what is required in the form: the basis on which the organization is eligible to opt out, as well as the type of plan it offers and contact information for the plan's insurer or TPA.

7. If the employer provides the self-certification form directly to the issuer, the issuer then has sole responsibility for providing contraceptive coverage. From that point on, the eligible organization does not contract, arrange, pay, or refer for contraceptive coverage.

8. If the employer provides notice to the Secretary of Health and Human Services, then the U.S. Department of Labor (working with the U.S. Department of Health and Human Services) will then send a separate notification to each of the plan's health insurance issuers informing the issuer that the Secretary has received a notice from an eligible organization. Once again, from that point on, the eligible organization does not contract, arrange, pay, or refer for contraceptive coverage.

9. Under the accommodation, a group health insurance issuer that received either the self-certification or notification from the Secretary, must expressly exclude contraceptive coverage from the group health coverage provided in connection with the employer's plan and provide separate payments for any contraceptive services required to be covered for plan employees and covered dependents.

10. The accommodation specifically provides that the issuer may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly on the eligible organization, or the group health plan.

11. The accommodation further requires the issuer to segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services.

12. Additionally, under the accommodation, the issuer is required to provide plan participants and beneficiaries written notice of the separate payments for contraceptive services separate from any application materials distributed in connection with enrollment in the group health coverage.

13. That notice must specify that the eligible organization does not administer or fund contraceptive benefits but that the issuer provides separate payment for contraceptive services, and must provide contact information for questions and complaints. The regulations provided sample language. Attached hereto as Exhibit 2 are true and correct copies of sample notice documents to employees.

14. The mechanics of implementing the accommodation can vary depending on whether the employer has a fully insured plan or a self-funded plan. By its own terms, the ACA obligates both group health plans and health insurance issuers to provide contraceptive coverage.

15. For fully insured plans—that is, benefit coverage purchased by the employer from a health insurer such as BlueCross BlueShield—once the issuer has been informed that the employer objects to covering some or all contraceptive methods, the carrier has the sole and exclusive responsibility to provide separate contraceptive coverage under the accommodation.

16. That separate contraceptive coverage does not utilize employer's group health plan coverage—or any "plan infrastructure" associated with that that employer's plan, in any way, including the plan's "network." An "insurance coverage network" is a set of doctors, hospitals,

and other providers with which an insurer carrier or third party administrator (TPA)[1] had pre-negotiated rates of payment. This "insurance coverage network" is also tied to the proximity of the enrollee. The accommodation ensures that women employees and their covered dependents receive contraceptive services from healthcare providers in their existing "insurance coverage networks"—i.e. from their regular doctor. And because those providers already have relationships with the women's insurers and TPAs, they also have the "coverage administration infrastructure" to verify the women's coverage for benefits and bill the insurers and TPAs for contraceptive services. But, the "networks" and "infrastructure" through which the insurers or TPAs provide contraceptive coverage are not owned or controlled by objecting employers—they are relationships among third-party insurers, TPAs, and healthcare providers.

17. For self-funded plans, employers do not purchase coverage from an insurer, they assume direct financial responsibility for employee health claims. Employers who use self-funded plans typically hire an insurance company or other outside entity to serve as a TPA responsible for developing a network of healthcare providers, negotiating payment rates, and processing claims for benefits.

18. When an employer elects to use self-funded plans, the accommodation works in a slightly different fashion. An employer who maintains a self-funded group health plan must comply with the regulatory requirements and is excused from providing contraceptive coverage if "[t]he eligible organization or its plan contracts with one or more third party administrators" and "[t]he eligible organization provides either a copy of the self-certification to each third party administrator or a notice to the Secretary of Health and Human Services that it is an eligible organization and of its religious objection to coverage of all or a subset of contraceptive services." 26 C.F.R. § 54.9815–2713AT(b)(1); 29 C.F.R. § 2590.715–2713A(b)(1).

19. Although the text of the ACA does not specify a role for TPAs, it expressly requires group health plans to include contraceptive coverage, and federal regulations impose obligations on TPAs that administer self-funded group health plans. *See* 42 U.S.C. § 300gg–13; 26 C.F.R. §

[1] A third-party administrator (TPA) is an entity that processes insurance claims or handles certain aspects of employee benefit plans.

54.9815–2713AT(b); 29 C.F.R. § 2590.715–2713A(b). The regulations require a TPA administering a group health plan to provide or arrange for contraceptive coverage without cost sharing with the organization or its beneficiaries when it: (1) receives a notification that an eligible employer has opted out of providing coverage and (2) decides to remain in a relationship with that employer or its plan to provide administrative services for the plan. 26 C.F.R. § 54.9815–2713AT(b)(2); 29 C.F.R. § 2590.715–2713A(b)(2). The TPA's obligations are enforceable under the Employee Retirement Income Security Act ("ERISA"). *See* 78 Fed.Reg. at 39,879–80.

20. The fact that ERISA provides the legal authority to require the TPA to provide separate contraceptive coverage does not mean that the separate contraceptive coverage is part of the employer's group health plan coverage. That is not the case. The employer's group health plan coverage remains completely separate from the TPA-provided contraceptive coverage. The employer's group health plan is not used in any way to provide that completely separate contraceptive coverage.

21. An ERISA plan is not a tangible thing. It is simply a set of rules that defines the rights of a beneficiary. Under the accommodation, the rules governing contraceptive coverage are established by the government, not the employer, and the employer does not fund, control, or have any other involvement in that separate coverage—instead, the TPA alone does so.

22. At bottom, regardless of the type of plan involved, the accommodation separates the objecting employer from the provision of contraceptive coverage. The employer does not provide or pay for contraceptive coverage.

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

Executed on 6/28, 2019, in Washington, DC.

Phyllis C Borzi

Phyllis C. Borzi

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MARI CANTWELL IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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 2017-18, the most recent fiscal year for which data is available, Family PACT served approximately 940,000 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 majority of costs for the Family PACT program according to applicable Federal Medical Assistance Percentage (FMAP) rates provided in Medicaid. Eligible 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— approximately 1.38 million—decreased 17.9% from the previous fiscal year. In 2015-16, the number of Family PACT clients decreased to approximately 1.16 million, representing a 15.9% decrease from 2014-15. In 2016-17, the number of Family PACT clients decrease to approximately 1.08 million, representing a 21.7% decrease from 2014-15. Finally, in 2017-18, the number of Family PACT clients decreased to approximately 940,000, representing an overall 31.8% decrease from 2014-15.

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 99,712 in 2014-15, 92,811 in 2015-16, and 72,303 in 2017-18. This represents a 21% decrease from 2013-14 to 2014-15, a 6.9% decrease from 2014-15 to 2015-16, a 28% decrease from 2015-16 to 2017-18 and an overall 43% decrease from 2013-14 to 2017-18.

15. It is my understanding that under the two 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 November 15, 2018 (Final Rules), 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 Final Rules, 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 Final Rules, additional individuals become eligible for and enroll in Family PACT, this will result in increased financial obligations for California's Medi-Cal program.

18. It is my understanding that the federal government suggests that women affected by the Final Rules should seek out services at Title X clinics. In California, in order for a clinic to receive Title X funding, that clinic must also be a Family PACT provider. Accordingly, all individuals in California who visit clinics that receive Title X funding are screened for Family PACT eligibility. Since more women may visit family planning clinics that receive Title X funding because of the broad exemptions created by the Final Rules, more women may be screened for Family PACT, and more women may be placed in the Family PACT program. As a result, state dollars may be diverted to provide care for this patient population that should instead be receiving contraceptive coverage through their employer-sponsored insurance.

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

Executed on June 24, 2019, in Sacramento, CA.



Mari Cantwell
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF RANDIE C. CHANCE, Ph.D, IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Randie C. Chance, Ph.D., 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 Director of the Department of Justice Research Center (the Research Center) within the California Justice Information Services Division of the California Department of Justice (CA DOJ).

3. The Research Center provides several functions to improve the work of the CA DOJ. Among other things, the Research Center supports divisions with their mandated reports by providing guidance and expertise on the content and the display of data in these reports; provides empirical research to improve social science research cited in the CA DOJ's litigation, in the development of legislative and policy proposals and in review of our law enforcement practices; and provides research and reports on public policy issues confronting California that affect the work of the CA DOJ.

4. I have worked for the CA DOJ since 2014. Prior to my current appointment, I served as the CA DOJ's lead researcher on a wide variety of research topics such as police practices, racial profiling and stop data, and issues related to immigration. I have also been leading a research team working to release criminal justice data for public access, and process data requests

in support of the research community. Previously, I was a Senior Associate with a consulting firm examining social issues through services such as program evaluation, statistical consulting, and survey design and research.

5. I completed my doctorate in Psychology with a focus on Applied Social Psychology and Diversity Issues at Southern Illinois University Carbondale. I received a master's degree in Experimental Psychology and bachelor's degree in Psychology from the California State University at San Marcos. I have been conducting research on social justice topics for nearly 15 years.

6. I have reviewed the final moral and religious exemption rules and the moral and religious interim final rules (IFRs), issued by the U.S. Department of Health and Human Services, the U.S. Department of the Treasury, and the U.S. Department of Labor (the Departments). Because the final moral rule claims that only 15 women may be affected by its provisions, I focus on the final religious rule in which the Departments give detailed estimates of the numbers of women who may be affected.

7. In the final religious exemption rule, the Departments use two methods to calculate the number of women who may be affected by the unavailability of contraception. I discuss the calculation methods in greater detail in the next few paragraphs. Yet in any case, in the rule the Departments admit that women will be harmed by losing cost-free access to contraception.

8. The first calculation method is based on the numbers of entities that have sued combined with entities that may switch from the accommodation to the exemption. This method yields an estimate of 70,500 women nationwide who would lose access to cost-free contraception. The second method, based on demographic calculations of the insured workforce, yields an estimate of 126,400 women.

The Final Religious Exemption Rule's First Estimate: 70,500 women

9. This calculation in the final rule relies on the numbers of litigating entities and estimates of the numbers of accommodated entities that would switch to the exemption, and gives a total of 70,500 women. In the calculation of both components of this estimate, the rule makes

use of data from the 2010 census indicating women aged 15-44 comprise 20.2 percent of the U.S. population. (This calculation is problematic, as I discuss in paragraphs 16-17.)

10. I apportioned the harm from the first estimate—70,500 women total—to the plaintiff, plaintiff-intervenor, and proposed-plaintiff-intervenor states using the proportion of women aged 15-44 in each state, per the 2010 census. Table A1 gives the state-by-state data, and Table A2 apportions the overall harm to 70,500 women to the plaintiff, plaintiff-intervenor, and proposed-plaintiff-intervenor states (rounded to nearest hundred).

**Table A1: State-by-state percentages of women aged 15-44 per the 2010 census**

| | | F 15-44<br>2010 census |
|---|---|---|
| *All U.S.* | *Number* | *62,374,964* |
| California | Number | 7,876,871 |
| | Percentage of U.S. | 12.63% |
| Colorado | Number | 1,025,085 |
| | Percentage of U.S. | 1.64% |
| Connecticut | Number | 691,265 |
| | Percentage of U.S. | 1.11% |
| Delaware | Number | 179,232 |
| | Percentage of U.S. | 0.29% |
| Hawaii | Number | 262,107 |
| | Percentage of U.S. | 0.42% |
| Illinois | Number | 2,631,753 |
| | Percentage of U.S. | 4.22% |
| Maryland | Number | 1,193,402 |
| | Percentage of U.S. | 1.91% |
| Michigan | Number | 1,918,594 |
| | Percentage of U.S. | 3.08% |
| Minnesota | Number | 1,045,681 |
| | Percentage of U.S. | 1.68% |
| Nevada | Number | 549,924 |
| | Percentage of U.S. | 0.88% |
| New York | Number | 4,047,947 |
| | Percentage of U.S. | 6.49% |
| North Carolina | Number | 1,949,350 |
| | Percentage of U.S. | 3.13% |
| Oregon | Number | 754,077 |
| | Percentage of U.S. | 1.21% |
| Rhode Island | Number | 214,647 |
| | Percentage of U.S. | 0.34% |
| Vermont | Number | 118,297 |
| | Percentage of U.S. | 0.19% |
| Virginia | Number | 1,652,698 |
| | Percentage of U.S. | 2.65% |
| Washington | Number | 1,355,704 |

| | | |
|---|---|---|
| | Percentage of U.S. | 2.17% |
| District of Columbia | Number | 162,314 |
| | Percentage of U.S. | 0.26% |
| **Plaintiff and Intervenor Total** | **Number** | **27,628,948** |
| | **Percentage of U.S.** | **44.29%** |

**Table A2: Harm apportioned according to the percentages in Table A1**

| | |
|---|---|
| California | 8,900 |
| Colorado | 1,200 |
| Connecticut | 800 |
| Delaware | 200 |
| Hawaii | 300 |
| Illinois | 3,000 |
| Maryland | 1,300 |
| Michigan | 2,200 |
| Minnesota | 1,200 |
| Nevada | 600 |
| New York | 4,600 |
| North Carolina | 2,200 |
| Oregon | 900 |
| Rhode Island | 200 |
| Vermont | 100 |
| Virginia | 1,900 |
| Washington | 1,500 |
| District of Columbia | 200 |
| **Plaintiff and Intervenor Total[1]** | **31,300** |

The Final Religious Exemption Rule's Second Estimate: 126,400 women

11. The second estimate of 126,400 affected women relies on two independent sets of federal statistics that can each be broken down by state. State-by-state data for each data set are presented in Tables B1 and B2, and Table B3 shows the apportionment of the 126,400 women by the various methods discussed (rounded to the nearest hundred).

12. First, the calculation in the rule uses the numbers of women under age 65 and between ages 15 and 44 from the 2017 American Community Survey (ACS): 137,021,411 women under

[1] Total may not equal the sum of each state figure due to rounding.

65 and 64,030,796 women aged 15-44.[2] If we compare these numbers with the state-by-state figures from the 2017 ACS, we can estimate the percentage of the 126,400 women who would reside in each plaintiff, plaintiff-intervenor, and proposed-plaintiff-intervenor state. Since the age distributions of each state differ, I get slightly different results if I base the apportionment on a state's share of women under age 65 versus on a state's share of women aged 15-44.

**Table B1: State-by-state percentages of women per the 2017 ACS**

| | | F under 65 2017 ACS | F 15-44 2017 ACS |
|---|---|---|---|
| *All U.S.* | *Number* | *137,021,411* | *64,030,796* |
| California | Number | 16,825,212 | 8,103,747 |
| | Percentage of U.S. | 12.28% | 12.66% |
| Colorado | Number | 2,366,494 | 1,140,167 |
| | Percentage of U.S. | 1.73% | 1.78% |
| Connecticut | Number | 1,497,628 | 673,900 |
| | Percentage of U.S. | 1.09% | 1.05% |
| Delaware | Number | 400,226 | 181,538 |
| | Percentage of U.S. | 0.29% | 0.28% |
| Hawaii | Number | 571,570 | 265,283 |
| | Percentage of U.S. | 0.42% | 0.41% |
| Illinois | Number | 5,407,686 | 2,532,430 |
| | Percentage of U.S. | 3.95% | 3.96% |
| Maryland | Number | 2,603,572 | 1,193,507 |
| | Percentage of U.S. | 1.90% | 1.86% |
| Michigan | Number | 4,132,912 | 1,870,995 |
| | Percentage of U.S. | 3.02% | 2.92% |
| Minnesota | Number | 2,325,564 | 1,065,835 |
| | Percentage of U.S. | 1.70% | 1.66% |
| Nevada | Number | 1,250,384 | 589,790 |
| | Percentage of U.S. | 0.91% | 0.92% |
| New York | Number | 8,403,814 | 3,996,449 |
| | Percentage of U.S. | 6.13% | 6.24% |
| North Carolina | Number | 4,356,128 | 2,025,262 |
| | Percentage of U.S. | 3.18% | 3.16% |
| Oregon | Number | 1,705,621 | 811,026 |
| | Percentage of U.S. | 1.24% | 1.27% |
| Rhode Island | Number | 445,925 | 211,995 |
| | Percentage of U.S. | 0.33% | 0.33% |
| Vermont | Number | 252,439 | 113,778 |
| | Percentage of U.S. | 0.18% | 0.18% |
| Virginia | Number | 3,599,947 | 1,692,571 |
| | Percentage of U.S. | 2.63% | 2.64% |
| Washington | Number | 3,098,021 | 1,464,469 |

[2] U.S. Census Bureau, ACS 1-Year Estimates, Age and Sex (2017), available at https://data.census.gov/cedsci/table?q=Population&hidePreview=true&table=S0101&tid=ACSST1Y2017.S0101.

| | | | |
|---|---|---|---|
| | Percentage of U.S. | 2.26% | 2.29% |
| District of Columbia | Number | 315,103 | 186,250 |
| | Percentage of U.S. | 0.23% | 0.29% |
| **Plaintiff and Intervenor Total** | **Number** | **59,548,246** | **28,118,992** |
| | **Percentage of U.S.** | **43.46%** | **43.91%** |

13. The second estimate also relies on statistics from the U.S. Department of Labor (DOL) on the number of individuals receiving health insurance from various sources, including employer-sponsored insurance (ESI) and Medicare.[3] Individuals with ESI are further broken down into those with insurance from the public sector and those with private sector-sponsored insurance. The rule relies on both the overall number of people with ESI as their primary insurance and the number who have private-sector ESI as their primary insurance. These numbers are not completely consistent with each other, since some states have a larger proportion of public-sector workers. Such states include Maryland and Virginia, likely due to a higher proportion of federal employees who live in these states.

**Table B2: State-by-state percentages of individuals with ESI, per DOL**

| | | With ESI | Private-sector ESI |
|---|---|---|---|
| *All U.S.* | *Number* | *168,700,000* | *131,600,000* |
| California | Number | 19,600,000 | 15,400,000 |
| | Percentage of U.S. | 11.62% | 11.70% |
| Colorado | Number | 3,000,000 | 2,400,000 |
| | Percentage of U.S. | 1.78% | 1.82% |
| Connecticut | Number | 2,000,000 | 1,500,000 |
| | Percentage of U.S. | 1.19% | 1.14% |
| Delaware | Number | 500,000 | 400,000 |
| | Percentage of U.S. | 0.30% | 0.30% |
| Hawaii | Number | 800,000 | 600,000 |
| | Percentage of U.S. | 0.47% | 0.46% |
| Illinois | Number | 7,400,000 | 6,200,000 |
| | Percentage of U.S. | 4.39% | 4.71% |
| Maryland | Number | 3,600,000 | 2,400,000 |
| | Percentage of U.S. | 2.13% | 1.82% |
| Michigan | Number | 5,600,000 | 4,600,000 |
| | Percentage of U.S. | 3.32% | 3.50% |
| Minnesota | Number | 3,300,000 | 2,500,000 |
| | Percentage of U.S. | 1.96% | 1.90% |
| Nevada | Number | 1,400,000 | 1,200,000 |
| | Percentage of U.S. | 0.83% | 0.91% |

[3] U.S. Department of Labor, Health Insurance Coverage Bulletin (July 25, 2017), at Table 1C, available at https://www.dol.gov/sites/default/files/ebsa/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf.

| | | | |
|---|---|---|---|
| New York | Number | 10,600,000 | 8,100,000 |
| | Percentage of U.S. | 6.28% | 6.16% |
| North Carolina | Number | 5,200,000 | 4,200,000 |
| | Percentage of U.S. | 3.08% | 3.19% |
| Oregon | Number | 2,100,000 | 1,600,000 |
| | Percentage of U.S. | 1.24% | 1.22% |
| Rhode Island | Number | 600,000 | 500,000 |
| | Percentage of U.S. | 0.36% | 0.38% |
| Vermont | Number | 300,000 | 300,000 |
| | Percentage of U.S. | 0.18% | 0.23% |
| Virginia | Number | 4,600,000 | 3,200,000 |
| | Percentage of U.S. | 2.73% | 2.43% |
| Washington | Number | 3,900,000 | 3,000,000 |
| | Percentage of U.S. | 2.31% | 2.28% |
| District of Columbia | Number | 400,000 | 300,000 |
| | Percentage of U.S. | 0.24% | 0.23% |
| **Plaintiff and Intervenor Total** | **Number** | **74,900,000** | **58,400,000** |
| | **Percentage of U.S.** | **44.40%** | **44.38%** |

**Table B3: Harm apportioned according to the percentages in Tables B1 and B2**

| | By percent of F under 65 (ACS) | By percent of F 15-44 (ACS) | By percent with ESI as primary | By percent with private sector as primary |
|---|---|---|---|---|
| California | 15,500 | 16,000 | 14,700 | 14,800 |
| Colorado | 2,200 | 2,300 | 2,200 | 2,300 |
| Connecticut | 1,400 | 1,300 | 1,500 | 1,400 |
| Delaware | 400 | 400 | 400 | 400 |
| Hawaii | 500 | 500 | 600 | 600 |
| Illinois | 5,000 | 5,000 | 5,500 | 6,000 |
| Maryland | 2,400 | 2,400 | 2,700 | 2,300 |
| Michigan | 3,800 | 3,700 | 4,200 | 4,400 |
| Minnesota | 2,100 | 2,100 | 2,500 | 2,400 |
| Nevada | 1,200 | 1,200 | 1,000 | 1,200 |
| New York | 7,800 | 7,900 | 7,900 | 7,800 |
| North Carolina | 4,000 | 4,000 | 3,900 | 4,000 |
| Oregon | 1,600 | 1,600 | 1,600 | 1,500 |
| Rhode Island | 400 | 400 | 500 | 500 |
| Vermont | 200 | 200 | 200 | 300 |
| Virginia | 3,300 | 3,300 | 3,500 | 3,100 |
| Washington | 2,900 | 2,900 | 2,900 | 2,900 |
| District of Columbia | 300 | 400 | 300 | 300 |
| **Plaintiff and Intervenor Total[4]** | **54,900** | **55,500** | **56,100** | **56,200** |

Analysis of Calculations

[4] Total may not equal the sum of each state figure due to rounding.

14. In the previous religious IFR, the Departments also gave two estimates: first that 31,700 women and second that 120,000 women would be affected by the loss of cost-free contraceptive access. In the final rule, the Departments use the same method to calculate the first estimate, but a different method for the second. In the following paragraphs I offer a few comments on problems with the calculations used in the rules and the reasons that the final rule gives different totals.

First Estimate:

15. The first component is the estimated number of contraceptive-using women of reproductive age (15-44) who will be affected by the use of the expanded exemption among litigating entities. This is calculated to be 8,700 in the IFR and 6,400 in the final rule. The difference between the two exists mainly because in the final rule, the Departments try to remove from consideration the women who work for entities that have received permanent injunctions. A key step in the calculation involves multiplying A) the total number of individuals covered by employer-based insurance at entities that will take the exemption by B) the percent of the overall population that is women aged 15-44. This step is problematic because it assumes that the demographics of people with employer-sponsored health insurance resemble the overall demographics of the country. Because most individuals over age 65 are insured through Medicare and many children receive insurance through CHIP, the proportion of women aged 15-44 who have employer-sponsored health insurance is likely much higher than the percentage used in the estimates (20.2%, based on the 2010 census).

16. The second component of the first estimate is an approximation of the number of women who might be affected by entities that switch from the accommodation to the exemption: 23,000 in the IFR and 64,000 in the final rule. The difference here is due to a large increase in the number of persons covered by self-insured plans that received user fee reimbursements for contraceptives in 2017. In the IFR, the Departments relied on 2015 data that 576,000 participants were covered by such plans; in the final rule, they cite 1,823,000 participants. This approximately threefold increase in the number of plan participants explains the approximately

threefold increase in this component of the first estimate. Like the first component, this component also makes use of a problematic calculation using the 20.2 percent of the overall population that is women aged 15-44. This component also uses the dubious assumption that large hospital plans will not shift to the exemption, estimating that only 25 percent of individuals covered by plans that received fee reimbursements will be affected by a shift from the accommodation to the exemption.

Second Estimate:

17. In the IFR, the second estimate uses as its starting point a 2015 data brief from the Assistant Secretary of Health and Human Services for Planning and Evaluation, which reports that 55.6 million women aged 15-64 have health insurance with cost-free preventive services under the ACA (ASPE Data Point, May 14, 2015, pp. 669062-669064 of the Administrative Record, attached as Exhibit A). In the final rule, the second estimate starts from the total number of individuals under age 65 that receive employer-based health insurance.

18. Despite the different starting points, the estimates rely on some of the same assumptions. They both use a Kaiser Family Foundation (KFF) survey from 2010 to estimate that 6 percent of plans may drop coverage for contraceptives, because 6 percent of plans did not cover contraceptives before the ACA.[5] This is a problematic assumption for at least two reasons. First, covering some contraception prior to the ACA is not equivalent to covering all FDA-approved contraceptive methods free of cost sharing, per the ACA's requirements. Second, though the results of the KFF survey suggested that 6 percent of firms overall did not cover contraceptives, the results also indicated that 11 percent for large firms (200 or more employees) did not cover contraceptives. According to the U.S. Small Business Administration, in 2014 approximately 72.4 million workers (59.8%) were employed at firms with 200 or more employees, compared to 48.6 million (40.2%) at firms with fewer than 200.[6] It would follow that more women were

[5] Kaiser Family Foundation, Employer Health Benefits 2010 Annual Survey (2010), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8085.pdf.

[6] U.S. Small Business Administration, Employer Firms, Establishments, Employment, and Annual Payroll Small Firm Classes, 1992-2014. Available via https://www.sba.gov/advocacy/firm-size-data.

employed by the 11 percent of large firms that did not offer coverage of contraceptives through their health plans prior to the ACA.

19. Additionally, the estimates in both the IFR and the final rule make use of the same assumption that one-third of plans that do not offer coverage of contraceptives do so for religious reasons. This assumed proportion appears to be arbitrary, suggesting that actual number of affected women could be three times greater.

Employees of Entities That Have Expressed Objections to Contraceptive Coverage

20. Two charts in the Administrative Records (pp. 670107-670133 and 805059-805065, attached as Exhibits B and C) present employers and higher education institutions that the federal administration expects will utilize an expanded objection. These charts are drawn from lawsuits filed against the administration as well as from employers that sent notice of their objection to the federal government. Many of these entities have locations in the plaintiff, plaintiff-intervenor, and proposed-plaintiff-intervenor states. Locations of employers and higher education institutions were found from publicly available information.

21. Table C presents a list of entities taken from the lists and litigants in the Administrative Record.

**Table C: Objecting Entities Identified in the Administrative Record**

| State | Employers |
|---|---|
| California | Hobby Lobby Stores, Inc.; Town & County Manor; Simpson University; Biola University; Thomas Aquinas College; Cherry Creek Mortgage Co.; Little Sisters of the Poor, St. Anne's Home (San Francisco); Little Sisters of the Poor, Jeanne Jugan Residence (San Pedro) |
| Colorado | Hobby Lobby Stores, Inc.; Association of Christian Schools, International; Colorado Christian University; Mardel; Continuum Health Partnerships Inc.; Mountain States Health Properties LLC; Continuum Health Management LLC; CH-Greeley LLC; Dr. James Dobson's Family Talk; Cherry Creek Mortgage Co.; Colorado Christian University; Little Sisters of the Poor, Sacred Heart Home (Denver); Hercules Industries; JE Dunn Construction |
| Connecticut | Hobby Lobby Stores, Inc.; Little Sisters of the Poor, St. Joseph's Residence (Enfield); Carolyn's Place, Inc. |
| Delaware | Little Sisters of the Poor, Jeanne Jugan Residence (Newark) |
| Illinois | Hobby Lobby Stores, Inc.; Samaritan Ministries |

| | |
|---|---|
| | International; Tyndale House Publishers, Inc.; Franciscan Alliance; Wheaton College; Cherry Creek Mortgage Co.; Feltl & Co.; Hart Electric; H.I. Hart; Korte & Luitjohan Contractors, Inc.; Lindsay, Rappaport & Postel, LLC; Little Sisters of the Poor, St. Joseph's Home (Palatine); Little Sisters of the Poor, St. Mary's Home (Chicago); Ozinga Brothers Inc.; Triune Health Group; Cummins-Allison Corp.; Greenville University (renamed from Greenville College); Olivet Nazarene University; University of St. Francis |
| Maryland | Hobby Lobby Stores, Inc.; Global Pump Co.; Mersino Management Co.; Little Sisters of the Poor, St. Martin's Home (Baltimore) |
| Michigan | Hobby Lobby Stores, Inc.; Autocam Medical; Midwest Fastener Corp.; Mersino Management Co.; Cherry Creek Mortgage Co.; Ave Maria University; Ave Maria Foundation; Ave Maria Communications; Domino's Farms; Thomas More Law Center; Barron Industries; Cornerstone University; Infrastructure Alternatives, Inc.; Weingartz Supply Company, Inc.; MK Chambers Co.; M&N Plastics; Willis & Willis PLC; Kent Manufacturing Co.; Luurtsema Sales, Inc. |
| Minnesota | Hobby Lobby Stores, Inc.; Crown College; Annex Medical Inc.; Sacred Heart Medical, Inc.; Doboszenski & Sons, Inc.; Feltl & Co., Inc.; American Mfg Co.; Hastings Automotive, Inc.; Hastings Chrysler Center, Inc.; Cherry Creek Mortgage Co.; Stinson Electric Inc.; The QC Group, Inc.; SMA, LLC; Little Sisters of the Poor, Holy Family Residence (Saint Paul); Stinson Elec. Inc.; JE Dunn Construction |
| Nevada | Hobby Lobby Stores, Inc.; Cherry Creek Mortgage Co. |
| New York | Hobby Lobby Stores, Inc.; Midwest Fastener Corp.; Catholic Health Services of Long Island; ArchCare; Little Sisters of the Poor, Queen of Peace Residence (Queens Village); Little Sisters of the Poor, Jeanne Jugan Residence (Bronx); Little Sisters of the Poor, Our Lady of Hope Residence (Latham) |
| North Carolina | Hobby Lobby Stores, Inc.; Conestoga Wood Specialties Corp.; Belmont Abbey College; JE Dunn Construction; Dunstone Co., Inc.; Miller Contacting Services LLC; Good Will Publishers |
| Oregon | Hobby Lobby Stores, Inc.; Cherry Creek Mortgage Co.; JE Dunn Construction |
| Rhode Island | Hobby Lobby Stores, Inc.; Little Sisters of the Poor, Jeanne Jugan Residence (Pawtucket) |
| Vermont | Hobby Lobby Stores, Inc. |
| Virginia | Hobby Lobby Stores, Inc.; Media Research Center; Trijicon, Inc.; Little Sisters of the Poor, St. Joseph's Home (Henrico); JE Dunn Construction |
| Washington | Hobby Lobby Stores, Inc.; Conestoga Wood Specialties Corp.; Cherry Creek Mortgage Co.; Little Sisters of the Poor, Jeanne Jugan Residence (Washington, DC); Conestoga Wood Specialties Corp. |
| District of Columbia | Catholic University of America |

22. To obtain an additional estimate of the number of employers that would be likely to choose an exemption from providing contraceptive coverage and the number of employees at these employers, I used the following protocol. This estimate is not intended to be exhaustive. For instance, it omits employees of for-profit corporations and students covered by university health plans, among other groups. Additionally, this second estimate overlaps with some entities listed in Table C.

- I searched the amicus briefs that were supported in support of petitioners in *Zubik v. Burwell*, accessed via http://www.scotusblog.com/case-files/cases/zubik-v-burwell/.
- For each entity amicus listed on a brief, I performed internet searches to determine if the entity was a religious organization exempt from making filings to the Internal Revenue Service (IRS), a nonprofit organization required to file Form 990 with the IRS, or a for-profit company.
- For the nonprofit entities I found, I performed internet searches to determine where each entity is located or headquartered.
- For the two amicus entities that were associations—the Council for Christian Colleges & Universities and the Association of Catholic Colleges and Universities, I visited their websites to find the names and locations of their member schools.
- I sorted the nonprofit entities and member schools by state and then I looked at their Form 990 filings (accessed through Guidestar.org) to determine the number of individuals employed by the entity in the most recent filing year that was available. This information was not available for all employer entities.
- For each state, I tabulated the number of employer entities and the total number of employees as reported on Forms 990.

23. My results from this estimate are summarized in Table D.

**Table D: Employers that have objected to contraceptive coverage and their employees**

| State | Number of employer entities | Approximate number of employees |
|---|---|---|
| California | 25 | 54,879 |
| Connecticut | 4 | 8,751 |
| Colorado | 2 | 4,917 |
| Hawaii | 1 | 877 |

| | | |
|---|---|---|
| Illinois | 21 | 41,582 |
| Maryland | 5 | 6,460 |
| Michigan | 10 | 12,994 |
| Minnesota | 11 | 24,413 |
| North Carolina | 4 | 4,169 |
| Oregon | 7 | 8,078 |
| Rhode Island | 2 | 4,534 |
| Vermont | 2 | 2,278 |
| Virginia | 10 | 3,853 |
| Washington | 7 | 17,239 |
| District of Columbia | 12 | 20,059 |

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

Executed on June 19, 2019, in Sacramento, California.

Randie C. Chance

Randie C. Chance, Ph.D.
Director, Department of Justice Research Center
California Department of Justice

# EXHIBIT A

# ASPE DATA POINT

May 14, 2015

## The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans

- **Private Insurance:** Under the Affordable Care Act most health insurance plans ("non-grandfathered" plans) are required to provide coverage for recommended preventive health care services without cost sharing.

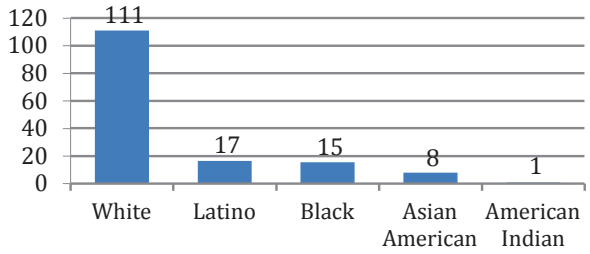
  These services include but are not limited to:

  * Blood pressure screening
  * Obesity screening and counseling
  * Well-woman visits
  * Domestic violence screening and counseling
  * Breastfeeding support and supplies
  * FDA-approved contraceptive methods
  * Well-baby and well-child visits
  * Flu vaccination and other immunizations
  * Tobacco cessation interventions
  * Vision screening for children
  * HIV screening
  * Depression screening

- Today, about **137 million Americans** have private insurance coverage of preventive services without cost sharing—including over **55 million women**.

| Estimated Number of Americans Who Have Preventive Services Coverage with Zero Cost Sharing | | | |
|---|---|---|---|
| Children | Women | Men | Total |
| 28.5 million | 55.6 million | 53.5 million | 137.7 million |

**Figure 1: Estimated Number of Americans Who Have Preventive Services Coverage with Zero Cost Sharing by Race and Ethnicity (in millions)**




*Note: The numbers presented in Figure 1 sum to more than the total number of Americans with preventive services coverage with no cost sharing because individuals reporting Latino ethnicity also reported a race category.*

- Some of the individuals with access to preventive services without cost sharing today may have had access to one or more of those services without cost sharing prior to the implementation of the Affordable Care Act. According to the Kaiser Family Foundation's Employer Health Benefits Survey in 2012, 41 percent of all workers were covered by employer-sponsored group health plans that expanded their list of covered preventive services due to the Affordable Care Act. Based on this and available Health Insurance Marketplace data at the time, HHS previously estimated that approximately **76 million Americans** – and **30 million women** – received expanded coverage of one or more preventive services because of the Affordable Care Act.[1]

| Estimated Number of Americans Who Have Preventive Services Coverage with Zero Cost Sharing | | | | |
|---|---|---|---|---|
| **State** | **Children** | **Women** | **Men** | **Total** |
| Alabama | 422,895 | 886,709 | 831,232 | 2,140,837 |
| Alaska | 66,269 | 124,149 | 126,100 | 316,518 |
| Arizona | 598,585 | 1,061,129 | 1,066,492 | 2,726,206 |
| Arkansas | 225,176 | 446,936 | 430,226 | 1,102,338 |
| California | 3,351,780 | 6,324,503 | 6,191,627 | 15,867,909 |
| Colorado | 556,491 | 990,235 | 972,911 | 2,519,638 |
| Connecticut | 364,693 | 746,444 | 708,801 | 1,819,938 |
| Delaware | 84,080 | 171,575 | 161,610 | 417,265 |
| District of Columbia | 39,399 | 127,531 | 114,305 | 281,235 |
| Florida | 1,423,940 | 3,024,126 | 2,841,807 | 7,289,873 |
| Georgia | 883,809 | 1,704,643 | 1,598,625 | 4,187,077 |
| Hawaii | 120,194 | 256,448 | 254,510 | 631,152 |
| Idaho | 170,463 | 261,743 | 267,497 | 699,703 |
| Illinois | 1,189,924 | 2,380,326 | 2,312,855 | 5,883,105 |
| Indiana | 627,525 | 1,166,726 | 1,121,576 | 2,915,827 |
| Iowa | 322,124 | 604,110 | 604,268 | 1,530,502 |
| Kansas | 290,340 | 524,509 | 495,399 | 1,310,249 |
| Kentucky | 378,519 | 762,897 | 743,303 | 1,884,719 |
| Louisiana | 358,711 | 713,642 | 670,731 | 1,743,084 |
| Maine | 107,573 | 251,322 | 229,386 | 588,281 |
| Maryland | 582,300 | 1,225,095 | 1,146,439 | 2,953,834 |
| Massachusetts | 654,577 | 1,412,394 | 1,332,122 | 3,399,092 |
| Michigan | 957,503 | 1,843,405 | 1,742,639 | 4,543,547 |
| Minnesota | 609,487 | 1,075,362 | 1,076,734 | 2,761,583 |
| Mississippi | 242,244 | 467,087 | 451,221 | 1,160,553 |
| Missouri | 596,633 | 1,097,512 | 1,084,657 | 2,778,803 |
| Montana | 83,639 | 160,099 | 157,979 | 401,717 |
| Nebraska | 201,150 | 361,467 | 361,309 | 923,926 |
| Nevada | 261,378 | 455,665 | 451,754 | 1,168,797 |
| New Hampshire | 132,043 | 285,949 | 272,532 | 690,524 |
| New Jersey | 887,353 | 1,701,115 | 1,621,714 | 4,210,183 |
| New Mexico | 151,593 | 305,157 | 278,722 | 735,472 |
| New York | 1,666,177 | 3,582,133 | 3,371,547 | 8,619,856 |
| North Carolina | 813,423 | 1,631,312 | 1,521,574 | 3,966,308 |
| North Dakota | 75,742 | 141,055 | 142,235 | 359,032 |
| Ohio | 1,070,945 | 2,120,337 | 2,049,292 | 5,240,575 |
| Oklahoma | 330,670 | 627,152 | 598,873 | 1,556,695 |
| Oregon | 346,157 | 721,318 | 669,765 | 1,737,240 |
| Pennsylvania | 1,170,391 | 2,511,285 | 2,445,708 | 6,127,383 |
| Rhode Island | 90,706 | 201,595 | 191,892 | 484,193 |
| South Carolina | 406,798 | 822,354 | 726,416 | 1,955,568 |
| South Dakota | 85,614 | 153,957 | 152,850 | 392,422 |
| Tennessee | 549,675 | 1,119,711 | 1,076,050 | 2,745,436 |
| Texas | 2,258,657 | 4,029,215 | 3,990,134 | 10,278,005 |
| Utah | 431,216 | 539,479 | 538,759 | 1,509,455 |
| Vermont | 47,185 | 122,892 | 115,781 | 285,858 |
| Virginia | 847,534 | 1,587,663 | 1,467,520 | 3,902,716 |
| Washington | 596,597 | 1,258,201 | 1,224,572 | 3,079,369 |
| West Virginia | 152,226 | 316,077 | 304,602 | 772,905 |
| Wisconsin | 573,028 | 1,123,460 | 1,107,770 | 2,804,258 |
| Wyoming | 58,596 | 101,204 | 107,459 | 267,259 |
| **50 states and D.C.** | **28,513,725** | **55,630,409** | **53,523,882** | **137,668,017** |

**Source:** ASPE analysis of 2011-2013 Census Bureau Current Population Survey data and CMS data on Marketplace Enrollment through February 2015. The age ranges for the estimates are ages 0-14 for children and15-64 for both men and women.

**Methodology:**

1) According to the Census Bureau, 177 million non-elderly Americans were covered by private insurance in 2013, the majority of whom (156 million) had employment-based insurance. A survey conducted by the Kaiser Family Foundation[2] found that 26 percent of individuals with employment-based insurance were in grandfathered plans, which are not required to cover recommended preventive services with zero cost sharing. This analysis assumes that the proportion of those in grandfathered plans with any private insurance is the same as those with employment-based insurance and estimates that 131 million Americans with private insurance have coverage of preventive services with zero cost sharing.

2) According to the most recently available data, about 11.7 million individuals have signed up for coverage through the Health Insurance Marketplace. Kaiser Family Foundation survey[3] data indicate that 57 percent of Marketplace enrollees from the first open enrollment period were previously uninsured. Putting these two facts together, for the purposes of this Data Point, we estimate nearly 6.7 million individuals on the Marketplace will gain access to coverage of preventive services with zero cost sharing as a result of being newly insured. Adding this 6.7 million to the 131 million estimate yields a total of about 137.7 million Americans who have private insurance coverage of preventive services with zero cost sharing.

[1] Burke, A., & Simmons, A. (2014, June 27). The Affordable Care Act Research Briefs. Retrieved from Office of the Assistant Secretary for Planning and Evaluation: http://aspe.hhs.gov/health/reports/2014/PreventiveServices/ib_PreventiveServices.pdf

[2] Kaiser Family Foundation & Health Research and Educational Trust (HRET). (2014, September 10). 2014 Employer Health Benefits Survey. Retrieved from Kaiser Family Foundation: http://kff.org/report-section/ehbs-2014-section-thirteen-grandfathered-health-plans/

[3] Hamel, L., Norton, M., Levitt, L., Claxton, G., Cox, C., Pollitz, K., et al. (2014, June 19). Survey of Non-Group Health Insurance Enrollees. Retrieved from Kaiser Family Foundation: http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/

# EXHIBIT B

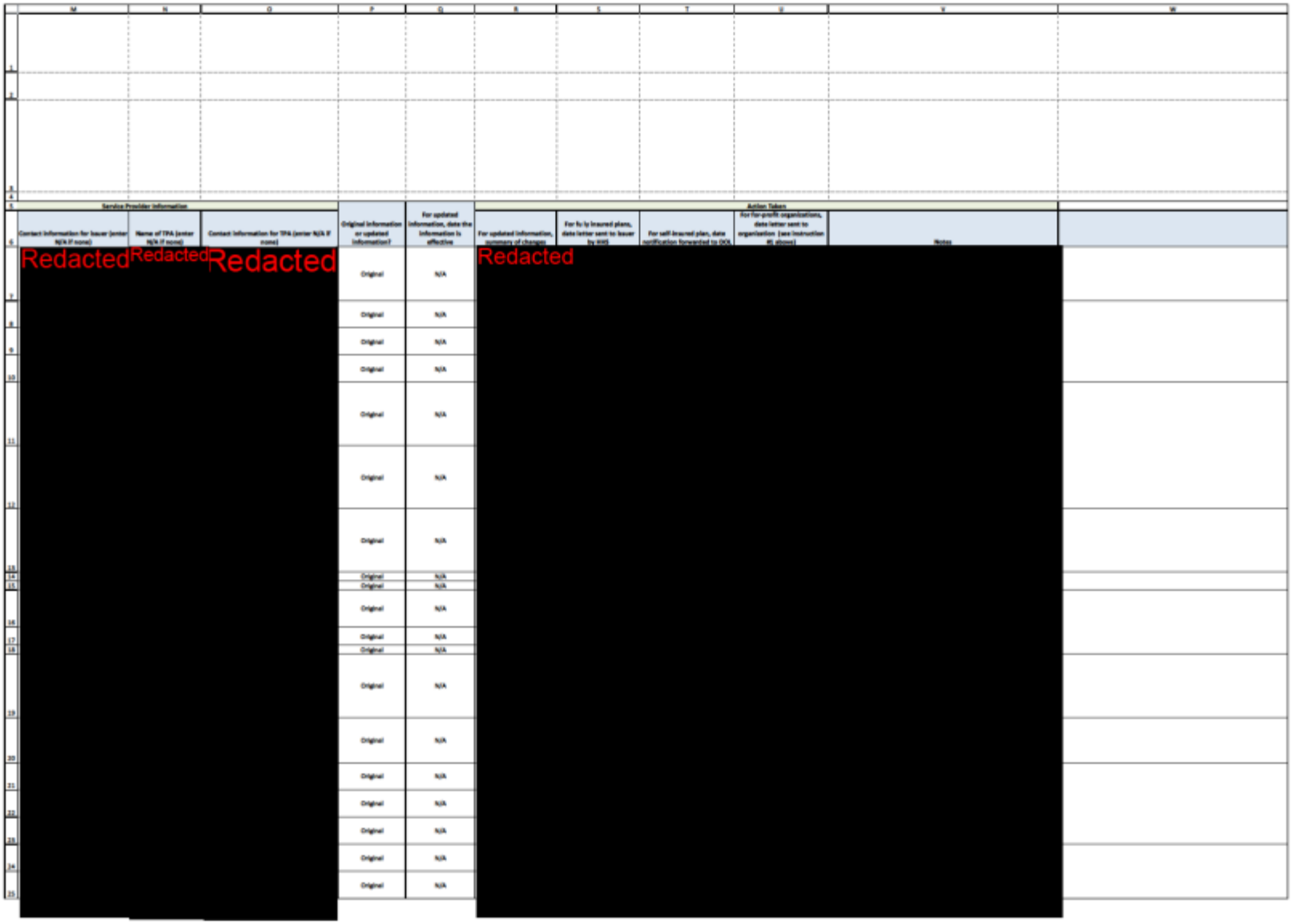
DRAFT: THIS INFORMATION IS NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Notification from Eligible Organizations to HHS Regarding Religious Objections to Providing Contraceptive Coverage

Redacted

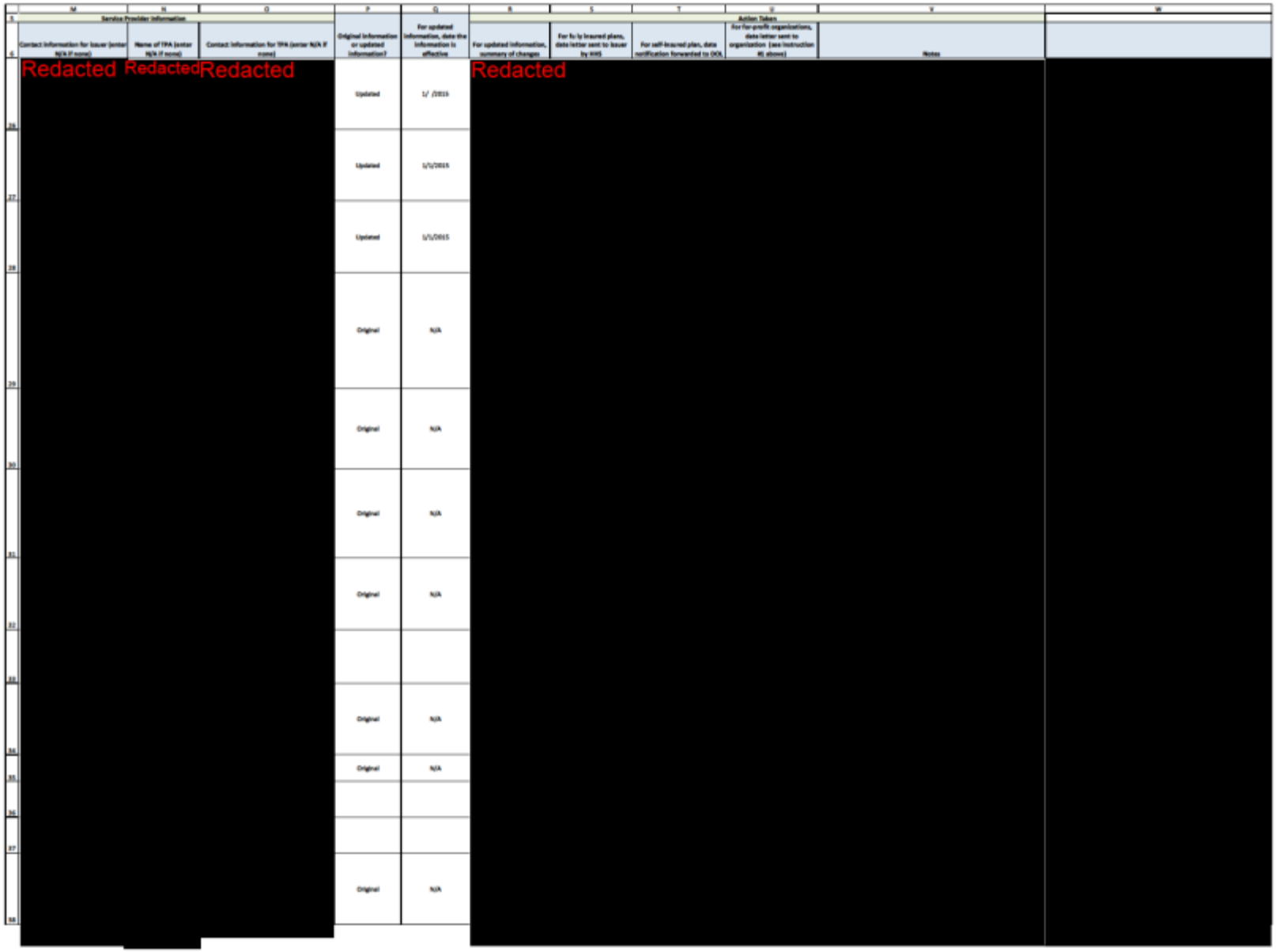
| | | Eligible Organization Information | | | | | | Plan Information | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Tracking Number | Date Notification Received | Received Via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services Not Provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| Redacted | 8/26/2014 | E-mail | Cummins-Allison Corp and Cummins Illinois Inc. | Redacted | Other | No | Plan B Ella Mirena Copper IUDs | Redacted | Other | self-insured | Redacted |
| | 9/8/2014 | E-mail | Loyola University | | Non-profit | No | All | | Other | Fully Insured | |
| | | | | | | | | | Other | Fully Insured | |
| | | | | | | | | | Other | Fully Insured | |
| | 9/10/2014 | E-mail | Valley Forge Christian College | | Non-profit | Yes | Ulipristal (aka Ella) Levonorgestrel (aka Plan B Plan B One-Step Next Choice) Intrauterine Devices (of any type) Abortion services except to save the life of the mother | | Other | Fully Insured | |
| | | | | | | | | | Other | self-insured | |
| | 9/19/2014 | E-mail | Sisters of the Order of St. Dominic of Grand Rapids (Dominican Sisters) | | Non-Profit | No | All | | Other | Fully Insured | |
| | 9/19/2014 | E-mail | Continuant | | Other | No | Emergency Contraceptives & IUD's | | Other | Fully Insured | |
| | | | | | | | | | Other | Fully Insured | |
| | 10/ /2014 | E-mail | Management Analysis and Ut lization Inc. | | Other | No | "All abortifacient coverages such as but not limited to morning after and week after services" | | Other | Both | |
| | | | | | | | | | Other | Both | |
| | | | | | | | | | Other | self-insured | |
| | 10/6/2014 | E-mail | Holy Ghost Preparatory School | | Non-profit | No | All | | Other | Fully Insured | |
| | 10/9/2014 | Mail | The Catholic Diocese of Memphis In Tennessee | | Non-profit | | | | Church Plan | self-insured | |
| | | | | | | | | | Other | self-insured | |
| | 10/9/2014 | Mail | Belhaven University | | Non-profit | | All | | Other | self-insured | |
| | | | | | | | | | Other | self-insured | |
| | 10/10/2014 | E-mail | Bingaman and Son Lumber Inc. PO Box 247 1195 Creek Mountain Rd Kreamer PA 17833 | | Other | | Plan B Ella Mirena Paraguard | | Other | Fully Insured | |
| | | | | | | | | | Other | Fully Insured | |

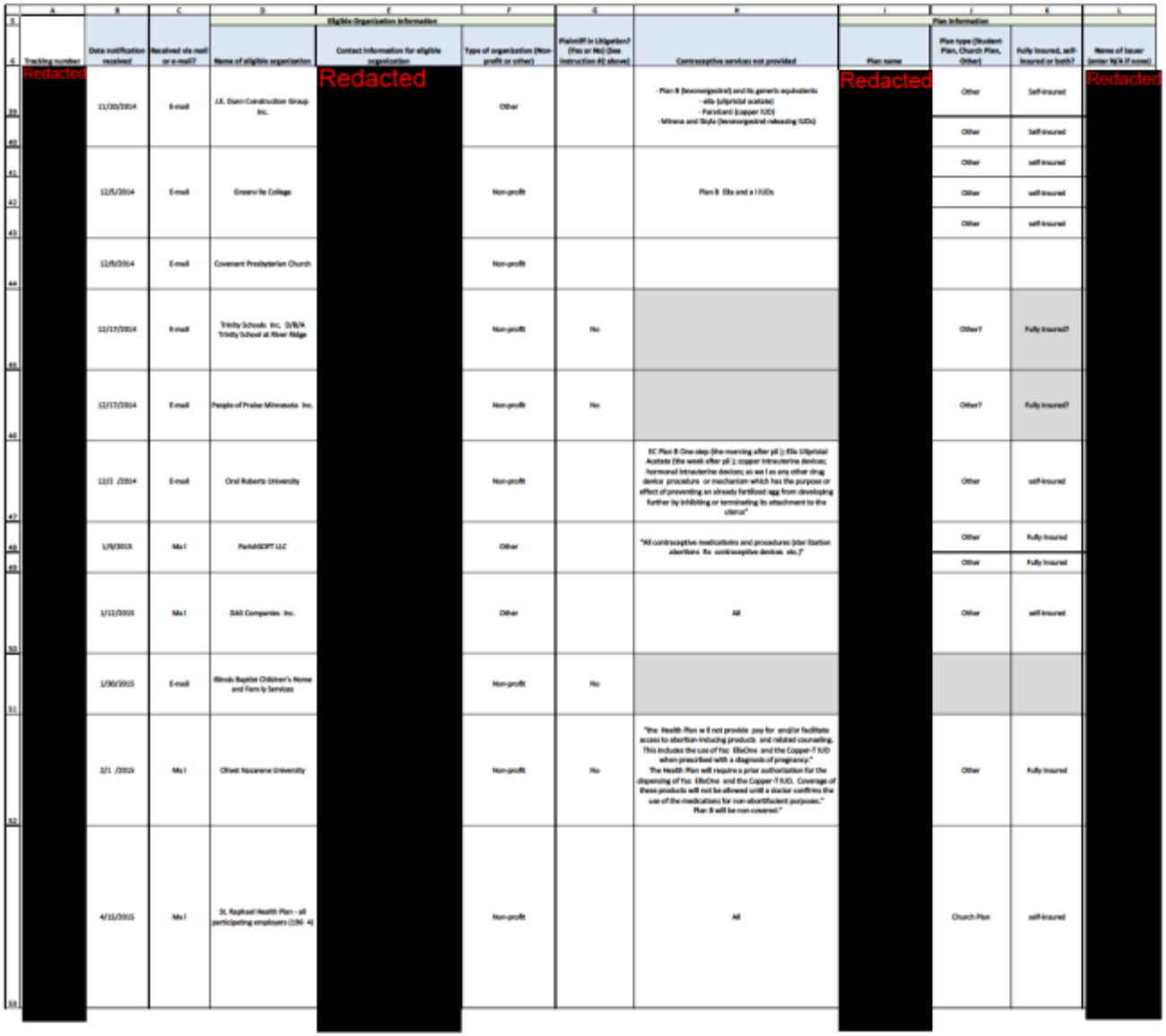
Notifications


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| | A | B | C | D | E | F | G | H | I | J | K | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification Received | Received via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or Other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services Not Provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 26 | Redacted | 10/15/2014 | E-mail | Loyola University | Redacted | Non-profit | No | All | Redacted | Other | Fully Insured | Redacted |
| 27 | | | | | | | | | | Other | Fully Insured | |
| 28 | | | | | | | | | | Other | Fully Insured | |
| 29 | | 10/16/2014 | Litigation | Wheaton College | | Non-profit | Yes | "Abortion-causing drugs abortion procedures and related services but has no religious objection to providing coverage for contraceptive drugs and devices that prevent conception (as opposed to interfering with the continued survival of the human embryo). Specifically identifies Plan B Ella and certain unspecified IUDs as drugs and devices to which it has religious objections." | | Other | Fully Insured | |
| 30 | | | | | | | | | | Other | self-insured | |
| 31 | | | | | | | | | | Other | self-insured | |
| 32 | | | | | | | | | | Student | Fully Insured | |
| 33 | | 10/20/2014 | Mail | Carithers-Wallace-Courtenay LLC | | Other | | | | | | |
| 34 | | 10/29/2014 | Email | Contract Packaging Inc. | | Other | | Plan B One-Step Ella Next Choice | | Other | | |
| 35 | | 11/5/2014 | Mail | Avesta Homes LLC | | Other | | All | | Other | Fully Insured | |
| 36 | | 11/1 /2014 | E-mail | Kent Manufacturing Company | | Other | | | | | | |
| 37 | | 11/14/2014 | Mail | Dakota Tube Inc | | Other | | | | | | |
| 38 | | 11/18/2014 | E-mail | Oral Roberts University | | Non-profit | | EC Plan B One-step (the morning after pill) Ella Ulipristal Acetate (the week after pill) Stopper Intrauterine devices hormonal intrauterine devices Ella any other drug device procedure or mechanism which has the purpose or effect of preventing an already fertilized egg from developing further by inhibiting or terminating its attachment to the uterus" | | Other | Fully Insured | |

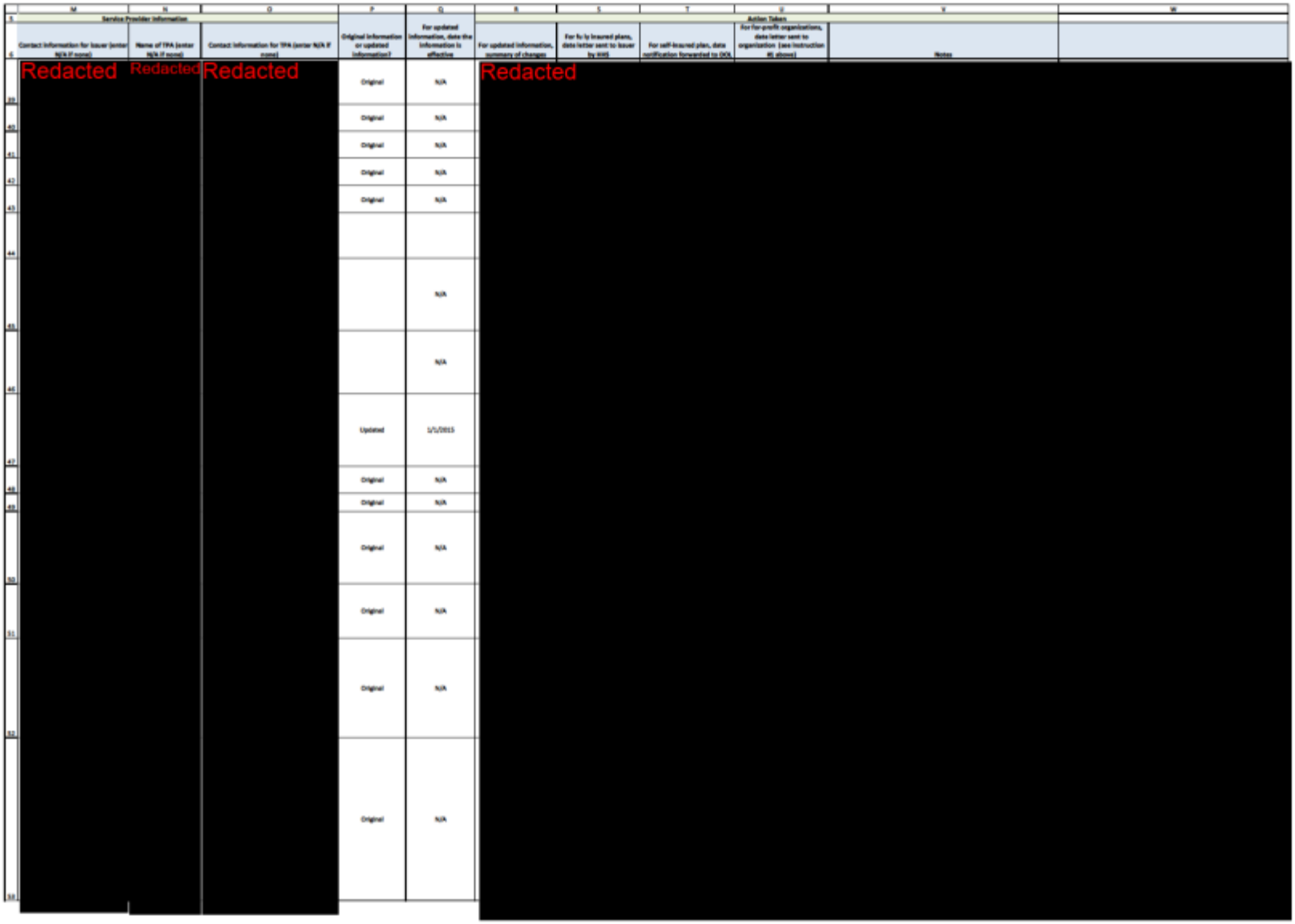
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| 3 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking number | Date notification received | Received via mail or e-mail? | Name of eligible organization | Contact information for eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #E above) | Contraceptive services not provided | Plan name | Plan type (Student Plan, Church Plan, Other) | Fully insured, self-insured or both? | Name of issuer (enter N/A if none) |
| 39 | Redacted | 11/20/2014 | E-mail | J.E. Dunn Construction Group Inc. | Redacted | Other | | - Plan B (levonorgestrel) and its generic equivalents<br>- ella (ulipristal acetate)<br>- ParaGard (copper IUD)<br>- Mirena and Skyla (levonorgestrel-releasing IUDs) | Redacted | Other | Self-Insured | Redacted |
| 40 | | | | | | | | | | Other | Self-Insured | |
| 41 | | 12/5/2014 | E-mail | Greenville College | | Non-profit | | Plan B Ella and a l IUDs | | Other | self-insured | |
| 42 | | | | | | | | | | Other | self-insured | |
| 43 | | | | | | | | | | Other | self-insured | |
| 44 | | 12/8/2014 | E-mail | Covenant Presbyterian Church | | Non-profit | | | | | | |
| 45 | | 12/17/2014 | E-mail | Trinity Schools Inc. D/B/A Trinity School at River Ridge | | Non-profit | No | | | Other? | Fully Insured? | |
| 46 | | 12/17/2014 | E-mail | People of Praise Minnesota Inc. | | Non-profit | No | | | Other? | Fully Insured? | |
| 47 | | 12/2 /2014 | E-mail | Oral Roberts University | | Non-profit | | EC Plan B One-step (the morning after pill ); Ella Ulipristal Acetate (the week after pill ); copper intrauterine devices; hormonal intrauterine devices; as we l as any other drug device procedure or mechanism which has the purpose or effect of preventing an already fertilized egg from developing further by inhibiting or terminating its attachment to the uterus" | | Other | self-insured | |
| 48 | | 1/9/2015 | Ma l | ParishSOFT LLC | | Other | | "All contraceptive medications and procedures (ster ilization abortions ifa contraceptive devices etc.)" | | Other | Fully Insured | |
| 49 | | | | | | | | | | Other | Fully Insured | |
| 50 | | 1/11/2015 | Ma l | DAS Companies Inc. | | Other | | All | | Other | self-insured | |
| 51 | | 1/30/2015 | E-mail | Illinois Baptist Children's Home and Fam ly Services | | Non-profit | No | | | | | |
| 52 | | 2/1 /2015 | Ma l | Olivet Nazarene University | | Non-profit | No | "the Health Plan w ll not provide pay for and/or facilitate access to abortion-inducing products and related counseling. This includes the use of Yaz EllaOne and the Copper-T IUD when prescribed with a diagnosis of pregnancy."<br>The Health Plan will require a prior authorization for the dispensing of Yaz EllaOne and the Copper-T IUD. Coverage of these products will not be allowed until a doctor confirms the use of the medications for non-abortifacient purposes."<br>Plan B will be non-covered." | | Other | Fully Insured | |
| 53 | | 4/15/2015 | Ma l | St. Raphael Health Plan - all participating employers (196 4) | | Non-profit | | All | | Church Plan | self-insured | |

Notifications


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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification received | Received via mail or e-mail? | Name of Eligible Organization | Contact Information for eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services not provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 54 | Redacted | 5/4/2015 | Mail | Society of the Precious Blood | Redacted | Non-profit | | All | Redacted | Other | Fully Insured | Redacted |
| 55 | | 5/22/2015 | E-mail | Michael James Sales Tax Solutions LLC | | Other | | "Any and all abortifacients" | | Other | Fully Insured | |
| 56 | | 07/087/15 | Litigation (Zubik v. Burwell) | The ROMAN CATHOLIC DIOCESE OF PITTSBURGH (*tax exempt) | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 57 | | 07/087/15 | Litigation (Zubik v. Burwell) | THE ROMAN CATHOLIC DIOCESE OF ERIE (*exempt) | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 58 | | 07/087/15 | Litigation (Zubik v. Burwell) | CATHOLIC CHARITIES OF THE DIOCESE OF PITTSBURGH INC. | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 59 | | 07/087/15 | Litigation (Zubik v. Burwell) | THE CATHOLIC CEMETERIES ASSOCIATION OF THE DIOCESE OF PITTSBURGH | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 60 | | 07/087/15 | Litigation (Zubik v. Burwell) | ST. MARTIN CENTER INC. | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 61 | | 07/087/15 | Litigation (Zubik v. Burwell) | PRINCE OF PEACE CENTER INC. | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 62 | | 07/087/15 | Litigation (Zubik v. Burwell) | ERIE CATHOLIC PREPARATORY SCHOOL | | Non-profit | Yes | All | | Church Plan | self-insured | |
| 63 | | 8/3/2015 | Mail | Oral Roberts University | | Non-profit | | ECP Plan B One-step (the morning after pill ); Ella Ulipristal Acetate (the week after pill ); Copper Intrauterine Devices; hormonal Intrauterine Devices; as well as any other drug device procedure or mechanism which has the purpose or effect of preventing an already fertilized egg from developing further by inhibiting or terminating its attachment to the uterus" | | Student | Fully Insured | |

Notifications

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact information for issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact information for TPA (enter N/A if none) | Original information or updated information? | For updated information, date the information is effective | For updated information, summary of changes | For fully insured plans, date letter sent to issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #13 above) | Notes | |
| 54 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 55 | | | | Original | N/A | | | | | | |
| 56 | | | | Original | N/A | | | | | | |
| 57 | | | | Original | N/A | | | | | | |
| 58 | | | | Original | N/A | | | | | | |
| 59 | | | | Original | N/A | | | | | | |
| 60 | | | | Original | N/A | | | | | | |
| 61 | | | | Original | N/A | | | | | | |
| 62 | | | | Original | N/A | | | | | | |
| 63 | | | | Original | N/A | | | | | | |

Notifications

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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification Received | Received Via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or Other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services Not Provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 64 | Redacted | 8/2 /2015 | E-mail | Cummins-Allison Corp and Cummins Illinois Inc | Redacted | Other | No | Plan B Ella Mirena Copper IUDs | Redacted | Other | self-insured | Redacted |
| 65 | | 9/25/2015 | E-mail | Weingartz Supply Co. Inc. & WI & PI Management LLC | | Other | Yes | All contraceptive services | | Other | Fully Insured | |
| 66 | | 10/14/2015 | Mail | Carolyn's Place Inc. | | Non-profit | | All contraceptive services | | | Fully Insured | |
| 67 | | 10/14/2015 | Mail | Dakota Tube Inc | | Other | | | | | | |
| 68 | | 10/28/2015 | Mail | Tyndale House Publishers Inc. | | Other | | post-conceptive medications and devices namely emergency contraceptives such as the morning-after pill "the week-after pill "and Intrauterine devices | | Other | Self-insured | |
| 69 | | 10/29/2015 | E-mail | Electrolock Inc. Dunstone Co. Inc. and Stone River Mgmt. Co. LLC. | | Other | | All | | Other | self-insured | |
| 70 | | 11/19/2015 | Mail | Management Analysis and Utilization Inc. | | Other | | Ella Plan B Plan B One Step Next Choice Next Choice One Dose My Way and Take Action | | Other | Fully Insured | |
| 71 | | | | | | | | | | | Fully Insured | |
| 72 | | | | | | | | | | | self-insured | |
| 73 | | 12/17/2015 | SWIFT | Conestoga Wood Specialties Corp. Conestoga Transportation Inc. Phone: 717-445-6701 | | Other | Yes | Any hormonal drugs or IUDs | | Other | self-insured | |
| 74 | | 12/2 /2015 | E-mail | St. Joseph's Abbey (AKA. Cistercian Abbey of Spencer) | | Non-profit | No | ALL contraceptive services required to be covered under PHS Act section 2713 as added by the Affordable Care Act and incorporated into ERISA Section 715 and Code Section 9815 | | Church Plan | Fully Insured | |
| 75 | | 12/2 /2015 | Mail | Dakota Tube Inc. | | Other | | | | | | |
| 76 | | 1/28/2016 | Mail | Community Foundation of Northwest Indiana Inc. St. Mary Medical Center St. Catherine Hospital | | Non-profit | | All objection to providing coverage of all contraceptive services required to be covered under PHS Act section 2713 as added by the Affordable Care Act and incorporated into ERISA Section 715 and Code Section 9815." | | Other | Self-insured | |
| 77 | | 2/2 /2016 | E-mail | Miller Contracting Services Inc. | | Other | | All | | Other | | |
| 78 | | 3/3/2016 | E-mail | Earth Sun Moon Trading company Inc | | Other | | All | | Other | Fully Insured | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact information for issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact information for TPA (enter N/A if none) | Original information or updated information? | For updated information, date the information is effective | For updated information, summary of changes | For fully insured plans, date letter sent to issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #1 above) | Notes | |
| 64 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 65 | | | | Original | N/A | | | | | | |
| 66 | | | | Original | N/A | | | | | | |
| 67 | | | | | | | | | | | |
| 68 | | | | Original | N/A | | | | | | |
| 69 | | | | Original | N/A | | | | | | |
| 70 | | | | Original | N/A | | | | | | |
| 71 | | | | Original | N/A | | | | | | |
| 72 | | | | Original | N/A | | | | | | |
| 73 | | | | Original | N/A | | | | | | |
| 74 | | | | Original | N/A | | | | | | |
| 75 | | | | | | | | | | | |
| 76 | | | | Original | N/A | | | | | | |
| 77 | | | | Original | N/A | | | | | | |
| 78 | | | | Original | N/A | | | | | | |

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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification Received | Received via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or Other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services not provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 79 | Redacted | 3/7/2016 | E-mail | Luurtsema Sales | Redacted | Other | | All | Redacted | Other | Fully Insured | Redacted |
| 80 | | | | Continuum Health Partnerships Inc. | | | | | | | | |
| 81 | | 3/24/2016 | E-mail | Continuum Health Management LLC | | Other | | Abortion causing drugs, devices and sterilizations; patient education and counseling for all women with reproductive capacity. | | Other | self-insured | |
| 82 | | | | Mountain States Health Properties LLC. | | | | | | | | |
| 83 | | 3/28/2016 | E-Mail | Fresh Unlimited Inc. | | Other | | All | | Other | Fully Insured | |
| 84 | | 4/1/2016 | E-mail | Sarkes Tarzian Inc. | | Other | | All | | Other | Fully Insured | |
| 85 | | | | Mersino Management Company | | | | | | | | |
| 86 | | | | Mersino Southwest, LLC | | | | | | | | |
| 87 | | 7/19/2016 | E-Mail | Mersino Enterprise Inc. | | Other | Yes | All | | Other | self-insured | |
| 88 | | | | Global Pump Company | | | | | | | | |
| 89 | | | | Mersino Properties Company LLC | | | | | | | | |
| 90 | | | | Mersino Dewatering Inc. | | | | | | | | |
| 91 | | 7/26/2016 | Litigation: 2nd Circuit Court 1:12-cv-02542-BMC Catholic Health Care System | Catholic Health Care System (aka ArchCare) | | | Yes | abortion-inducing drugs sterilizations contraceptives | | | self-insured | |
| 92 | | | | Cardinal Spellman High School | | | Yes | | | | self-insured | |
| 93 | | | | Monsignor Farrell High School | | | | | | | self-insured | |
| 94 | | | | Catholic Health Services of Long Island | | | Yes | | | | self-insured | |
| 95 | | 7/26/2016 | Litigation: Geneva 3nd Circuit Court 2:12-cv-00207 | Geneva College (employee) | | | Yes | abortion-inducing drugs | | Other | Fully Insured | |
| 96 | | | | Geneva Co legel (Student) | | | Yes | | | Student | Fully Insured | |
| 97 | | | | The Roman Catholic Diocese of Erie* (exempt) | | Non-profit | | | | | | |
| 98 | | 7/26/2016 | Litigation: Persico 3nd Circuit Court 1-13-cv-00303 | Erie Catholic Preparatory School | | Non-profit | Yes | abortion-inducing drugs contraceptives or sterilization | | Church Plan | self-insured | |
| 99 | | | | PRINCE OF PEACE CENTER INC. | | Non-profit | | | | | | |
| 100 | | | | ST. MARTIN CENTER INC. | | Non-profit | | | | | | |
| 101 | | 7/26/2016 | Litigat on Zubik 3nd Circuit Court 2-12-cv-00676 | Catholic Charities of Pittsburgh | | Non-profit | Yes | abortion-inducing drugs contraceptives or sterilization | | Church Plan | self-insured | |
| 102 | | | | Diocese of Pittsburgh* (Exempt) | | | | | | | | |
| 103 | | 7/26/2016 | Litigation: Catholic Diocese of Beaumont 5th Circuit Court | Catholic Charities of Southeast Texas | | | Yes | abortifacients contraception and ster lization | | Other | self-insured | |
| 104 | | | | Catholic Diocese of Beaumont* (Exempt) | | | | | | | | |

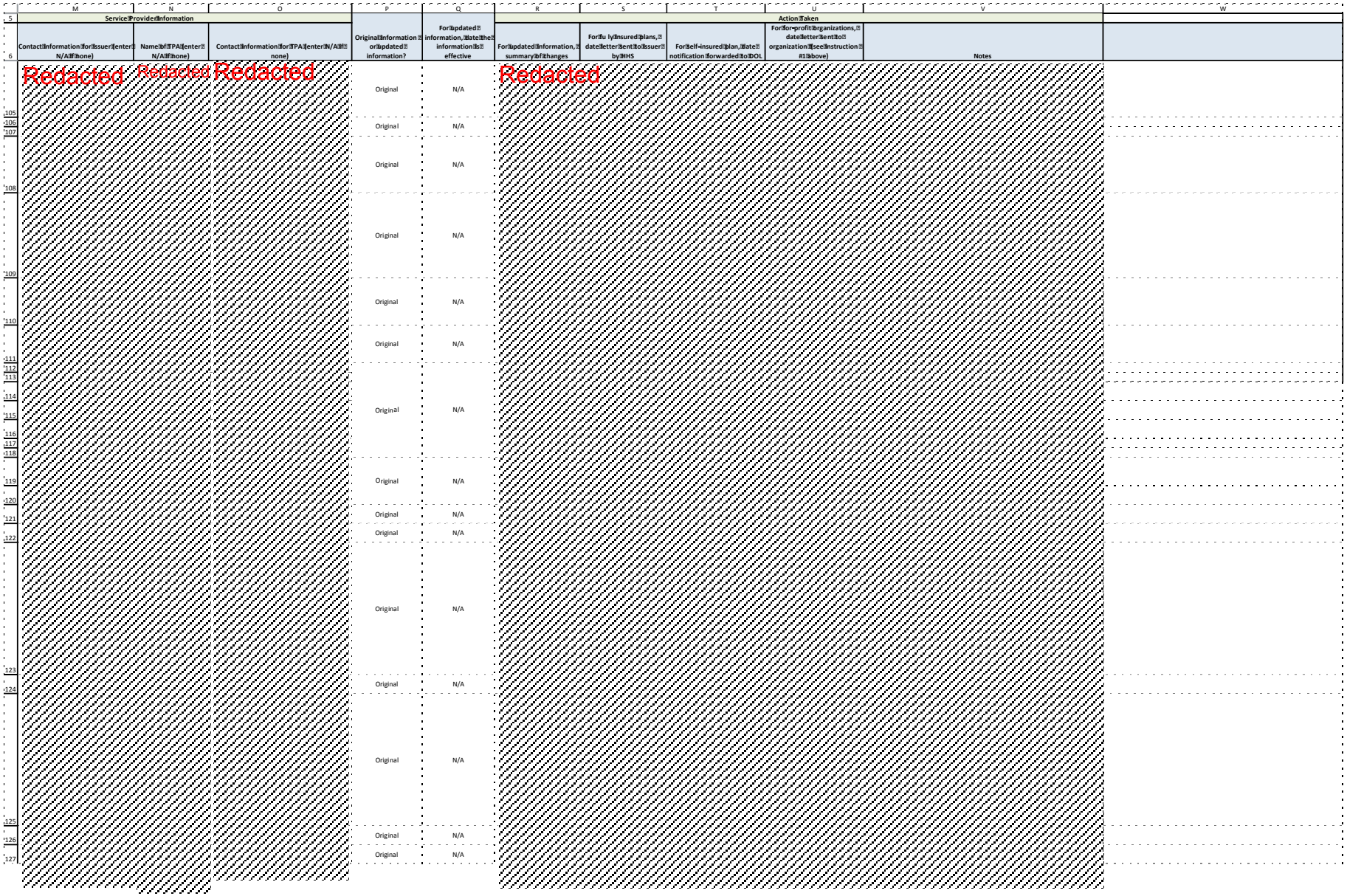
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| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact Information for Issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact Information for TPA (enter N/A if none) | Original Information or Updated information? | For updated information, date the information is effective | For updated Information, summary of changes | For fully insured plans, date letter sent to Issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #11 above) | Notes | |
| 79 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 80 | | | | Original | N/A | | | | | | |
| 81 | | | | Original | N/A | | | | | | |
| 82 | | | | Original | N/A | | | | | | |
| 83 | | | | Original | N/A | | | | | | |
| 84 | | | | Original | N/A | | | | | | |
| 85 | | | | Original | N/A | | | | | | |
| 86 | | | | Original | N/A | | | | | | |
| 87 | | | | Original | N/A | | | | | | |
| 88 | | | | Original | N/A | | | | | | |
| 89 | | | | Original | N/A | | | | | | |
| 90 | | | | Original | N/A | | | | | | |
| 91 | | | | Original | N/A | | | | | | |
| 92 | | | | Original | N/A | | | | | | |
| 93 | | | | Original | N/A | | | | | | |
| 94 | | | | Original | N/A | | | | | | |
| 95 | | | | Original | N/A | | | | | | |
| 96 | | | | Original | N/A | | | | | | |
| 97 | | | | Updated | N/A | | | | | | |
| 98 | | | | | | | | | | | |
| 99 | | | | | | | | | | | |
| 100 | | | | | | | | | | | |
| 101 | | | | Updated | N/A | | | | | | |
| 102 | | | | | | | | | | | |
| 103 | | | | Original | N/A | | | | | | |
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Notifications

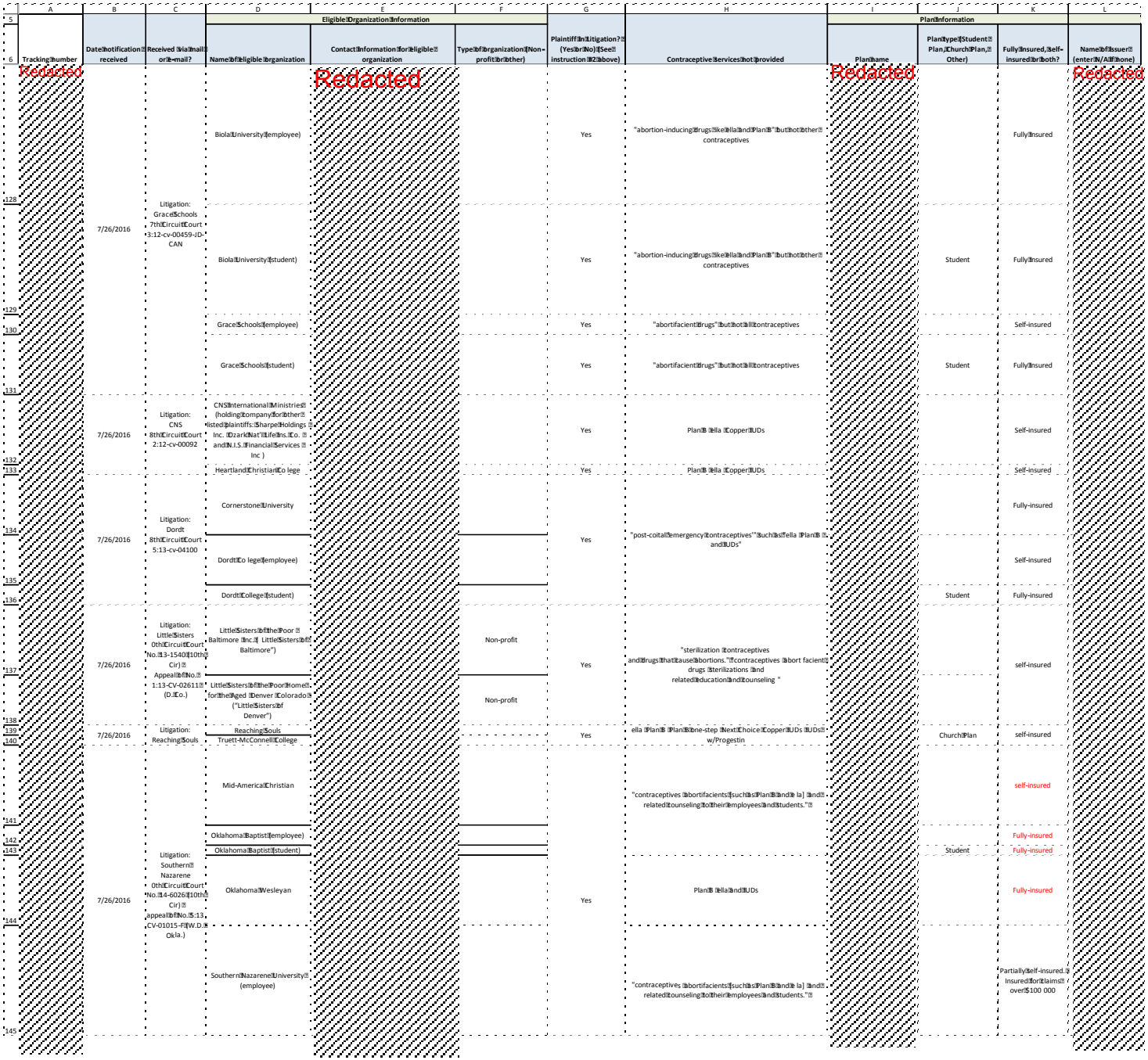
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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date notification received | Received via mail or e-mail? | Name of eligible organization | Contact information for eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services not provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 105 | Redacted | 7/26/2016 | Litigation: ETBU 5th Circuit Court 4:12-CV-3009 | East Texas Baptist University (employee) | Redacted | | Yes | "abortion-inducing drugs [...] and related services" (NOT including contraceptives) (compl. ¶ 28) | Redacted | Other | self-insured | Redacted |
| 106 | | | | Houston Baptist | | | Yes | | | | | |
| 107 | | | | Westminster | | | Yes | | | | self-insured | |
| 108 | | 7/26/2016 | Litigation: University of Dallas 5th Circuit Court 4:12-cv-314 | Roman Catholic Diocese of Fort Worth *(Exempt) | | Non-profit | Yes | "abortion-inducing drugs "sterilization and contraception | | Church Plan | self-insured | |
| 109 | | | | University of Dallas (employee) | | | Yes | "abortion-inducing drugs" and steri ization | | | self-insured | |
| 110 | | | | University of Da las (student) | | | Yes | "abortion-inducing drugs "sterilization and contraception (prescribed to treat a medical condition only not to prevent pregnancy) | | Student | Fully-insured | |
| 111 | | | | Catholic Charities of Fort Worth | | | Yes | abortion-inducing drugs sterilization and contraception | | | Fully Insured | |
| 112 | | 7/26/2016 | Litigation: Catholic Diocese of Nashville 6th Circuit Court 3:13-cv-01303 | Aquinas College (Nashv lle | | | Yes | "abortion-inducing products "steri ization and contraception | | | Fully Insured | |
| 113 | | | | Camp Marymount Inc. | | | | | | | | |
| 114 | | | | Catholic Charities of Tennessee | | | | | | | | |
| 115 | | | | The Catholic Diocese of Nashvi le *(Exempt) | | | | | | | | |
| 116 | | | | Dominican Sisters of St. Cecilia *(Exempt) | | | | | | | | |
| 117 | | | | Mary Queen of Angels | | | | | | | | |
| 118 | | | | St. Mary's V lla Inc. | | | | | | | | |
| 119 | | 7/26/2016 | Litigat on MCC 6th Circuit Court 1:13-cv-01247-GJQ | Catholic Family Services (aka Catholic Charities of Kalamazoo) | | | Yes | contraception and steri ization | | | self-insured | |
| 120 | | | | Michigan Catho ic Conference* (Exempt) | | | | | | | | |
| 121 | | 7/26/2016 | Litigation: Catho ic Charities of Ft. Wayne 7th Circuit Court 1:12-cv-00159-JD-RBC | Catholic Charities of Ft. Wayne | | | Yes | "abortion-inducing products "steri ization and contraception | | | Self-insured | |
| 122 | | | | Diocese of Ft. Wayne *(Exempt) | | | Yes | "abortion-inducing products "steri ization and contraception | | | Self-insured | |
| 123 | | | | Franciscan Alliance | | | Yes | "abortion-inducing products "steri ization and contraception | | | Both | |
| 124 | | | | Our Sunday Visitor | | | Yes | "abortion-inducing products "steri ization and contraception | | | Self-insured | |
| 125 | | | | Specialty Physicians of I linois | | | Yes | "abortion-inducing products "steri ization and contraception | | | Fully-insured | |
| 126 | | | | St. Anne Home | | | Yes | "abortion-inducing products "steri ization and contraception | | | Self-insured | |
| 127 | | | | University of St. Francis | | | Yes | "abortion-inducing products "steri ization and contraception | | | Self-insured | |

Notifications



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| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact information for issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact information for TPA (enter N/A if none) | Original information or updated information? | For updated information, date the information is effective | For updated information, summary of changes | For fully insured plans, date letter sent to issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #13 above) | Notes | |
| 105 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 106 | | | | Original | N/A | | | | | | |
| 107 | | | | Original | N/A | | | | | | |
| 108 | | | | Original | N/A | | | | | | |
| 109 | | | | Original | N/A | | | | | | |
| 110 | | | | Original | N/A | | | | | | |
| 111 | | | | Original | N/A | | | | | | |
| 112 | | | | | | | | | | | |
| 113 | | | | | | | | | | | |
| 114 | | | | Original | N/A | | | | | | |
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| 117 | | | | | | | | | | | |
| 118 | | | | | | | | | | | |
| 119 | | | | Original | N/A | | | | | | |
| 120 | | | | | | | | | | | |
| 121 | | | | Original | N/A | | | | | | |
| 122 | | | | Original | N/A | | | | | | |
| 123 | | | | Original | N/A | | | | | | |
| 124 | | | | Original | N/A | | | | | | |
| 125 | | | | Original | N/A | | | | | | |
| 126 | | | | Original | N/A | | | | | | |
| 127 | | | | Original | N/A | | | | | | |

Notifications



| | A | B | C | D | E | F | G | H | I | J | K | L |
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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification received | Received via mail and/or e-mail? | Name of Eligible Organization | Contact Information for Eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services that provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 128 | Redacted | | | Biola University (employee) | Redacted | | Yes | "abortion-inducing drugs like ella and Plan B" but not other contraceptives | Redacted | | Fully Insured | Redacted |
| 129 | | 7/26/2016 | Litigation: Grace Schools 7th Circuit Court 3:12-cv-00459-JD-CAN | Biola University (student) | | | Yes | "abortion-inducing drugs like ella and Plan B" but not other contraceptives | | Student | Fully Insured | |
| 130 | | | | Grace Schools (employee) | | | Yes | "abortifacient drugs" but not all contraceptives | | | Self-insured | |
| 131 | | | | Grace Schools (student) | | | Yes | "abortifacient drugs" but not all contraceptives | | Student | Fully Insured | |
| 132 | | 7/26/2016 | Litigation: CNS 8th Circuit Court 2:12-cv-00092 | CNS International Ministries (holding company for other listed plaintiffs: Sharpe Holdings Inc. Ozark Nat'l Life Ins. Co. and N.S. Financial Services Inc ) | | | Yes | Plan B ella Copper IUDs | | | Self-insured | |
| 133 | | | | Heartland Christian Co lege | | | Yes | Plan B ella Copper IUDs | | | Self-insured | |
| 134 | | 7/26/2016 | Litigation: Dordt 8th Circuit Court 5:13-cv-04100 | Cornerstone University | | | Yes | "post-coital emergency contraceptives" "such as ella Plan B and IUDs" | | | Fully-insured | |
| 135 | | | | Dordt Co lege (employee) | | | | | | | Self-insured | |
| 136 | | | | Dordt College (student) | | | | | | Student | Fully-insured | |
| 137 | | 7/26/2016 | Litigation: Little Sisters 0th Circuit Court No. 13-1540 (10th Cir) Appeal of No. 1:13-CV-02611 (D. Co.) | Little Sisters of the Poor Baltimore Inc. ( Little Sisters of Baltimore") | | Non-profit | Yes | "sterilization contraceptives and drugs that cause abortions." "contraceptives abort facient drugs sterilizations and related education and counseling " | | | self-insured | |
| 138 | | | | Little Sisters of the Poor Home for the Aged Denver Colorado ("Little Sisters of Denver") | | Non-profit | | | | | | |
| 139 | | 7/26/2016 | Litigation: Reaching Souls | Reaching Souls | | | Yes | ella Plan B Plan B one-step Next Choice Copper IUDs IUDs w/Progestin | | Church Plan | self-insured | |
| 140 | | | | Truett-McConnell College | | | | | | | | |
| 141 | | | | Mid-America Christian | | | | "contraceptives abortifacients [such as Plan B and ella] and related counseling to their employees and students." | | | self-insured | |
| 142 | | | | Oklahoma Baptist (employee) | | | | | | | Fully-insured | |
| 143 | | | | Oklahoma Baptist (student) | | | | | | Student | Fully-insured | |
| 144 | | 7/26/2016 | Litigation: Southern Nazarene 0th Circuit Court No. 14-6026 (10th Cir) appeal of No. 5:13-CV-01015-F (W.D. Okla.) | Oklahoma Wesleyan | | | Yes | Plan B ella and IUDs | | | Fully-insured | |
| 145 | | | | Southern Nazarene University (employee) | | | | "contraceptives abortifacients [such as Plan B and ella] and related counseling to their employees and students." | | | Partially Self-insured. Insured for claims over $100 000 | |

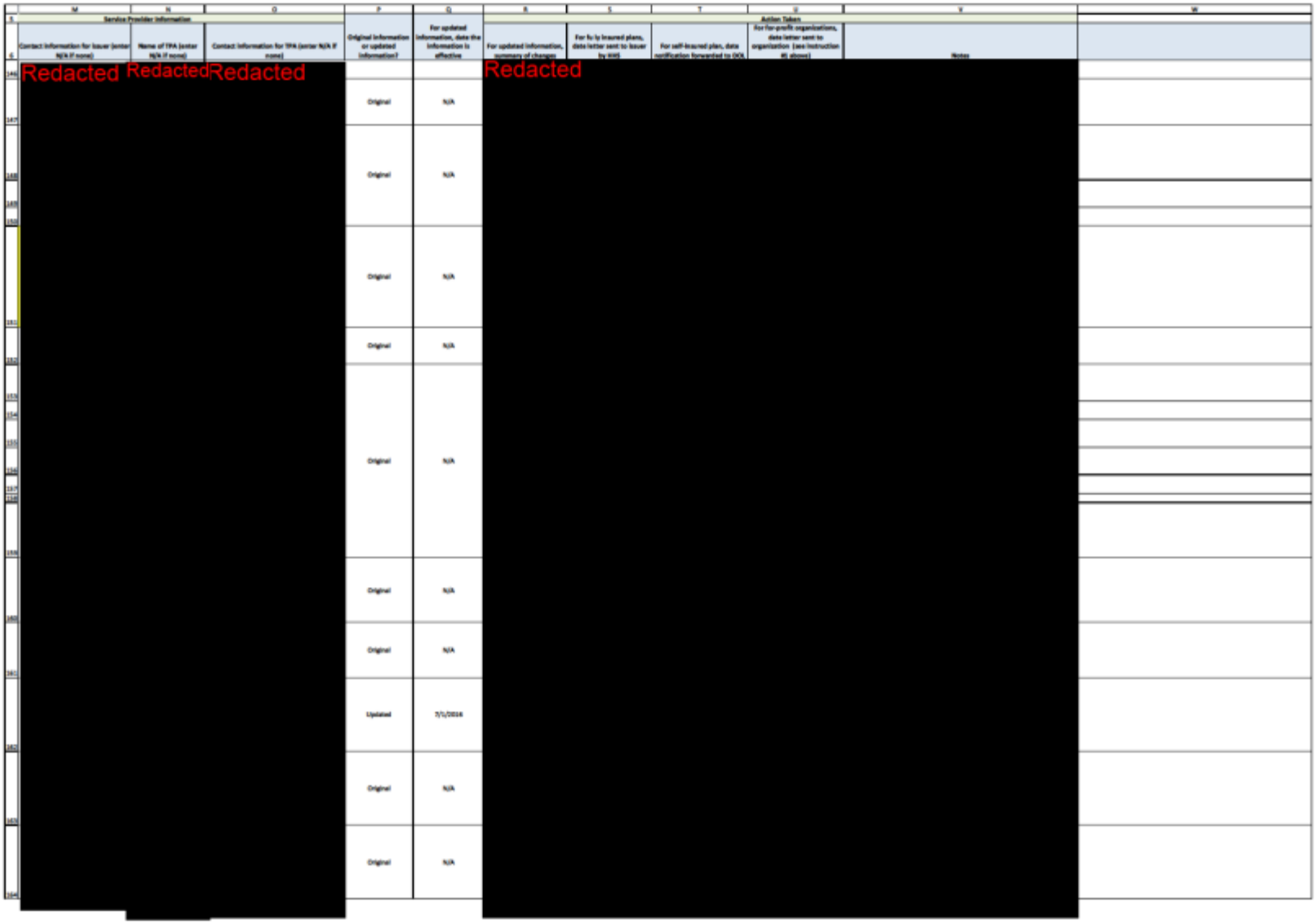
Notifications

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| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact Information for Issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact Information for TPA (enter N/A if none) | Original Information or Updated Information? | For updated information, date the information is effective | For updated Information, summary of changes | For fully insured plans, date letter sent to Issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #11 above) | Notes | |
| 128 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 129 | | | | Original | N/A | | | | | | |
| 130 | | | | | | | | | | | |
| 131 | | | | Original | N/A | | | | | | |
| 132 | | | | Original | N/A | | | | | | |
| 133 | | | | Original | N/A | | | | | | |
| 134 | | | | Original | N/A | | | | | | |
| 135 | | | | Original | N/A | | | | | | |
| 136 | | | | Original | N/A | | | | | | |
| 137 | | | | Original | N/A | | | | | | |
| 138 | | | | | | | | | | | |
| 139 | | | | Original | N/A | | | | | | |
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| 141 | | | | | | | | | | | |
| 142 | | | | | | | | | | | |
| 143 | | | | | | | | | | | |
| 144 | | | | Original | N/A | | | | | | |
| 145 | | | | | | | | | | | |

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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification Received | Received via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or Other) | Plaintiff In Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services Not Provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 146 | Redacted | | | Southern Nazarene University (student) | Redacted | | | | Redacted | Student | Fully-insured | Redacted |
| 147 | | 7/26/2016 | Litigation: Priests for Life DC 1:13-cv-01261 | Priests for Life | | | Yes | "contraception Sterilization [and] abortifacients" | | | Fully-insured | |
| 148 | | | | Archdiocese of Washington (listed in Complaint as "Roman Catholic Archbishop of Washington D.C." and as "Archdiocese of Washington") * (exempt) | | | | | | | self-insured | |
| 149 | | | | Catholic Charities of the Archdiocese of Washington Inc. | | | | | | | | |
| 150 | | | | Catholic Information Center Inc | | | | | | | | |
| 151 | | | | The Catholic University of America | | | | | | | Fully-insured | |
| 152 | | 7/26/2016 | Litigation: RCAW DC 1:13-cv-01441 | The Catholic University of America (student) | | | Yes | abortion-inducing products contraception or sterilization | | Student | Fully-insured | |
| 153 | | | | The Consortium of Catholic Academies of the Archdiocese of Washington D.C. | | | | | | | self-insured | |
| 154 | | | | Archbishop Carroll High School | | | | | | | | |
| 155 | | | | Don Bosco Cristo Rey High School of the Archdiocese of Washington D.C. | | | | | | | | |
| 156 | | | | Mary of Nazareth Roman Catholic Elementary School Inc. | | | | | | | | |
| 157 | | | | Roman Catholic Archbishop of Washington | | | | | | | | |
| 158 | | | | Victory Housing Inc. | | | | | | | | |
| 159 | | | | Thomas Aquinas College | | | | | | | | |
| 160 | | 7/26/2016 | Litigation: Beckwith Electric 11th Circuit (M.D. Fl.) 8:16-cv-01944 | Beckwith Electric Co. Inc. | | Other | Yes | "emergency contraception "if abort facients "if any drugs devices and services capable of ending innocent human life" (specifically lists Plan B Ella and the IUD as examples of "abortifacients") | | Other | self-insured | |
| 161 | | 7/26/2016 | Litigation: Johnson Welded DC(DCC) 1:16-cv-00557 | Johnson Welded Products Inc. | | Other | Yes | "all of the contraceptive services required by the Contraceptive services mandate" | | Other | Not Indicated | |
| 162 | | 8/5/2016 | Ma l | Society of the Precious Blood | | Non-profit | No | All | | Other | Fully Insured | |
| 163 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Catholic Charities of the Archdiocese of Philadelphia d/b/a Catholic Social Services | | Non-profit | Yes | "a list of the required contraceptive services with the exception of the prescription and use of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 164 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | St. John's Orphan Asylum | | Non-profit | Yes | "a list of the required contraceptive services with the exception of the prescription and use of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |

Notifications


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Original
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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date Notification Received | Received Via Mail or E-mail? | Name of Eligible Organization | Contact Information for Eligible Organization | Type of Organization (Non-profit or Other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive Services Not Provided | Plan Name | Plan Type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 165 | Redacted | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | St. Edmond's Home for Crippled Children | Redacted | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | Redacted | Church Plan | Self-insured | Redacted |
| 166 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Don Guanella Village of the Archdiocese of Philadelphia | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 167 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Divine Providence Village | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 168 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Philadelphia Protectory (for Boys) d/b/a St. Gabriel's System | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 169 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Catholic Community Services Inc. | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 170 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Nutritional Development Services Inc. | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 171 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Catholic Health Care Services Supportive Independent Living d/b/a Villa St. Martha and Community Based Services | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 172 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | St. John Vianney Center | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 173 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Catholic Clinical Consultants | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 174 | | 9/1/2016 | Litigation: Catholic Charities Archdiocese of Philadelphia 3rd Circuit 2:14-cv-03096-AB | Roman Catholic Archdiocese of Philadelphia | | Non-profit | Yes | "a list of the required contraceptive services (with the exception of the prescription and use list of contraceptive medications for non-contraceptive medical purposes." | | Church Plan | Self-insured | |
| 175 | | 9/15/2015 | Litigation: Diocese of Cheyenne 10th Circuit Court 14-8040 | Diocese of Cheyenne | | Non-profit | Yes | "to [providing, procuring, or facilitating access to] abortion-inducing products [for abortion, sterilization, or contraceptives" except when prescribed with the intent of treating a medical condition that with the intent to prevent pregnancy [or to induce] abortion." | | Church Plan | Self-insured | |
| 176 | | 9/15/2015 | Litigation: Diocese of Cheyenne 10th Circuit Court 14-8040 | Catholic Charities of Wyoming | | Non-profit | Yes | "to [providing, procuring, or facilitating access to] abortion-inducing products [for abortion, sterilization, or contraceptives" except when prescribed with the intent of treating a medical condition that with the intent to prevent pregnancy [or to induce] abortion." | | Church Plan | Self-insured | |
| 177 | | 9/15/2015 | Litigation: Diocese of Cheyenne 10th Circuit Court 14-8040 | Saint Joseph's Children's Home | | Non-profit | Yes | "to [providing, procuring, or facilitating access to] abortion-inducing products [for abortion, sterilization, or contraceptives" except when prescribed with the intent of treating a medical condition that with the intent to prevent pregnancy [or to induce] abortion." | | Church Plan | Self-insured | |

Notifications

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| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact Information for Issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact Information for TPA (enter N/A if none) | Original Information or Updated Information? | For updated information, date the information is effective | For updated information, summary of changes | For fully insured plans, date letter sent to Issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #11 above) | Notes | |
| 165 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 166 | | | | Original | N/A | | | | | | |
| 167 | | | | Original | N/A | | | | | | |
| 168 | | | | Original | N/A | | | | | | |
| 169 | | | | Original | N/A | | | | | | |
| 170 | | | | Original | N/A | | | | | | |
| 171 | | | | Original | N/A | | | | | | |
| 172 | | | | Original | N/A | | | | | | |
| 173 | | | | Original | N/A | | | | | | |
| 174 | | | | Original | N/A | | | | | | |
| 175 | | | | Original | N/A | | | | | | |
| 176 | | | | Original | N/A | | | | | | |
| 177 | | | | Original | N/A | | | | | | |

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| 5 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 6 | Tracking Number | Date notification received | Received via mail or e-mail? | Name of eligible organization | Contact information for eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #2 above) | Contraceptive services not provided | Plan name | Plan type (Student Plan, Church Plan, Other) | Fully Insured, Self-insured or both? | Name of Issuer (enter N/A if none) |
| 178 | Redacted | 9/15/2015 | Litigation: Diocese of Cheyenne 10th Circuit Court 14-8040 | St. Anthony Tri-Parish Catholic School | Redacted | Non-profit | Yes | "to providing procuring or facilitating access to abortion-inducing products abortion sterilization or contraceptives" except when prescribed with the intent of treating a medical condition not with the intent to prevent pregnancy or to induce abortion." | Redacted | Church Plan | Self-insured | Redacted |
| 179 | | 9/15/2015 | Litigation: Diocese of Cheyenne 10th Circuit Court 14-8040 | Wyoming Catholic College | | Non-profit | Yes | "abortion-inducing products or sterilization" except if contraceptives only when prescribed with the intent of treating a medical condition not with the intent to prevent pregnancy." | | Church Plan | self-insured | |
| 180 | | 9/15/2015 | Litigation: Colorado Christian University 10th Circuit Court 14-1329 | Colorado Christian University (employee) | | Non-profit | Yes | "coverage for all services drugs and devices that could terminate human life from the moment of conception including medical abortions emergency contraceptives like Plan B and Ella and IUDs" and other contraceptives." | | Other | self-insured | |
| 181 | | 9/15/2015 | Litigation: Colorado Christian University 10th Circuit Court 14-1330 | Colorado Christian University (student) | | Non-profit | Yes | "coverage for abortions and all contraceptives including emergency contraceptives and IUDs." | | Student | Fully Insured | |
| 182 | | 9/15/2015 | Litigation: Dobson 10th Circuit Court 14-1233 | Family Talk | | Non-profit | Yes | "abortion-inducing or implantation-preventing drugs abortifacient items and related education and counseling specifically IUDs and emergency contraception" such as Plan B and Ella" and any counseling or referrals to promote or refer for such abortion-inducing drugs and IUDs " | | Other | Partially Self-Insured with a stop-loss provider and a third-party administrator | |
| 183 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Association of Christian Schools International (employee) | | Non-profit | Yes | "the procurement of participation in facilitation of or payment for abortion (including abortion-causing drugs and devices like Plan B Ella and IUDs)" | | Other | self-insured | |
| 184 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Samaritan Ministries International (employee) | | Non-profit | Yes | "the procurement of participation in facilitation of or payment for abortion (including abortion-causing drugs and devices like Plan B Ella and IUDs)" | | Other | self-insured | |
| 185 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Taylor University (employee) | | Non-profit | Yes | "the procurement of participation in facilitation of or payment for abortion (including abortion-causing drugs and devices like Plan B Ella and IUDs)" | | Other | self-insured | |
| 186 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Indiana Wesleyan University | | Non-profit | Yes | "the procurement of participation in facilitation of or payment for abortion (including abortion-causing drugs and devices like Plan B Ella and IUDs)" | | Other | self-insured | |
| 187 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Asbury Theological Seminary | | Non-profit | Yes | "the procurement of participation in facilitation of or payment for abortion (including abortion-causing drugs and devices like Plan B Ella and IUDs)" | | Other | self-insured | |
| 188 | | 9/15/2015 | Litigation: Ass'n of Christian Schools Int'l v. Burwell 10th Circuit Court No. 14-1492 | Alliance Defending Freedom | | Non-profit | Yes | "emergency contraceptive medications hormonal contraceptive medications and devices and implanted contraceptive devices or related counseling or referrals to promote the use of such items" | | Other | self-insured | |
| 189 | | 9/20/2016 | Litigation: Catholic Benefits Ass'n LCA v. Burwell 10th Circuit Court Nos. 14-6163 & 14-6171 | Good Will Publishers Inc. | | Other | Yes | "contraception abortion-inducing drugs or devices sterilization and related counseling" | | Other | Fully-insured | |
| 190 | | 9/20/2016 | Litigation: Catholic Benefits Ass'n LCA v. Burwell 10th Circuit Court Nos. 14-6163 & 14-6171 | Catholic Charities of the Archdiocese of Oklahoma City | | Non-profit | Yes | "contraception abortion-inducing drugs or devices sterilization and related counseling" | | likely church plan but never alleged | self-insured | |
| 191 | | 9/20/2016 | Litigation: Catholic Benefits Ass'n LCA v. Burwell 10th Circuit Court Nos. 14-6163 & 14-6171 | All Saints Catholic School | | Non-profit | Yes | "contraception abortion-inducing drugs or devices sterilization and related counseling" | | likely church plan but never alleged | self-insured | |

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| 178 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 179 | | | | Original | N/A | | | | | | |
| 180 | | | | Original | N/A | | | | | | |
| 181 | | | | Original | N/A | | | | | | |
| 182 | | | | Original | N/A | | | | | | |
| 183 | | | | Original | N/A | | | | | | |
| 184 | | | | Original | N/A | | | | | | |
| 185 | | | | Original | N/A | | | | | | |
| 186 | | | | Original | N/A | | | | | | |
| 187 | | | | Original | N/A | | | | | | |
| 188 | | | | Original | N/A | | | | | | |
| 189 | | | | Original | N/A | | | | | | |
| 190 | | | | Original | N/A | | | | | | |
| 191 | | | | Original | N/A | | | | | | |

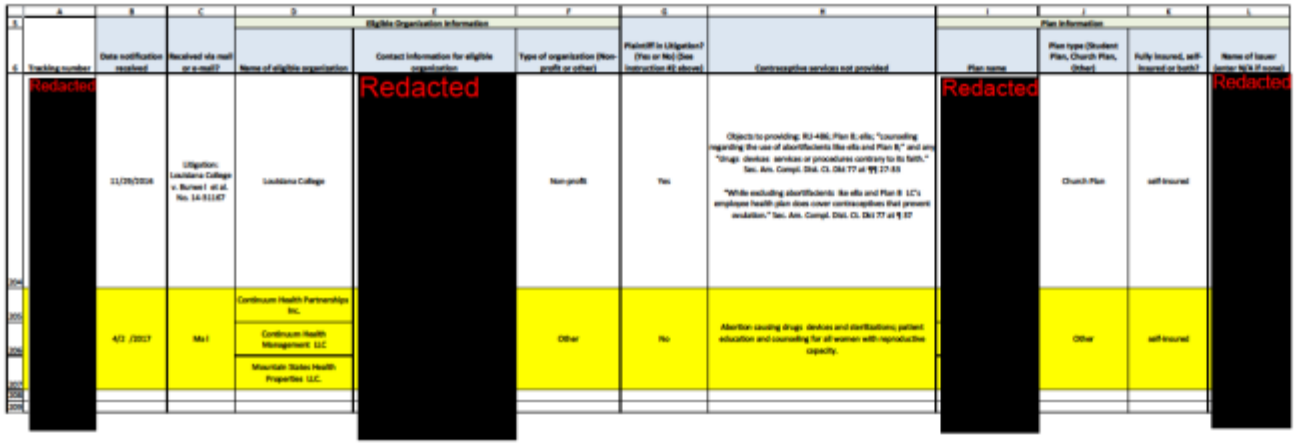
Notifications

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| 7 | Redacted | 9/20/2016 | Litigation: Catholic Benefits Ass'n LCA v. Burwell 10th Circuit Court Nos. 14-6163 14-6171 | The Cathedral Foundation (d/b/a) Catholic Review Media | Redacted | Non-profit | Yes | "contraception abortion-inducing drugs or devices sterilization and related counseling" | Redacted | likely church plan but never alleged | self-insured | Redacted |
| 10 | | 9/20/2016 | Litigation: Catholic Benefits Ass'n LCA v. Burwell 10th Circuit Court Nos. 14-6163 14-6171 | Via St. Francis Catholic Care Center Inc. | | Non-profit | Yes | "contraception abortion-inducing drugs or devices sterilization and related counseling" | | Other | Fully-insured | |
| 15 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13239 | THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA An association of churches and schools | | Non-profit | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | self-insured | |
| 19 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13240 | THE MOST REVEREND WILTON D GREGORY and his successors Archbishop of the Roman Catholic Archdiocese of Atlanta | | Non-profit | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | self-insured | |
| 19 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13241 | CATHOLIC CHARITIES OF THE ARCHDIOCESE OF ATLANTA INC. a Georgia non-profit corporation | | Non-profit | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | Self-Insured | |
| 19 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13242 | Catho ic Education of North Georgia Inc. (CENGI) | | Other | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | Self-Insured | |
| 15 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13243 | THE ROMAN CATHOLIC DIOCESE OF SAVANNAH an ecclesiastical territory | | Non-profit | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | Self-Insured | |
| 19 | | 10/6/2016 | Litigation: Roman Catholic Archdiocese of Atlanta et al. v. Secretary U.S. Dep't of Health & Human Servs et al Nos. 14-12890 14-13244 | THE MOST REVEREND JOHN HARTMAYER and his successors Bishop of The Roman Catholic Diocese of Savannah et al. | | Non-profit | Yes | "abortion-inducing products contraception steri ization and related counse ing" "unless they are necessary for medica ly diagnosed conditions unrelated to contraception." | | Church Plan | Self-Insured | |
| 20 | | 10/6/2016 | Eternal Word Television Network v. Burwell No. 14-12696 | Eternal Word Television Network Inc. | | Non-profit | Yes | "artificial contraception ster lization abortion related education and counseling." | | other | Self-Insured | |
| 20 | | 11/ /2016 | Email/mail | Bick Group Inc. | | Other | Yes | "all contraceptive services" | | Other | Fully-insured | |
| 20 | | 11/9/2016 | Email | The Energy Lab INC | | Other | No | All | | Other | Fully-insured | |
| 20 | | 11/2 /2016 | Email | Mariani University | | Non-profit | No | All | | Church Plan | self-insured | |

Notifications

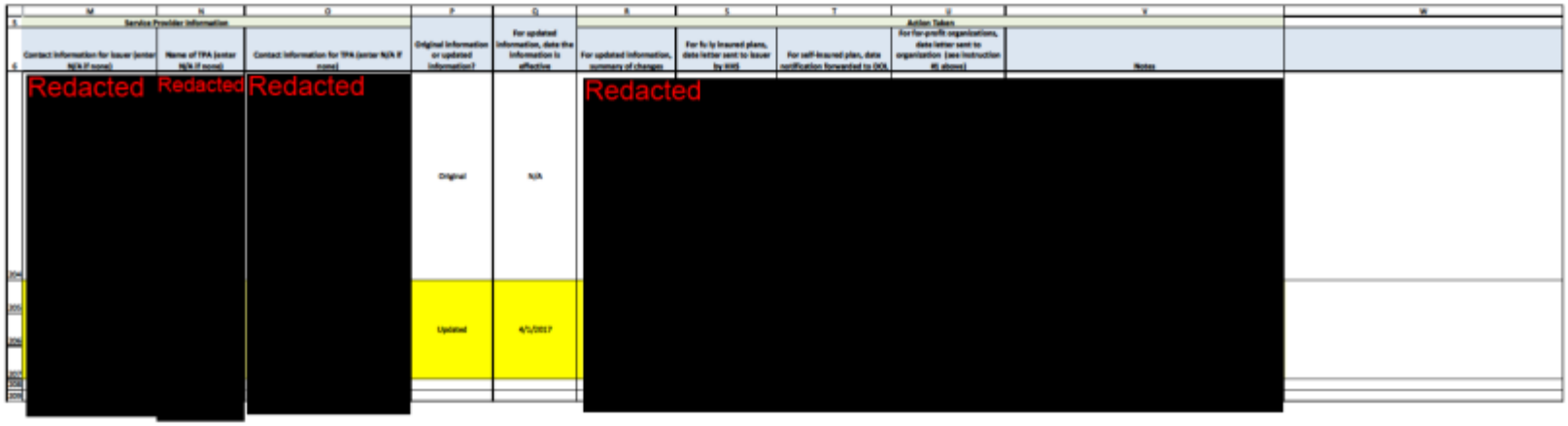
| | M | N | O | P | Q | R | S | T | U | V | W |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5 | Service Provider Information | | | | | Action Taken | | | | | |
| 6 | Contact Information for Issuer (enter N/A if none) | Name of TPA (enter N/A if none) | Contact Information for TPA (enter N/A if none) | Original Information or Updated Information? | For updated information, date the information is effective | For updated information, summary of changes | For fully insured plans, date letter sent to Issuer by HHS | For self-insured plan, date notification forwarded to DOL | For for-profit organizations, date letter sent to organization (see Instruction #11 above) | Notes | |
| 192 | Redacted | Redacted | Redacted | Original | N/A | Redacted | | | | | |
| 193 | | | | Original | N/A | | | | | | |
| 194 | | | | Original | N/A | | | | | | |
| 195 | | | | Original | N/A | | | | | | |
| 196 | | | | Original | N/A | | | | | | |
| 197 | | | | Original | N/A | | | | | | |
| 198 | | | | Original | N/A | | | | | | |
| 199 | | | | Original | N/A | | | | | | |
| 200 | | | | Original | N/A | | | | | | |
| 201 | | | | Original | N/A | | | | | | |
| 202 | | | | Original | N/A | | | | | | |
| 203 | | | | Original | N/A | | | | | | |

Notifications



| | A | B | C | D | E | F | G | H | I | J | K | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | | | | Eligible Organization Information | | | | | Plan Information | | | |
| 4 | Tracking number | Date notification received | Received via mail or e-mail? | Name of eligible organization | Contact information for eligible organization | Type of organization (Non-profit or other) | Plaintiff in Litigation? (Yes or No) (See instruction #5 above) | Contraceptive services not provided | Plan name | Plan type (Student Plan, Church Plan, Other) | Fully insured, self-insured or both? | Name of issuer (enter N/A if none) |
| 254 | Redacted | 11/29/2016 | Litigation: Louisiana College v. Burwell et al. No. 14-51167 | Louisiana College | Redacted | Non-profit | Yes | Objects to providing RU-486, Plan B, ella; "counseling regarding the use of abortifacients like ella and Plan B," and any "drugs, devices, services or procedures contrary to its faith." Sec. Am. Compl. Dist. Ct. Dkt 77 at ¶¶ 27-33<br><br>"While excluding abortifacients like ella and Plan B LC's employee health plan does cover contraceptives that prevent ovulation." Sec. Am. Compl. Dist. Ct. Dkt 77 at ¶ 37 | Redacted | Church Plan | self-insured | Redacted |
| 255 | | 4/2 /2017 | Mail | Continuum Health Partnerships Inc. | | Other | No | Abortion causing drugs devices and sterilizations; patient education and counseling for all women with reproductive capacity. | | Other | self-insured | |
| 256 | | | | Continuum Health Management LLC | | | | | | | | |
| 257 | | | | Mountain States Health Properties LLC. | | | | | | | | |
| 258 | | | | | | | | | | | | |
| 259 | | | | | | | | | | | | |

Notifications




Notifications


Redacted

# EXHIBIT C

| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| Am. Pulverizer Co. v. U.S. Dep't of Health and Human Servs., No. 6:12-cv-03459, 2012 WL 6951316 (W.D. Mo. Dec. 20, 2012); | | 175 employees | Complaint | Yes | | 175 | 175 | |
| American Family Association v. Sebelius, 1:13-cv-00032-SA-DAS (N.D. Miss. Feb. 20, 2013) | | 135 employees | Complaint | Yes | | 135 | 135 | |
| Annex Med., Inc. v. Burwell, No. 13-1118, 2013 WL 1276025 (8th Cir. Feb. 1, 2013) | | 18 employees | Complaint | Yes | | 18 | 18 | |
| Archdiocese of St. Louis v. Burwell, No. 4:13-cv-02300 (E.D. MO), No. 14-3016 (8th Cir.) | Archdiocese of St. Louis | 7,800 employees/staff | Complaint | No | Diocese self-insured plan (see Brandt v Burwell note below) | 0 | 0 | |
| | Catholic Charities of St. Louis | 1600 employees | Complaint | No | same | 0 | 0 | |
| Armstrong v. Burwell, No. 1:13-cv-00563-RBJ (D. Colo. Sept. 17, 2013); gov't appeal dismissed Sept. 4 2014 (10th Cir. order); | | 730 employees | Complaint | Yes | | 730 | 730 | |
| Association of Christian Schools International v. Burwell, No. 1:14-cv-2966 (D. Colo.), No. 14-1492 (10th Cir.) | Association of Christian Schools International | 140 employees | Complaint | Yes | | 140 | 140 | |
| | Samaritan Ministries International | 133 employees | Complaint | Yes | | 133 | 133 | |
| | Taylor University | 1,900 Students; 641 Employees | Complaint | Students = no; employees = yes | Complaint does not state that they offer a student health plan; therefore students not counted | 641 | 641 | 0 |
| | Indiana Wesleyan University | 15,000 students; 3,565 employees (1,018 FT and 2,547 PT) | Complaint | Students = no; employees = partial | Complaint does not state that they offer a student health plan; therefore students not counted. Complaint states that 890 employees enroll in the plan. Because other entities usually provide the overall number of employees, not the number enrolled in the plan, and in the IFR we estimate 62% of all employees are in plans, this number is upscaled to $890/62\% = 1,435$ | 1,435 | 1,435 | 0 |
| Autocam Corp. v. Burwell, 730 F.3d 618 (6th Cir. Sept. 17, 2013); | Autocam | 478 employees | Complaint | Yes | | 478 | 478 | |
| | Autocam Medical | 183 employees | Complaint | Yes | | 183 | 183 | |
| Ave Maria Foundation v. Burwell, No. 2:13-cv-15198 (E.D. Mich.), Nos. 14-1310 (6th Cir.) | The Ave Maria Foundation | 51 employees | Estimated number based on online information | Yes | | 51 | 51 | |
| | Ave Maria Communications | 19 employees | Form W-3 filing | Yes | | 19 | 19 | |
| | Domino's Farms Petting Farm | 18 employees | Form W-3 filing | Yes | | 18 | 18 | |
| | Rhodora J. Donahue Academy, Inc. | 26 employees | Website | Yes | | 26 | 26 | |
| | Thomas More Law Center | 14 employees | Form W-3 filing | Yes | | 14 | 14 | |
| Ave Maria School of Law v. Burwell, No. 2:13-cv-00795 (M.D. Fl.), Nos. 14-15777 (11th Cir.) | | 68 employees | Complaint | Employees = yes; students = no | Permanent injunction 07/11/2018 | 0 | 0 | 0 |
| Ave Maria University v. Burwell, No. 2:13-cv-00636 (M.D. Fla.), Nos. 14-15780 (11th Cir.) | | 150 employees | Complaint | Employees = yes; students = no | Permanent injunction 07/11/2018 | 0 | 0 | 0 |
| Barron Indus., Inc. v. Burwell, No. 1:13-cv-01330 KBJ (D.D.C. Sept. 25, 2013); | | 56 employees | Complaint | Yes | | 56 | 56 | |
| Beckwith Elec. Co. v. Burwell, No. 8:16-cv-1944 (M.D. Fla.) | | 126 employees | Complaint | Yes | | 126 | 126 | |
| Belmont Abbey College v. Sebelius, et al., No. 1:11-cv-01989 (D.D.C. Nov. 10, 2011) | | 1,600 students; 305 employees | Complaint | Yes | | 1,600 students; 305 employees | 305 | 1,600 |
| Bick Holdings, Inc. v. Burwell, No. 4:13-cv-00462 AGF (E.D. Mo. Apr. 1, 2013); | | 196 employees | Complaint | Yes | | 196 | 196 | |
| Brandt v. Burwell, No. 2:14-cv-00681 (W.D. Pa.), Nos. 14-3663, 14-4087 (3d Cir.) | Diocese of Greensburg | 3,100 employees; 5,000 other participants in plan (this is a high number- it includes employees from other Dioceses) | Complaint | No | Diocese self-insured plan; Government argued that these and all similar Catholic diocese-sponsored self-insured plans and entities participating in such plans that are litigants represented by Jones Day likely qualify to be church plans exempt from ERISA. See, e.g., Doc. # 23, 2:14-cv-00681-AJS (W.D. Pa.). We cannot force such plan TPAs to offer contraceptive payments, and it is likely the churches will tell them not to, and the TPAs will not make the offers. | 0 | 0 | |
| | Catholic Charities | 18 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | St. John School | 13 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |



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Draft - For Discussion Purposes

| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| Briscoe v. Burwell, No. 1:13-cv-00285-WYD-BNB (D. Colo. Sept. 6, 2013); gov't appeal dismissed Sept 4, 2014 (10th Cir. order); | Briscoe owns all plaintiff organizations involved: Continuum Health Partnerships, Inc./ Mountain States Health Properties, LLC/ Continuum Health Management, LLC/ CH-Greeley, LLC | 200 employees | Complaint | Yes | | 200 | 200 | |
| Catholic Benefits Association LCA v. Burwell (CBA I), No. 5:14-cv-00240 (W.D. Okla.), Catholic Benefits Association LCA v. Burwell (CBA II), No. 5:14-cv-00685 (W.D. Okla.),Nos. 14-6171, 14-6163, 15-6029, 15-6037, 15-6139, 16-6030, 16-6217 (10th Cir.) | Catholic Benefits Associaton | Unknown | N/A | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Catholic Insurance Company | Unknown | N/A | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Archdiocese of Baltimore | 5, 500 participants | Complaint | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Cathedral Foundation (AKA Catholic Review Media) | 32 employees | Complaint | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Archdiocese of Oklahoma City- Complaint lists Mount St. Mary, St. Ann, and Office of Catholic Schools as sub-ministries | Unknown (see St. Ann, Mount St. Mary and Office of Catholic Schools below) | | No | Permanent injunction 03/07/2018 | 0 | | |
| | St. Ann | 78 employees | Form W-3 filing | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Mount St. Mary | Unknown | | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Office of Catholic Schools | | | | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Villa St. Francis Catholic Care Center | 100 participants | Complaint | Yes | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Goodwill Publishers | 140 employees | Complaint | Yes | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Catholic Charities Oklahoma City | 103 employees | Form W-3 filing | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | All Saints | Unknown | | No | Permanent injunction 03/07/2018 | 0 | 0 | |
| | Catholic Charities and Family Services, Diocese of Norwich | 69 employees | Second Complaint | Yes | Permanent injunction 03/07/2018 | 0 | 0 | |
| Catholic Charities of the Archdioceses of Philadelphia v. Burwell, No. 2:14-cv-3096 (E.D. Pa.), No. 14-3126 (3d Cir.) | Catholic Social Services | 626 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Francis Homes for Boys | 227 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Edmund's Home for Children | 226 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Don Guanella Village | 413 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Divine Providence Village | 667 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Gabriel's System | 458 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Community Services | 92 | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Nutritional Development Services | 64 | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Villa St. Martha | 117 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Monica Manor | 356 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. John Neumann Nursing Home | 360 Employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Immaculate Mary Home | 490 Employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Francis Country House | 488 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Martha Manor | 272 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. Mary Manor | 339 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | St. John Vianney Center | 84 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Clinical Consultants | 19 | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| Catholic Diocese of Beaumont v. Burwell, No. 1:13-cv-00709 (E.D. Tex.), No. 14-40212 (5th Cir.) | Diocese | 950 employees; 232 staff at schools | Complaint | No | Offers coverage through Christian Brothers Employee Benefit Trust- a self insured church plan | 0 | 0 | |
| | Catholic Charities of Southeast Texas, Inc. | 18 employees | Complaint | | Offers coverage through Christian Brothers Employee Benefit Trust- a self insured church plan | 0 | 0 | |
| Catholic Diocese of Biloxi v. Burwell, No. 1:14-cv-00146 (S.D. Miss.) | Diocese of Jackson | 900 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities | 140 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Vicksburg | 70 employees | Website | No | Diocese self-insured plan | 0 | 0 | |
| | St Joseph | 85 employees | Website | No | Diocese self-insured plan | 0 | 0 | |
| | Diocese of Biloxi | 600 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | De L'epee Deaf Center | 5 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Social & Community Services Inc. | 20 employees | Form W-3 filing | no | Diocese self-insured plan | 0 | 0 | |
| | Resurrection Catholic and Sacred Heart | 200 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |



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| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| | St. Dominic-Jackson Memorial Hospital and affiliated locations and programs | 2,200 employees | Complaint | No | Self-insured plan sponsored by Catholic affiliated hospital; grandfathered and already omits contraceptives, so could retain grandfathered status or pursue church plan status to continue omitting. | 0 | 0 | |
| Conlon, Bishop of Catholic Diocese of Joliet v. Sebelius, 1:12-cv-03932 (N.D. Ill. May 21, 2012) | Diocese of Joliet | At least 1,570 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities of Joliet | 240 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Diocese of Springfield | 2585 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities of Springfield | 200 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities of Chicago | 2700 employees | Complaint | Yes | Self-funded welfare benefit plan but not sure if church plan | 2,700 | 2,700 | |
| Catholic Diocese of Nashville v. Burwell, No. 3:13-cv-1303 (M.D. Tenn.), No. 13-6640 (6th Cir.) | Diocese of Nashville | 1200 employees | Complaint | No | House of Worship, fully insured | 0 | 0 | |
| | Catholic Charities | 115 employees | Complaint | Yes | | 115 | 115 | |
| | Aquinas College | 16 employees | Website | employees: yes; students: no | Website/news reports indicate recent drastic downsizing of workforce; students not counted because complaint does not allege a student plan | 16 | 16 | 0 |
| | Camp Marymount | 75 employees | Complaint | Yes | | 75 | 75 | |
| | MQA | 85 employees | Complaint | Yes | | 85 | 85 | |
| | St. Mary Villa | 50 employees | Complaint | Yes | | 50 | 50 | |
| | Dominican Sisters | 23 employees | | No | Religious order | 0 | 0 | |
| Catholic Diocese of Peoria v. Sebelius, 1:12-cv-01276-JES-BGC (C.D. Ill. August 9, 2012) | | Unknown | | No | Diocese self-insured plan (court order, 2013 WL 74240), and grandfathered | 0 | 0 | |
| Catholic Health Care System v. Burwell, No. 1:12-cv-02542 (E.D.N.Y.), No. 14-427 (2d Cir.); PACER | Archdiocese of New York | 10,000 employees | Complaint | No | In the lawsuit the government took th position that this is a self-insured church plan. See, e.g., 987 F.Supp.2d at 242 | 0 | 0 | |
| | ArchCare | 4,000 employees | Complaint | No | Catholic hospital self-insured plan | 0 | 0 | |
| | Catholic Health Services of Long Island | 17,000 employees | Complaint | No | Catholic hospital self-insured plan | 0 | 0 | |
| | The Diocese of Rockville Centre | 2,000 employees | Complaint | No | In the lawsuit the government took th position that this is a self-insured church plan. See, e.g., 987 F.Supp.2d at 242 | 0 | 0 | |
| | Monsignor Farrel High School | 73 employees | Website | No | In the lawsuit the government took th position that this is a self-insured church plan. See, e.g., 987 F.Supp.2d at 242 | 0 | 0 | |
| | Cardinal Spellman High School | 100 employees | Complaint | No | In the lawsuit the government took th position that this is a self-insured church plan. See, e.g., 987 F.Supp.2d at 242 | 0 | 0 | |
| Christian & Missionary Alliance Foundation, Inc., No. 2:14-cv-00580 (M.D. FL.), Nos. 15-11437, 15-11635 (11th Cir.) | CMA d/b/a Shell Point Retirement Center | 1247 employees | Form W-3 filing | Yes | | 1,247 | 1,247 | |
| | Alliance Community for Retirement Living | 344 employees | Form W-3 filing | Yes | | 344 | 344 | |
| | Alliance Home of Carlisle | 219 employees | Form W-3 filing | Yes | | 219 | 219 | |
| | Town and Country Manor | 365 employees | Form W-3 filing | Yes | | 365 | 365 | |
| | Simpson University | 815 employees | Complaint | employees: yes; students: no | Complaint does not seek relief for any student plan | 815 | 815 | 0 |
| | Crown College | 114 employees | Form W-3 filing; student enrollment: https://www.crown.edu/about/quick-facts/ ("nearly 1,300 students") | Yes | | 1,275 students; 114 employees | 114 | 1,275 |
| Christian Employers Alliance v. Burwell, No. 3:16-cv-309 (D.N.D.) | Christian Employers Alliance | Unknown | | No | No claim was made for CEA plans, and no list of members beyond TBC and TIC | 0 | 0 | |
| | Trinity Bible College | 249 employees | Form W-3 filing | employees: yes; students: no | complaint does not mention student plan | 249 | 249 | |
| | Treasure Island Com | 9 staff | Website | Yes | | 9 | 9 | |
| Colorado Christian Univ. v. Burwell, No. 1:13-cv-02105 (D. Colo.), No. 14-1329 (10th Cir.) | Colorado Christian University | 5,300 students; 680 employees | Complaint | Yes | Permanent injunction 07/11/2018 | 0 | 0 | 0 |
| Conestoga Wood Specialties Corp. v. Burwell (Burwell v. Hobby Lobby Stores, Inc.), No. 13-356 (U.S. June 30, 2014); | Conestoga Wood Specialties Corp. (Individual operators of Conestoga Wood Specialities Corporation are the three other named plaintiffs) | 950 employees | Complaint | Yes | | 950 | 950 | |



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| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| DeOtte v. Azar, No. 4:18-cv-00825-Y (N.D. Tex. Complaint Oct. 6, 2018) | Richard W. DeOtte, Yvette DeOtte, John Kelley, Alison Kelley, Hotze Health & Wellness Center | 75 employees | Complaint | Yes | | 75 | 75 | |
| Diocese of Cheyenne v. Burwell, No. 2:14-cv-00021 (D. Wyo.), No. 14-8040 (10th Cir.) | Diocese of Cheyenne | 16 employees plus over 100 teachers | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities | 6 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | St. Anthony School | 41 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | St. Joseph's Home | 130 employees, 62 orphan children | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | JPIICS | 20 | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Wyoming Catholic College | 32 employees | Complaint | No | Offers coverage through Christian Brothers Employee Benefit Trust- a self insured church plan | 0 | 0 | 0 |
| Diocese of Fort Wayne-South Bend Inc. v. Burwell, No. 1:12-cv-00159 (N.D. Ind.), No. 14-1431 (7th Cir.) | Diocese of Fort Wayne South Bend | 2,741 employees | Complaint | No | Diocese self-insured plan; also grandfathered | 0 | 0 | |
| | Catholic Charities | 39 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | St Anne Home | 310 employees | Complaint | Yes | Self-insured plan, but not sure if it is a church plan | 310 | 310 | |
| | University of St Francis | 2,300 students, 413 employees | Complaint | employees: yes; students: no | No student plan discussed; Employees are offered a self-insured health plan, but not sure it is a church plan, so included | 413 | 413 | 0 |
| | Our Sunday Visitor | 300 employees | Complaint | Yes | Self-insured plan, but not sure if it is a church plan | 300 | 300 | |
| | Specialty Physicians | 342 employees | Complaint | Yes | | 342 | 342 | |
| | Franciscan Alliance | 18,000 employees | Complaint | Partial | All but 1,733 employees are on a church plan exempt from ERISA. See: https://www.franciscanhealth.org/sites/default/files/2015%20employee%20benefit%20booklet.pdf (Only employees in Illinois are in BCBS plans and there are 1733 of those employees according to complaint | 1,733 | 1,733 | |
| Doboszenski & Sons, Inc. v. Burwell, No. 0:13-cv-03148-JNE-FLN (D. Minn. Nov. 11, 2013); | | 32 employees | Complaint | Yes | | 32 | 32 | |
| Dobson v. Burwell, No. 1:13-cv-03326 (D. Colo.), No. 14-1233 (10th Cir.) | | 28 employees | Complaint | Yes | | 28 | 28 | |
| Domino's Farms Corporation v. Sebelius et al., No. 12-cv-15488 (E.D. Mich. Dec. 20, 2012) | | 89 employees | Complaint | Yes | | 89 | 89 | |
| Dordt Coll. v. Burwell, No. 5:13-cv-04100 (N.D. Iowa, Western Divison), No. 14-2726 (8th Cir.) | Dordt College | 1,400 students, 280 employees | Complaint | Yes | Permanent injunction 06/14/2018 | 0 | 0 | 0 |
| | Cornerstone University | 2,923 students, 294 employees | Complaint | employees: yes; students: no | Permanent injunction 06/14/2018 | 0 | 0 | 0 |
| East Texas Baptist Univ. v. Burwell, No. 4:12-cv-03009 (S.D. Tex.), No. 14-20112 (5th Cir.) | Houston Baptist University | 2,589 students, 416 employees | Complaint | No | Self-insured church plan | 0 | 0 | 0 |
| | East Texas Baptist Univeristy | 1,290 students, 283 employees | Complaint | Yes | | 1,290 students, 283 employees | 283 | 1,290 |
| | Westminster Theological Seminary (Intervenor) | 60 FT, 65 PT employees, 620 students | Complaint in intervention | employees: yes; students: no | complaint does not mention student plan | 125 | 125 | 0 |
| Eden Foods, Inc. v. Burwell, No. 13-1677 (6th Cir. June 28, 2013), | | 128 employees | Complaint | Yes | | 128 | 128 | |
| Eternal Word Television Network, Inc. v. Burwell, No. 1:13-cv-00521 (S.D. Al.), No. 14-12696 (11th Cir.) | | 350 employees | Complaint | Yes | | 350 | 350 | |
| Fellowship of Catholic University Students v Burwell, No. 1:13-cv-03263-MSK-KMT (D. Colo. Apr. 23, 2014) | | 450 employees | Complaint | No | Case resolved on basis that plaintiff is integrated auxilary | 0 | 0 | |
| Feltl & Co., Inc. v. Burwell, No. 13-CV-2635 DWF/JJK (D. Minn. Nov. 8, 2013); | Complaint lists bro owners of the company as individual plaintiffs | 4 employees | Website | Yes | | 4 | 4 | |
| Franciscan University v. Sebelius, 2:12–CV–440 (S.D. Ohio) | | Unknown | Complaint | No | Sued while grandfathered and then dropped student plan. With no additional suit, no apparent affect from rule. | 0 | 0 | 0 |
| Geneva College v. Burwell, No. 2:12-cv-00207 (W.D. Pa.), Nos. 13-3536, 14-1374 (3rd. Cir.) | Geneva College | 1,850 students, 350 employees | Complaint | Yes | Permanent injunction docket # 144 | 0 | 0 | 0 |
| | Seneca Hardwood Lumber | 22 employees | Complaint | No | Permanent injunction shields from previous rule | 0 | 0 | |
| Gilardi v. U.S. Dep't of Health and Human Servs., No. 13-5069, 2013 WL 5854246 (D.C. Cir. Nov. 1, | Freshway Foods | 340 employees | Complaint | Yes | | 340 | 340 | |
| | Freshway Logistics | 55 employees | Complaint | Yes | | 55 | 55 | |
| Grace Schools v. Burwell, No. 3:12-cv-00459 (N.D. Ind.), No. 14-1430 (7th Cir.) | Grace College and Seminary | 2,700 students, 457 employees | Complaint | Yes | Permanent injunction 06/14/2018 | 0 | 0 | 0 |
| | Biola University | 6,222 students, 856 employees | Complaint | Yes | Permanent injunction 06/14/2018 | 0 | 0 | 0 |



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Draft - For Discussion Purposes

| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| Grote Indus. LLC v. Burwell, No. 13-1077, 2013 WL 5960692 (7th Cir. Nov. 8, 2013), cert. denied sub nom. Burwell v. Korte, No. 13-937 (U.S. July 1, 2014); | | 1,148 employees | Complaint | Yes | | 1,148 | 1,148 | |
| Hall v. Burwell, No. 0:13-cv-00295-JRT-LIB (D. Minn. Apr. 2, 2013); | | Approximately 50 employees | Complaint and online news reports | Yes | | 50 | 50 | |
| Hartenbower v. U.S. Dep't of Health and Human Servs., No. 1:13-cv-02253 (N.D. Ill. Apr. 18, 2013); | Hart Electric | 54 employees (including owners) | Complaint | Yes | | 54 | 54 | |
| | H.I. Hart | 7 employees | Complaint | Yes | | 7 | 7 | |
| Hastings Chrysler Center, Inc. v. Burwell, No. 0:14 cv-00265-PAM-JJG (D. Minn. May 28, 2014); | | 60 employees | Complaint | Yes | | 60 | 60 | |
| Hobby Lobby Stores, Inc., et al. v. Sebelius, et al., No: CIV-12-1000-HE (W.D. Okla. Oct. 2, 2012); | Hobby Lobby | 13,240 employees | Complaint | Yes | | 13,240 | 13,240 | |
| | Mardel | 372 employees | Complaint | Yes | | 372 | 372 | |
| Holland v. U.S. Dep't of Health and Human Servs, No. 13-15487 (S.D. W. Va. July 15, 2014); | | 150 employees | Complaint | Yes | | 150 | 150 | |
| Infrastructure Alternatives, Inc. v. Burwell, No. 1:13 cv-00031-RJJ (W.D. Mich. Sept. 30, 2013) | | 70 employees | Complaint | Yes | | 70 | 70 | |
| Insight for Living Ministries v. Burwell, No. 4:14-cv 675 (E.D. Tex.), No. 15-40031 (5th Cir.) | | 108 employees | Form W-3 filing | Yes | | 108 | 108 | |
| Johnson Welded Prods. v. Burwell, No. 1:16-cv-557 (D.D.C.) | | 421 employees (including Lilli Johnson) | Complaint | Yes | | 421 | 421 | |
| Korte v. Burwell, No. 12-3841, 2013 WL 5960692 (7th Cir. Nov. 8, 2013), cert. denied No. 13-937 (U.S. July 1, 2014); | | 90 employees | Complaint | Yes | | 90 | 90 | |
| Legatus v. Burwell, No. 2:12-cv-12061-RHC-MJH (E.D. Mich. Dec. 20, 2013) | Legatus | 69 employees | Complaint | Yes | Legatus injunction 12/20/2013, case dismissed 02/02/2018 | 0 | 0 | |
| | Weigmartz Supply Company, W&P Management LLC, and subsidiaries | 170 employees | Complaint | Yes | | 170 | 170 | |
| Lindsey v. U.S. Dep't of Health and Human Servs., No. 13-cv-1210 (N.D. Ill. Mar. 20, 2013); | | 70 employees | Complaint | Yes | | 70 | 70 | |
| Little Sisters of the Poor Home for the Aged v. Burwell, No. 1:13-cv-2611 (D. Colo.), No. 13-1540 (10th Cir.) | Christian Brothers Employee Benefit Trust ( Little Sisters uses Christian Brothers Employee Benefit Trust, and Christian Brothers Services is the TPA for the Christian Brothers Employee Benefit Trust) | 5,000 employees | Complaint | No | Self-insured church plan, and permanent injunction 05/29/2018 | 0 | 0 | |
| Louisiana Coll. v. Burwell, No. 1:12-cv-00463 (W.D. La.), No. 14-31167 (5th Cir.) | | 1,450 students, 260 employees | Complaint | No | Self-insured church plan | 0 | 0 | 0 |
| March for Life v. Burwell, No. 1:14-cv-1149 (D.D.C.), No. 15-5301 (D.C. Cir.) | | 2 employees covered in plan; less than 10 overall | | No | All employees must/do oppose the coverage; therefore not counting as affected by rules | 0 | 0 | |
| Media Research Center v. Sebelius, No. 1:14-CV-379 (E.D. Virginia) | | 114 employees | Complaint | Yes | | 114 | 114 | |
| Mersino Mgmt. Co. v. Burwell, No. 13-1944 (6th Cir. July 9, 2014) | | 110 employees | Complaint | Yes | | 110 | 110 | |
| Michigan Catholic Conf. v. Burwell, No. 1:13-cv-1247 (W.D. Mich.), No. 13-2723 (6th Cir.) | Michigan Catholic Charities | 6,429 employees | Complaint | No | Self-insured church plan | 0 | 0 | |
| | Catholic Charities | 55 employees | Complaint | No | Self-insured church plan | 0 | 0 | |
| Midwest Fastener Corp. v. Burwell, No. 1:13-cv 01337-ESH (D.D.C. Oct. 16, 2013); | | 187 employees | Complaint | Yes | | 187 | 187 | |
| MK Chambers Co. v. Dep't of Health and Human Servs., No. 13-cv-11379 (E.D. Mich. Nov. 21, 2014) | | 106 employees | Business profile on manta.org | Yes | | 106 | 106 | |
| Nagle, Christopher, et al. v. Kathleen Sebelius, et al., No. 2:13-cv-12036-VAR-DRG (E.D. Mich. May 10, 2013) (AKA *"M&N Plastics"*) | | 109 employees | Complaint | Yes | | 109 | 109 | |
| Newland v. Burwell, 881 F. Supp. 2d 1287 (D. Colo. July 27, 2012), affirmed on appeal, No. 12-1380 (10th Cir. Oct. 3, 2013) | | 265 employees | Dist Ct Brief 4/30/12 | No | Permanent injunction | 0 | | |
| O'Brien v. U.S. Dep't of Health & Human Servs., No. 12-3357 (8th Cir. Nov. 28, 2012) | | 87 employees | Complaint | Yes | | 87 | 87 | |
| Ozinga v. Burwell, No. 1:13-cv-3292 (N.D. Ill.), No. 15-3648 (7th Cir.) | | 675+ employees | Complaint | Partial | Only 110 obtain insurance through the plan that would be affected by the exemption. This is upscaled to 110/62%=178 | 178 | 178 | |
| Persico v. Burwell, No. 1:13-cv-0303 (W.D. Pa.), Nos. 14-1376 (3d Cir.); formerly Most Reverend Donald W. Trautman, Bishop of the Roman Catholic Diocese of Erie, et al. v. Sebelius, No. 1:12-cv-00123-SPB (W.D. Pa. May | Catholice Diocese of Erie | 1,500 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | St Martin Center | 61 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Prince of Peace Center | 20 employees | Form W-3 filing | No | Diocese self-insured plan | 0 | 0 | |
| | Erie Catholic Preparatory School | 80 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| Priests for Life, No. 1:13-cv-01261 (D.D.C.), No. 13 5368 (D.C. Cir.) | | 60 employees | Website | Yes | | 60 | 60 | |



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| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| Randy Reed Auto. Inc. v. Burwell, No. 5:13-cv-6117-SJ-ODS (W.D. Mo. Dec. 3, 2013); | | approximately 179 employees | Complaint | Yes | | 179 | 179 | |
| Reaching Souls Int'l, Inc. v. Burwell, No. 5:13-cv-01092 (W.D. Okla.), No. 14-6028 (10th Cir.) | | 78,000 participants (pastors, employees, and their families) | Complaint | No | Self insured church plan and permanent injunction 03/15/2018 | 0 | 0 | |
| Real Alternatives, Inc. v. Burwell, No. 1:15-cv-105 (M.D. Pa.), No. 16-1275 (3d Cir.) | | 3 employees | Complaint | No | All employees must/do oppose the coverage; therefore not counting as affected by rules | 0 | 0 | |
| Right to Life of Michigan v. Kathleen Sebelius, No. 1:13-CV-01202 (W.D. Mich. Nov. 22, 2013) | | 43 employees | Complaint | No | All employees must/do oppose the coverage; therefore not counting as affected by rules | 0 | 0 | |
| Roman Catholic Archbishop of Washington v. Burwell, No. 1:13-cv-01441 (D.D.C.), Nos. 13-5371, 14-5021 (D.C. Cir.) | Catholic University | 7,000 students, 1,766 employees | Complain | Yes | | 7,000 students, 1,766 employees | 1,766 | 7,000 |
| | Archdiocese of Washington | 2,100 eligible employees 1,200 teachers/employees at schools | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Thomas Aquinas College | 370 students, 78 eligible employees | Complaint | No | Church plan and complaint does not state that it offers student insurance | 0 | 0 | 0 |
| | Consortium of Catholic Academies | 119 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Archbishop Carroll | 70 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Don Bosco | 51 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Information Center | 9 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Mary of Nazareth | 44 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities | 890 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Victory Housing | 184 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| Roman Catholic Archdiocese of Atlanta v. Burwell, No. 1:12-cv-03489 (N.D. Ga.), Nos. 14-12890, 14-13239 (11th Cir.) | Roman Catholic Archdiocese of Atlanta | 9,800 students, 4,200 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities | 75 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | CENG | 200 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Diocese of Savannah | 5,000 students; hundreds of employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| Roman Catholic Diocese of Dallas v. Sebelius, No. 3:12-cv-01589-B (N.D. Tex.) | | 900 teachers/staff, 100+ employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| School of the Ozarks v. Rightchoice Managed Care, Inc., No. 6:13-cv-03157 (W.D. Mo.), No. 15-1330 (8th Cir.) | | 1,442 students, 601 employees | Students - online; employees Form w3 Filing | Employees only | Complaint does not say they offer a student plan | 601 | 601 | |
| Sharpe Holdings, Inc. v. Burwell, No. 2:12-cv-92 (E.D. Mo.) and CNS Int'l Ministries, No. 14-1507 (8th Cir.) | Sharpe | 50 employees | 2dam complaint and Linked in | Yes | | 50 | 50 | |
| | Ozark | 51 employees | 2dam complaint and Linked in | Yes | | 51 | 51 | |
| | CNS International Ministries | 204 employees | Form W-3 filing | Yes | | 204 | 204 | |
| | NIS Financial | 49 employees | 2dam Complaint | Yes | | 49 | 49 | |
| | CNS Corp | 49 employees | 2dam Complaint | Yes | | 49 | 49 | |
| | Heartland Christian College | 12 employees | Form W-3 filing | Employees only | Complaint does not say they offer a student plan | 12 | 12 | 0 |
| Sioux Chief Mfg. Co. v. Burwell, No. 13-0036-CV W-ODS (W.D. Mo. Feb. 28, 2013); | | 370 employees | Complaint | Yes | | 370 | 370 | |
| SMA, LLC v. Burwell, No. 0:13-cv-01375-ADM-LIB (D. Minn. July 8, 2013); | | 35 employees | Complaint | Yes | | 35 | 35 | |
| Southern Nazarene Univ. v. Burwell, No. 5:13-cv-1015 (W.D. Okla.), No. 14-6026 (10th Cir.) | Southern Nazarene University | 2,100 students, 505 employees | Complaint | Yes | Permanent injunction 05/15/2018 | 0 | 0 | 0 |
| | OK Wesleyan University | 1,220 students, 557 employees | Complaint | Employees only | Permanent injunction 05/15/2018 | 0 | 0 | 0 |
| | OK Baptist University | 1,900 students, 328 employees | Complaint | Yes | Permanent injunction 05/15/2018 | 0 | 0 | 0 |
| | Mid America Christian University | 1,447 students, 298 employees | Complaint | No | Permanent injunction 05/15/2018 | 0 | 0 | 0 |
| Stewart v. Burwell, No. 1:13-cv-01879 (D.D.C. Apr. 3, 2014); | Encompass Develop, Design & Construct, LLC | 43 employees | Complaint | Yes | | 43 | 43 | |
| Stinson Electric, Inc. v. Burwell, No. 14-00830-PJS-JJG (D. Minn. April 30, 2014); | | 19 employees | Business profile on manta.org | Yes | | 19 | 19 | |
| The C.W. Zumbiel Co. v. Burwell, No. 1:13-cv-01611 (D.D.C. Nov. 27, 2013); | | 350 employees | Complaint | Yes | | 350 | 350 | |
| The Criswell College v. Sebelius, No. 3:12-cv-04404-N (N.D. Tex.) | | 522 students, 50 employees | Complaint | Employees only | Complaint does not say they offer a student plan | 50 | 50 | |
| The QC Grp., Inc., v. Burwell, No. 0:13-cv-01726-JRT-SER (D. Minn. Sept. 11, 2013); | | 62 employees | Complaint | Yes | | 62 | 62 | |



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| Case | Plaintiffs | Number of Employees/Students | Document employee number located within | Are students/employees counted in final total? | If not counted, explanation why | Number counted towards final total | Total employees (minus HoW/IA and SICPs) | Total students at relevant universities |
|---|---|---|---|---|---|---|---|---|
| Thomas G. Wenski v. Kathleen Sebelius; No. 12-cv-23820-Graham/Goodman (S.D. Fla. Nov. 7, 2012) | Archdiocese of Miami | Unknown | | No | House of worship | 0 | 0 | |
| | Catholic Health Services | 2,000 employees | Complaint | Yes | | 2,000 | 2,000 | |
| | Catholic Hospice | 610 employees | Form W-3 filing | Yes | | 610 | 610 | |
| | St. Thomas University | Unknown | | No | Lawsuit mentions St. Thomas University but asserts no claims for its health plans | 0 | 0 | 0 |
| Tonn & Blank Constr. v. Burwell, No. 1:12-cv-00527-JD-RBC (N.D. Ind. Apr. 1, 2013); | | 60 employees | Complaint | Yes | | 60 | 60 | |
| Trijicon, Inc. v. Burwell, No. 1:13-cv-1207 (D.D.C.) | | 469 employees | Complaint | Yes | | 469 | 469 | |
| Tyndale House Publishers, Inc. v. Burwell, 904 F. Supp. 2d 106 (D.D.C. Nov. 16, 2012); | | 260 employees | Complaint | Yes | | 260 | 260 | |
| Union University v. Burwell, No. 1:14-cv-1079 (W.D. Tenn.) | | 2,829 students; 1,116 employees | Students - online; employees Form w3 Filing | Employees only | Complaint does not say they offer a student plan | 1,116 employees | 1,116 | 0 |
| Univ of Dallas v. Burwell, No. 4:12-cv-00314 (N.D. Tex.), No. 14-10241 (5th Cir.), Nos. 14-10661 (5th Cir.) | Roman Catholic Diocese of Fort Worth | 6,500 students, 2,000 employees | Complaint | No | Offers coverage through Christian Brothers Employee Benefit Trust- a self insured church plan | 0 | 0 | |
| | University of Dallas | 2,600 students, 725 employees | Complaint | Yes | | 2,600 students, 725 employees | 725 | 2,600 |
| | Catholic Charities | 332 employees | Complaint | Yes | | 332 | 332 | |
| | Our Lady Of Victory Catholic School | 23 employees | Complaint | No | Offers coverage through Christian Brothers Employee Benefit Trust- a self insured church plan | 0 | 0 | |
| Univ. of Notre Dame v. Burwell, No. 3:13-cv-1276 (N.D. Ind.), No. 13-3853 (7th Cir.) | | 11,500 students, 5,000 employees | Complaint | yes | | 11,500 students, 5,000 employees | 5,000 | 11,500 |
| Valley Forge Christian College of the Assemblies of God v. Burwell; No. 14-4622 (E.D. Pa. Aug. 14, 2014) | | Unknown | Complaint | No | Plaintiff voluntarily dismissed suit; our understanding is they were satisfied with previous | 0 | 0 | 0 |
| Weingartz Supply Co. v. Burwell, No. 2:12-cv-12061 (E.D. Mich.), No. 14-1183 (6th Cir.) | | 170 employees | DC Ruling | Yes | | 170 | 170 | |
| Wheaton College v. Burwell, No. 1:13-cv-08910 (N.D. Ill.), No. 14-2396 (7th Cir.) | | 870 Employees | Complaint | Yes | Permanent injunction 02/22/2018 | 0 | 0 | 0 |
| Williams v. Burwell, No. 1:13-cv-01699 (D.D.C. Nov. 19, 2013); | | 3 employees | Complaint | Yes | | 3 | 3 | |
| Willis Law v. Burwell, No. 1:13-cv-01124-CKK (D.D.C. Aug. 23, 2013); | | 15 employees | Complaint | Yes | | 15 | 15 | |
| Yep v. Sebilus, No. 1:12-cv-6756 (N.D. Ill.), Triune Health Group, Inc. v. Burwell, No. 1:12-cv-06756 (N.D. Ill.); No. 13-1478 (7th Cir.) | | 4 employees | Website | Yes | | 4 | 4 | |
| Zubik v. Burwell, No. 2:13-cv-1459 (W.D. Pa.), Nos. 14-1377 (3d Cir.) | Diocese | 140+ full-time employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Charities | 115 employees | Complaint | No | Diocese self-insured plan | 0 | 0 | |
| | Catholic Cemeteries | 207 employees | Complaint | No | Diocese self-insured plan. Cemeteries was covered by the diocese's previous self-insured plan the Catholic Employers Benefits Plan; the new complaint says that CEBS was converted to the Catholic Benefits Trust, and Cemeteries are omitted as co-plaintiffs | 0 | 0 | |
| | | | | | | Total | 48,654 | 25,265 10.4% of students covered in 2014 |
| | | | | | | Total | 48,654 employees in affected plans | 2,626 students in affected plans |

estimated 2,100,000 students were covered by plans of four-year granting institutions of higher education, and there were a total of 20,207,000 students in degree-granting postsecondary institutions other than 2-year degree programs, see at https://www.acha.org/documents/Networks/Coalitions/Why_SHIPs_Matter.pdf and https://nces.ed.gov/programs/digest/d16/tables/dt16_105.20.asp?current=yes.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF DEANNA CHAREST IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

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,

and,

THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,

Defendant-Intervenors.

I, Deanna Charest, declare:

1. I make this declaration from personal knowledge and based on records from the Michigan Department of Health and Human Services (MDHHS) and would testify to the following facts if called as a witness at hearing or trial.

2. I am the Reproductive Health Unit Manager within the Division of Maternal and Infant Health, Bureau of Family Health Services at the Michigan Department of Health and Human Services. I have a Master's in Public Health and more than fifteen years' experience in family planning and reproductive health, of which thirteen years has been with the Michigan Family Planning Program.

3. MDHHS is the Title X grantee in Michigan. I directly oversee the administration of MDHHS' Michigan Family Planning Program, the sole Title X funded program in the State of Michigan, which operates 92 clinic locations through a statewide network of 31 local sub-grantees. The Michigan Family Planning Program is a safety-net program and provides reproductive health services, including access to a broad range of FDA approved contraception to low-income, uninsured, or underinsured women and men in Michigan.

4. The Healthy Michigan Plan is Michigan's Medicaid Section 1115 Demonstration waiver program (established by Michigan Public Act 107 of 2013). The Healthy Michigan Plan provides health care coverage, including a full range of contraceptive methods and related preventive health services, to Michigan residents aged 19-64 years, with incomes at or below 133% of the federal poverty level (determined through the Modified Adjusted Gross Income methodology) and who meet the eligibility requirements. As of February 2019, over 686,000 beneficiaries are enrolled. Of those enrolled, 48% are women and 31% are women of reproductive age (i.e., 19-44 years).

5. The *Contraception Exemption Rules*, 83 Fed. Reg. 57,536 (Nov. 15, 2018) ("Religious Exemption Rule") and 83, Fed. Reg. 57,592 (Nov. 15, 2018) ("Moral Exemption Rule") implies that state-level contraceptive coverage requirements exist. Michigan does not currently have a contraceptive equity law that assures women access to contraceptive services without copay or other limiting restrictions. The protections covered under the Affordable Care Act are the only safeguards ensuring Michigan women access to contraceptive benefits and services approved by the FDA without cost-sharing.

6. According to the MDHHS Division for Vital Records, among women aged 15-44, it is estimated that 50 percent of pregnancies in Michigan are unintended (three-year average 2009-2011). Based on my experience and expertise, I believe that the *Contraception Exemption Rules* will raise that percentage even higher. The *Rules*, if implemented, will impose significant barriers to women who lose contraceptive coverage through their employer and are forced to identify other coverage if any, pay for contraception out of pocket, or find a publicly funded clinic to access contraception. Women will be at risk for an unintended pregnancy during this time. Unintended pregnancies can increase the risk of adverse health outcomes for women and infants and can contribute to infant and maternal morbidity and mortality.

7. The *Contraception Exemption Rules* will burden publicly funded clinics, such as those participating in Michigan's Family Planning Program, which are funded through a combination of federal and state funding sources. The increase in clients will tax an already underfunded public health system and may result in access issues for all women seeking services at the clinics. In Michigan, the capacity of the Family Planning Program is also threatened by the Final Title X Rule issued on February 22, 2019. The Final Title X Rule issued could prohibit the largest Title X service providers in Michigan from participating in the program. According to preliminary calendar year 2018 data, that provider served 42,330 of the total program's 62,707 clients; serving over 67% of the state's total Title X caseload. This will severely reduce access for reproductive health services for the women and men of Michigan.

8. Many working women, whose employers use the *Contraception Exemption Rules,* will not qualify for Michigan Medicaid's income eligibility, which in 2018 was just over $16,000 for a family of one and just over $34,000 for a family of four. For the limited number that do qualify and successfully enroll, Michigan's Medicaid program will incur increased contraceptive costs. The cost of providing contraception to a woman for a year varies.

9. According to the National Women's Health Network, one year of contraceptives can cost an average of $600 for oral contraceptives to $1,000 for the vaginal ring. In the Final Title X Rule, it is recommended to use $600 per year as an estimate, if the actual amount is not available. Given that the average woman, who wants two children, uses contraception to prevent pregnancy for up to three decades, the estimated contraceptive cost for one woman per lifetime on average is $18,000. A potential cost that could be incurred by Medicaid versus an employer sponsored plan.

10. If lack of contraceptive coverage results in a pregnancy, the average Michigan Medicaid-covered birth costs $16,608 inclusive of child birth, related prenatal and postpartum care, and costs for a Medicaid-covered child for the first year of life.

11. The above statements illustrate several ways in which the *Contraception Exemption Rules*, if implemented, will result in increased cost and burden for the State of Michigan and most importantly, unnecessary reproductive health access challenges for the women and men of the State of Michigan.

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

Executed on June 18, 2019, in Lansing, Michigan.

Deanna Charest
Reproductive Health Unit Manager
Division of Maternal and Infant Health,
Bureau of Family Health Services
Michigan Department of Health and Human Services

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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.

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF DR. JENNIFER CHILDS-ROSHAK**

I, Jennifer Childs-Roshak, M.D. M.B.A., declare:

1. I am the President and CEO of Planned Parenthood League of Massachusetts (PPLM). I have held these positions since November 23, 2015.

2. Before joining PPLM, I served as the Boston Regional Medical Director for Atrius Health while personally caring for 1,000 patients as a primary care physician. I earned my medical degree from Temple University School of Medicine in Philadelphia, and my Masters of Business Administration from the Boston University School of Management.

3. I practiced as a primary care physician for over twenty years, practicing in Massachusetts specifically from 2001 until 2015 when I joined PPLM. During my career I provided care to a diverse population of women and families, both insured and uninsured, in a variety of settings including community health centers, regional hospitals, and urban medical centers.

4. As both a physician and a health care executive, I have long been concerned about the cost of reproductive health care, including contraception, and the impact that cost has on patient access to appropriate care.

5. As President and CEO of PPLM, I lead the largest freestanding reproductive health care provider and advocate in Massachusetts. PPLM operates five medical facilities throughout Massachusetts.

6. The mission of PPLM is to protect and promote sexual and reproductive health and freedom of choice by providing clinical services, education, and advocacy. Our vision is that sexual health is essential to every person's well-being.

7. Every year, PPLM provides a wide range of sexual and reproductive health care services to more than 32,000 patients, at more than 50,000 patient visits, across Massachusetts

and educates thousands of young people, parents, and professionals through PPLM's nationally recognized sexual health education programs.

8. PPLM is committed to providing high-quality, affordable care to all of the patients we serve. We seek to offer medically appropriate care and counseling in a confidential and nonjudgmental manner.

9. Some of the most vulnerable patients, including those who are uninsured or underinsured, seek out care from PPLM because of our reputation as a supportive and culturally sensitive provider.

10. Founded in 1928, PPLM has a long history of providing care to the women of Massachusetts, including removing financial barriers to contraception and reproductive health services.

11. In FY 2016, PPLM provided nearly $15 million of medical services. PPLM received roughly $5 million from Medicaid, $776,000 from Title X funding, and $240,000 from the Massachusetts Department of Public Health's (DPH) Sexual and Reproductive Health Program (SRHP) grant.

12. Some of the patients to whom PPLM provides medical services do not have health insurance, do not have coverage for the care they are seeking, or need confidential care and cannot utilize their health insurance for their visit.

13. Because of the Affordable Care Act (ACA), the percentage of patients who did not have or could not use insurance has significantly decreased over the past five years at PPLM. Nevertheless, approximately 18% of all patients, about 7,000 individuals, did not or could not utilize insurance coverage during their visits in FY 2016.

14. In these situations, PPLM does one of the following things: if the patient qualifies, PPLM will assist the patient in enrolling in Medicaid, known as MassHealth in Massachusetts; if

the patient qualifies for funding under PPLM's SRHP grant, PPLM will bill the services to the grant; depending on the patient's income, PPLM will charge the patient directly on a sliding scale from 0 to 80% of the cost; or PPLM will charge the patient directly at the self-pay rate (cash), which is discounted. In nearly all cases, PPLM generally will take a loss on those services.

15. PPLM exhausts the public funding available to it each year, including funding it receives through its SRHP grant. If there is an increase in individuals seeking care from PPLM who are eligible for one of the payment methods listed above, PPLM's budget, including money it receives through the SRHP grant, will be further strained.

16. Some of PPLM's patients are students or dependents who are covered by someone else's employer-sponsored health plan. Some of these insured patients receive coverage from either employers or family members who reside in another state. In some instances, the family member resides in a second state and the employer is headquartered in a third state.

17. I am familiar with the Final Rules issued by the Defendants in this case regarding expansion of the exemptions to the contraceptive mandate under the Affordable Care Act.

18. It is my understanding that approximately 60% of Massachusetts' insured are covered through an employer-sponsored health plan, either directly or as a dependent.

19. I anticipate that additional women who lose coverage for contraceptive services because of the Final Rules, either as the primary insured or as a dependent, will seek care at our health centers.

20. In those instances, PPLM will utilize the processes outlined above to find funding to cover the increased number of patients.

21. The women and families impacted by the Final Rules will come from a wide range of social and economic backgrounds. I believe that a direct consequence of the Final Rules will be an increase in unintended pregnancy which will in turn work to undermine the economic security

of families in Massachusetts as well as exacerbate the disparities that women face with regard to access to education, career advancement, and economic stability.

22. The Final Rules will also impact health outcomes. For example, birth control pills are used for health conditions beyond pregnancy planning such as reducing the symptoms of severe menstrual pain; treating excessive menstrual bleeding, which can lead to anemia; treating the pelvic pain that accompanies endometriosis; and treating bleeding due to uterine fibroids. Blocking access for hormonal treatments limits women's ability to manage these, and other, important medical issues.

23. Regarding family planning specifically, unintended pregnancies lead to poor health outcomes for both mothers and children. In turn, along with poor health outcomes, the overall cost of women's health care will increase. Studies have shown that for every dollar spent on family planning, there is a seven-dollar savings to the Medicaid program downstream.

24. Based on our experience providing care at PPLM, I believe that another direct consequence of the Final Rules will be that women whose contraceptive care is excluded from employer-sponsored insurance will opt for less expensive and less effective contraceptive services.

25. For example, under the cost elimination regime of the ACA, PPLM has seen a dramatic change in the types of birth control utilized by women in Massachusetts. In FY 2011, nearly 91% of all PPLM patients receiving contraceptive care sought hormonal treatment (birth control pills, mostly). Five years later, in FY 2016, that figure was reduced to 55%, with Long-Acting Reversible Contraception services rising five-fold to 45%. Prior to the ACA, there was, generally speaking, a considerable difference in the out-of-pocket costs of these types of birth control.

26. Though not appropriate for all patients in all situations, Long-Acting Reversible Contraception is generally far more effective in preventing unintended pregnancies. Thus, for women who lose their coverage because of the Final Rules, at least some will choose less effective versions of birth control because of the costs associated.

27. Access to effective and appropriate contraception allows women and families to plan whether and when to grow their family. There are too many studies to count that show a direct link between access to affordable and effective contraception and a decrease in unintended pregnancies. Studies also show a direct link between a decrease in unintended pregnancies and an improvement in health outcomes, increased economic stability for women and families, and broader health care cost savings.

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

Executed on December 19, 2018, in Boston, Massachusetts.

Dr. Jennifer Childs-Roshak
President and CEO
Planned Parenthood League of Massachusetts

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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.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF DR. CARYN DUTTON**

I, Caryn Dutton, M.D. M.S., declare:

1. I am an obstetrician-gynecologist based at the Brigham & Women's Hospital in Boston, Massachusetts (the "Brigham"). I have been a practicing physician for more than 21 years.

2. I earned my medical degree from the University of Connecticut School of Medicine. I earned my Masters in Science in Applied Biostatistics and Epidemiology from the University of Southern California. My bachelor's degree in Chemistry is from Amherst College.

3. I currently serve as the Medical Director of the Gynecology Practice at the Brigham (the "Brigham GYN Clinic"). I have held that role for almost 8 years. In that capacity, my responsibilities include leadership for the physician preceptors, supervision of resident clinic sessions, and both development and training relevant to clinical guidelines for the practice of inpatient and ambulatory Gynecology.

4. I am also an Instructor at the Harvard Medical School, a role I have held for almost eight years. I serve as the Associate Fellowship Director for the Fellowship in Family Planning at the Brigham/Harvard Medical School.

5. Prior to this work, I was an Assistant Professor in Obstetrics and Gynecology at University of Wisconsin School of Medicine and Public Health in Madison, Wisconsin. I also served as Associate Medical Director at Planned Parenthood of Wisconsin. I completed a fellowship in Family Planning Clinical Care and Research at Los Angeles County/University of Southern California Medical Center, and was a Rabkin Fellow in Medical Education at Beth Israel Deaconess Medical Center.

6. I have been certified by the American Board of Obstetrics and Gynecology since 2003.

7. During my career, I have provided care to a diverse population of women and families, both insured and uninsured, in a variety of settings including Planned Parenthood Clinics, academic health centers, regional hospitals, and publicly-funded urban medical centers.

8. The Brigham GYN Clinic currently provides over 5,500 patient visits annually, and includes a staff of nine faculty physicians and 44 resident physicians. Approximately one-third of these visits involve contraceptive counseling or prescription.

9. Some of Brigham GYN Clinic's patients are students or dependents who are covered on someone else's employer-sponsored health plan. Some of these insured patients receive coverage either from employers located in other states or through insured family members who reside and/or work in other states.

10. Some of the patients to whom the Brigham GYN Clinic provides medical services do not have health insurance, do not have coverage for the care they are seeking, or need confidential care and cannot utilize their health insurance for their visit.

11. As part of our practice at the Brigham GYN Clinic, we refer patients who cannot utilize their insurance or do not have coverage for the care they are seeking to facilities that can cover patient visits through federal and state funding, including the Massachusetts Department of Public Health's ("DPH") Sexual and Reproductive Health Program ("SRHP").

12. As part of our practice at the Brigham GYN Clinic, we assist patients who cannot utilize their insurance or do not have coverage for the care they are seeking in determining whether they are eligible for coverage under the state Medicaid program, MassHealth. If these patients are eligible for MassHealth, as either a primary or secondary insurer, we assist the patients in enrolling in MassHealth.

13. Our practice at the Brigham GYN Clinic includes caring for patients who have medical conditions that require them to take medications that could place a fetus at risk. For these patients, in particular, access to contraception and continuity of care are critical.

14. Our practice at the Brigham GYN Clinic includes caring for patients who have medical conditions that put the mother at risk if she were to have an unplanned or unintended pregnancy. For these patients, in particular, access to contraception and continuity of care are critical.

15. As a physician and clinical educator, I have long been concerned about the cost of reproductive health care, including contraception, and the impact that cost has on patient access to appropriate care as well as economic and professional opportunity for women.

16. Access to contraception is critical for women's health. Planning pregnancies can help women optimize their health prior to pregnancy and minimize pregnancy complications.

17. Pregnancy planning is particularly important for the growing population of young women with chronic conditions such as diabetes, hypertension and obesity. Data demonstrate that as the population of pregnant and reproductive-age women with chronic conditions grows, severe pregnancy-related morbidity is rising, and U.S. rates of maternal deaths remain among the highest in the industrialized world. Contraception is one critical tool in addressing this trend.

18. Unintended pregnancies also put babies at risk. Effective contraception is essential for the 11.7 million American women annually who need to take medications that would be harmful for a fetus.

19. In an unintended pregnancy, a mother is more likely to experience symptoms of postpartum depression. Unplanned pregnancies also create a higher risk of preterm birth and delivery of a low-birth weight infant.

20. Contraception is also crucial for women's well-being and contributions to society and the economy. Unintended pregnancy is a serious economic burden, while broad access to contraception has a profound impact on women's attainment of higher education, greater employment and earning power, a narrowing of the gender pay gap.

21. Historically, cost has been a significant barrier to access to effective contraceptive use in the United States. Some commonly used contraceptives, such as the oral contraceptive pill, are relatively inexpensive but must be purchased on a regular basis, and have a higher failure rate.

22. The most effective reversible contraceptive methods are long-acting reversible contraceptive (LARC) methods, such as intrauterine devices (IUDs) and the contraceptive implant. These methods require a one-time purchase and offer months or years of contraceptive coverage. A high upfront cost has been shown to prevent patients from choosing LARC methods.

23. Studies have shown that when contraceptive costs are covered, patients are better able to choose the best form of contraception for them, and that they often prefer LARCs over other contraceptive methods. As a result, rates of LARC utilization have increased and unintended pregnancies have declined.

24. The Patient Protection and Affordable Care Act (ACA) had had some promising effects on increasing contraceptive access by requiring insurance coverage without copays or deductibles.

25. I am familiar with the Final Rules issued by the Defendants in this case, regarding expansion of the exemptions to the contraceptive mandate under the ACA.

26. It is my understanding that approximately 60% of Massachusetts' insured are covered through an employer-sponsored health plan, either directly or as a dependent. Many of these individuals have their coverage through self-funded plans, and therefore are not protected by Massachusetts state laws mandating contraceptive coverage.

27. If the Final Rules are permitted to go into effect, I anticipate that some women in Massachusetts will lose coverage for contraceptive services as a result of their employer's exercise of one of the exemptions.

28. When any of those women visit the Brigham GYN Clinic for contraceptive services, we will help them find alternative means to cover the cost of their care, including by: (i) determining if they are eligible for MassHealth coverage (as a secondary payer) so they can continue their care with us; or (ii) determining if they may qualify for coverage through DPH's SRHP funding and can see a provider at a facility that receives such funding.

29. The women and families impacted by the Final Rules will come from a wide range of social and economic backgrounds.

30. The Final Rules will also impact health outcomes for women, including for those women who are eligible for alternative forms of coverage, such as MassHealth and DPH's SRHP. Even minor obstacles to contraceptive care, including additional doctor's visits, finding a new provider, and cost can deter utilization of contraception, which can in turn increase the risk of unintended pregnancies.

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

EXECUTED ON December 17, 2018 in Boston, Massachusetts.



Dr. Caryn Dutton

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, in his Official Capacity as Secretary of the U.S. Department of Health & Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER**

4:17-cv-05783-HSG

**DECLARATION OF MEAGAN GALLAGHER IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Meagan Gallagher, declare and state as follows:

1. I am the President & CEO for Planned Parenthood Northern New England (PPNNE). Before starting my current position, I was the Senior Vice President of Business Operations at PPNNE, and prior to that I served at the Planned Parenthood League of Massachusetts as Chief Financial Officer, Chief Operating Officer, and Senior Vice President of Strategic Initiatives and Growth. I began my career at PricewaterhouseCoopers in Boston, Massachusetts. I received my B.S. in mathematics at Tufts University in 1997.

2. This declaration is based on my personal knowledge, my review of PPNNE's business records, information in the public domain, and the knowledge I have acquired in the course of my eighteen 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. PPNNE is a tax exempt 501(c)(3) organization and the largest reproductive health care and sexuality education provider and advocate in northern New England and specifically in Vermont. The mission of PPNNE is to provide, promote, and protect access to reproductive health care and sexuality education so that all people can make voluntary choices about their reproductive and sexual health. PPNNE operates 21 health centers across Vermont, New Hampshire, and Maine and served more than 45,000 patients in 2018.

4. As discussed more fully below, the two 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 November 15, 2018 (Final Rules) would have devastating consequences for the women in Vermont who rely on Planned Parenthood for a variety of reproductive health and family planning care. The Final Rules would also have a devastating impact on the State of Vermont, which reimburses PPNNE for those patients' care through a combination of state and federal funding.

5. PPNNE operates 12 health centers throughout Vermont, and provides services to approximately 19,000 patients annually at those health centers. The care for 46% of patients at those health centers is reimbursed through a combination of Vermont's Medicaid program and the Vermont Access Plan. Ten of the 12 Vermont health centers are Title X funded, and 60% of patients at those health centers receive Title X services. In the last fiscal year, 62% of PPNNE's Vermont patients were at or below 200% of the federal poverty line.

6. PPNNE's 12 health centers in Vermont are geographically disbursed throughout the State. 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.

7. PPNNE offers 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, all PPNNE health centers in Vermont offer PEP and PReP for HIV prevention; trans-health services for transgender patients; primary care; prenatal screenings and referrals; and referrals for female and male sterilizations (Essure and vasectomies).

8. In 2017, PPNNE served Vermont with:

a. Contraception to 9,600 patients

b. Nearly 4,800 pregnancy tests

c. Nearly 2,500 cervical cancer screenings

d. Over 3,500 breast exams

e. Over 37,000 tests for sexually transmitted infections

f. Sexual health education programs reaching more than 2,100 youth.

9. Planned Parenthood primarily serves low income patients in Vermont who have limited access to health care services.

a. Approximately eighty-seven percent (87%) of our patients are women, almost all of those are in the prime reproductive age range of 18 to 39;

b. Sixty-two percent (62%) are below 200% of the federal poverty level (FPL). Of those, 49% are below 150% of the federal poverty level;

c. The demographics of our patients roughly mirror the demographics of Vermont: 90% are white, 2% Black; 3% Hispanic, 2% Asian/Pacific Islander, and 3% other or unknown:

d. We also serve a number of special-needs populations, including people with physical, mental or other social challenges; migrant workers; refugees and other immigrants; 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.

10. PPNNE operates its health centers in many rural, medically underserved areas. For example, ten out of twelve PPNNE health centers in Vermont receive funding through the federal Title X program, which aims to provide high quality family planning and related services, education, and counseling to Vermonters who would not otherwise have access, with a special focus on low-income and rural populations. Our ten Title X health centers are located in medically underserved areas, or serve patients who live in medically underserved areas. PPNNE operates a statewide network of health centers, which are the only Title X-funded health centers in Vermont, and have been for decades. To my knowledge, there are no organizations other than

PPNNE that are able to provide Title X services statewide.

11. Planned Parenthood health centers 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.

12. 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.

13. PPNNE receives funding for family planning services through the federal Title X program, Medicaid, and the Vermont Access Plan.

14. The Vermont Access Plan is funded through a state contract supported by a Section 1114 Medicaid waiver. It supports the cost of a wide range of reproductive health services for patients who are Vermont residents, not currently pregnant, and with incomes less than 200% of the Federal Poverty Level. Last year, the Vermont Access Plan served 3,200 patients, or 17% of the patients at PPNNE health centers in Vermont.

15. The State of Vermont also funds PPNNE's services focused on STDs through separate grants. Vermont also funds PPNNE's programs focused on outreach, education and infrastructure through a different contract supported by a Section 1114 Medicaid waiver.

16. I have reviewed and am familiar with the new contraceptive coverage Final Rules, 2018-24512 and 2018-24514. Under them, any employer that claims a religious or moral objection to providing contraceptive coverage would be exempt. In addition, the Final Rules 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.

17. Although Vermont's Reproductive Health Equity in Health Insurance Coverage Act, 8 V.S.A. § 4099c, requires private health insurers and Vermont Medicaid to provide "no

cost" contraceptive coverage, self-insured plans are governed by the Employee Retirement Income Security Act (ERISA), not state law.

18. After considering this change in the law and based on my experience at Planned Parenthood, I believe that of the Vermont women who lose coverage under the Final Rules, many who are income-eligible—those whose incomes are at or under 200% and are not covered under Medicaid—will enroll in the Vermont Access Plan and seek services from Planned Parenthood. This may be particularly true of younger patients who currently receive insurance through their parents. Forty percent of our patients in Vermont 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 the Vermont Access Plan.

19. The State will have added costs to reimburse Planned Parenthood for every new Vermont Access Plan patient who previously received contraceptive coverage through her, or her family member's, employer.

20. I also believe that Vermont will see an increase in unintended pregnancies as a result of the Final Rules. Those women who do not qualify for the Vermont Access Plan may not get contraception at all, or 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.

21. I anticipate that PPNNE will have to increase charitable contributions to our assistance funds to help insured patients with high co-pays or deductibles, and those who have lost coverage for contraception, afford birth control.

22. I am also familiar with the final Title X regulations published at 84 Fed. Reg. 7714-7791 ("Title X Final Rule"). If the Title X Final Rule goes into effect, Vermont will likely become ineligible for Title X funds. Vermont has no known, sustainable source of funds available to replace the Title X funding. The loss of Title X funds to Vermont means the State will have added costs to maintain the quality and quantity of family planning services needed to continue serving low-income Vermont patients on an income-based sliding fee scale. I believe that Vermont will also see an increase in unintended pregnancies as a result of the Title X Final Rule. Some patients who formerly benefitted from Title X funding may not get family planning

services at all, or may opt against the most effective forms of birth control. As a result, they will be at a higher risk of unintended pregnancy.

23. If both the Final Rule and the Title X Final Rule go into effect, I believe that the resulting increase in unintended pregnancies in Vermont, and the financial impact to the State of Vermont and PPNNE, will be compounded.

I declare under penalty of perjury that the foregoing is correct and that this declaration is executed June 18, 2019 in Colchester, Vermont.



Meagan Gallagher
President & CEO
Planned Parenthood of Northern New England

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MARIE L. GANIM, PhD, IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Marie L. Ganim, PhD, declare:

1. I have served as the Health Insurance Commissioner for the State of Rhode Island since 2017. As Commissioner, my role is to ensure the solvency of health insurers, protect consumers, encourage the fair treatment of providers, and work to improve healthcare quality, accessibility and affordability.

2. The State of Rhode Island has state insurance laws that require some, but not all, of the contraceptive coverage mandated by the Affordable Care Act (Public Health Service Act § 2713). Rhode Island law provides that every individual or group health insurance contract, plan, or policy that provides prescription coverage and is delivered, issued for delivery, or renewed in Rhode Island must provide coverage for FDA-approved prescription contraceptive drugs and devices, except for prescription drug RU 486. R.I. Gen. Laws §§ 27-18-57(a), 27-19-48(a), 27-20-43(a), and 27-41-59(a). Also, every health insurance issuer offering group or individual health insurance coverage in Rhode Island that covers prescription contraception may not restrict reimbursement for dispensing a covered prescription contraceptive up to 365 days at a time. R.I. Gen. Laws §§ 27-18-57(f), 27-18-84, 27-19-48(e), 27-19-76, 27-20-43(e), 27-20-72, 27-41-59(e), and 27-41-89.

3. Rhode Island law does not eliminate cost-sharing for contraceptive drugs and devices and related services.

4. Rhode Island law does not require insurance coverage for family planning and counseling, except for women determined eligible for Medicaid or CHIP under federal guidelines. R.I. Gen. Laws § 42-12.3-3(f). Those deemed eligible only receive extended family planning services up to twenty-four months post-partum. Id.

5. Rhode Island insurance law does not apply to women and covered dependents who have coverage through an employer that uses a self-insured plan. As of April 2018, there were at least 192,368 Rhode Islanders covered through self-insured employer groups.

6. As a result of the Rules, Rhode Island women will either increasingly (a) utilize and seek coverage through the Title X Family Planning Program (continued funding of which is in jeopardy at the federal level) or (b) they will forgo coverage and experience an unintended pregnancy. In both scenarios, the State will suffer increased costs and its residents will be harmed.

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

Executed on June 25, 2019, in CRANSTON, RHODE ISLAND.

Marie Ganim, PhD
Health Insurance Commissioner
State of Rhode Island Office of the Health Insurance Commissioner

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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.

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF ALFRED J. GOBEILLE, SECRETARY, VERMONT AGENCY OF HUMAN SERVICES**

I, ALFRED J. GOBEILLE, declare:

1. I am the Secretary of the Vermont Agency of Human Services (AHS). I have served in this position since January 2017. I declare under penalty of perjury that the foregoing is true and correct, and of either my own personal knowledge or, with respect to those matters for which I do not have personal knowledge, I have reviewed information gathered from AHS records and other publicly available information.

2. AHS was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human services activities within state government. AHS is led by the Secretary, who is appointed by the Governor. The Secretary's Office is responsible for leading the agency and its departments: the Department for Children and Families; the Department of Corrections, the Department of Disabilities, Aging and Independent Living; the Department of Health (VDH); the Department of Mental Health; and the Department of Vermont Health Access (DVHA). Within the Agency, one of the Divisions operated under VDH is the Division of Maternal and Child Health, which encompasses Preventive Reproductive Health, Children with Special Health Needs, Maternal Infant and Child Nutrition (including WIC), the Child Development clinic, the Early Childhood system (including nurse home visiting), and the Help Me Grow system for optimal child development. Separate from public health programs, DVHA is the state department responsible for the management of Medicaid, the State Children's Health Insurance Program, and other publicly funded health insurance programs in Vermont. Most of Vermont's Medicaid program is funded by approximately 54% federal funding and 46% state funding. However, the "enhanced match" programs, like the Children's Health Insurance Program, are 90% federal funds and 10% state funds. Because DVHA manages Vermont's Medicaid programs, it is the largest insurer in Vermont in terms of dollars spent and the second largest insurer in terms of covered lives. DVHA is also responsible for administering Vermont Health Connect, which is the State's health insurance marketplace.

3. Vermont has a law that provides contraceptive coverage which matches the federal guarantee provided by the Affordable Care Act (Public Health Service Act 2713(c)), specifically requiring coverage for the full range of contraceptive methods, counseling and services used by

women; eliminating out-of-pocket costs for at least some methods of contraception; and limiting other health plan restrictions. 8 V.S.A. § 4099c. Some of Vermont's provisions go beyond the federal guarantee by ensuring that women may receive an extended supply of a method at one time (usually a one-year supply, rather than a typical one- or three-month supply), and by requiring coverage of male sterilization without out-of-pocket costs. The Vermont law does not affect women and covered dependents who have coverage through an employer that uses a self-insured plan, because these plans are exempt from State insurance laws by the federal Employee Retirement Security Act (ERISA). And, the Vermont law does not cover the uninsured.

4. The Agency of Human Services has a long-standing commitment to providing access to affordable reproductive health services and reducing the number of unintended pregnancies. Nationwide, nearly half (45%)[1] of all pregnancies are reported as being unintended with the estimated public cost of these births in 2010 reaching $21 billion.[2] Nationally, for every public dollar spent on contraceptive care and family planning an estimated $7.09 in public dollars was saved.[3] There is no reason to think the savings are not comparable in Vermont. The U.S. Department of Health and Human Services identified family planning and the prevention of unintended pregnancies as one of its primary initiatives in Healthy People 2020.[4] Similarly, the Centers for Disease Control and Prevention (CDC) also included the prevention of unintended pregnancies in its 6|18 Initiative, a program developed to improve health and control health care costs.[5] Vermont has taken steps to work in conjunction with both federal partners to implement the objectives of these programs.

5. In addition to contraception coverage available to Vermont Medicaid recipients and coverage provided through Title X funding, the State of Vermont provides coverage for

[1] Lawrence B. Finer, Ph.D., and Mia R. Zolna, M.P.H. Declines in Unintended Pregnancy in the United States, 2008–2011, N Engl J Med 2016; 374:843-852 March 3, 2016 DOI: 10.1056/NEJMsa1506575. Available at http://www.nejm.org/doi/full/10.1056/NEJMsa1506575

[2] Sonfield A and Kost K (2015). Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2010, the Guttmacher Institute. Available at https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy

[3] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014.

[4] *See* https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

[5] *See* https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-pregnancy.pdf

contraceptive services through several different state and federally funded programs. Some of the VDH's programs with state funding sources include, but are not limited to:

- The Medicaid Family Planning Initiative, also known as the Vermont Access Plan, which provides contraceptive and family planning services to individuals at or below 200% of the Federal Poverty Level (FPL). Up to $2,000,000 is allocated annually, with 46.21% coming from state funds.
- The Global Commitment Grant which provides outreach to individuals seeking reproductive health services.
    - Approximately $300,000 annually is allocated for this program, 46.21% of which come from state funds.

6. Vermont estimates that a total of 116,123 Vermonters are self-insured through plans that are exempt from Vermont's contraceptive coverage requirements. Of that population, the number of women within reproductive age (between 15 and 45 years old) is estimated at 25,973. However, these are likely to be under-estimates, as self-insured plan reporting to the All Payer Claims Database is voluntary and therefore incomplete. According to the 2014 Vermont Household Insurance Survey, approximately 17% of Vermonters who hold private insurance plans (through an employer group plan, a direct purchase plan, or another type of private employer plan) were below the 200% FPL. If the population of individuals insured through plans exempt under ERISA were to mirror the same demographics as the populations of total private insurance holders, it would be expected that approximately 4,400 women could be both at risk of losing their contraceptive care coverage and immediately eligible for one of the publicly-funded programs listed above. As a result of these rules, women will either (a) utilize and seek coverage through State programs, resulting in increased enrollment, or (b) they will forgo coverage and experience an unintended pregnancy, which substantially increases the cost of care. In both scenarios, the State will suffer increased costs. Some women and their dependents may become eligible for Medicaid as a result of an unintended pregnancy, which further adds to the State's costs. Women with incomes that disqualify them from publicly-funded programs will bear the full cost of contraceptive services and products. Unintended pregnancies also create well-

documented, long-term social and economic impacts for women and children, and therefore for the State of Vermont, beyond the costs associated with birth.

7. Forgoing contraceptive services results in a higher unintended pregnancy rate. In 2010, the most recent year for which data is immediately available, 50.2% of all births were publicly funded in Vermont.[6] For all *unplanned* births in Vermont, 73.5% were publicly funded, resulting in total public costs of $31.4 million.[7] Of that figure, $21.8 million came from federal sources and $9.6 million came from state sources.[8] And those are only the public costs for unplanned pregnancies resulting in births. In 2014, 44% of unwanted pregnancies ended in abortions in Vermont.[9] The cost to the State of Vermont for publicly-funded abortions in 2010 was $402 per abortion.[10] No federal funding is available to offset the cost of abortions.

8. Based on my knowledge and experience as the Secretary of the Vermont Agency of Human Services, I believe that the final rules on religious and moral exemptions to the coverage of contraceptives ("Final Rules") will result in women losing access to contraceptives and an increase in unintended pregnancies, abortions, and increased social and economic costs. Through the programs outlined above, the Final Rules will result in increased costs to the State of Vermont.

Executed on December 19, 2018, in Waterbury, Vermont.

Alfred J. Gobeille
Secretary
Vermont Agency of Human Services

[6] 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: Gutmacher Institute, 2015. Available at https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf

[7] *Id.*

[8] *Id.*

[9] Kost K, Maddow-Zimet I and Kochhar S, Pregnancy Desires and Pregnancies at the State Level: Estimates for 2014, New York: Guttmacher Institute, 2018. Available at https://www.guttmacher.org/reports/ pregnancy-desires-and-pregnancies-state-level-estimates-2014

[10] Sonfield A and Gold RB, Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980-2010, New York: Guttmacher Institute, 2012. Available at https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-fp-2010.pdf

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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.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF DANIEL GROSSMAN**

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) at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. 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

[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.

rates. A survey I was involved with sought to determine how women's contraceptive choices 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

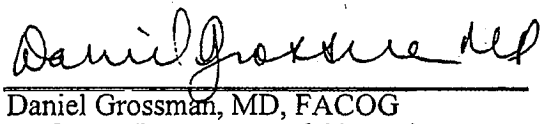
[2] J.E. Potter *et al.* 2017. "Contraception After Delivery Among Publicly Insured Women in Texas: Use Compared with Preference," *Obstetrics & Gynecology* 130: 393-402. Available at https://www.ncbi.nlm.nih.gov/pubmed/28697112.

[3] N.V. Becker, *et al.* 2015. "Women Saw Large Decrease In Out-Of-Pocket Spending For

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 December 6, 2018, in San Francisco, California.



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

Contraceptives After ACA Mandate Removed Cost Sharing," *Health Affairs* 34. Available at http://content.healthaffairs.org/content/34/7/1204.abstract#aff-2.

[4] C.S. Carlin, *et al.* 2016. "Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices Of Women With Employer Coverage," *Health Affairs* 35. Available at http://content.healthaffairs.org/content/35/9/1608.abstract. A. Sonfield, *et al.* 2015. "Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update," *Contraception* 91: 44-48. Available at http://www.contraceptionjournal.org/article/S0010-7824(14)00687-8/abstract.

[5] J.M. Bearak, *et al.* 2016. "Changes in out-of-pocket costs for hormonal IUDs after implementation of the Affordable Care Act: an analysis of insurance benefit inquiries," Contraception: 93:139-44. Available at https://www.ncbi.nlm.nih.gov/pubmed/26386444.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF CYNTHIA HARRIS IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Cynthia Harris, declare:

1. I am over the age of 18 and have personal knowledge of all the facts stated herein.

2. I am the program manager for the Family Planning Program at the Washington State Department of Health. My primary duties include overseeing the Family Planning Program's grant-making process and monitoring our grant recipients. I have held this position since 2013. From 2000 to 2013, I was a health services consultant at the Family Planning Program. I have personal knowledge of the Family Planning Program's funding structure, grant making process, its grant recipients, and the eligibility criteria to receive its services.

3. The Family Planning Program provides grants to 16 agencies with 85 clinic sites throughout Washington that offer affordable contraceptive services, including birth control and long-acting reversible contraception, to individuals whose income is equal to or less than 250% of the Federal Poverty Level and who are uninsured or whose insurance does not cover contraception.

4. In 2018, providers funded through the Family Planning Program served 93,120 clients over 130,459 clinic visits in Washington. Approximately 96% or 89,395 of these clients were women of reproductive age (15-44).

5. The clinics funded through the Family Planning Program include federally qualified health centers, community health centers, local health jurisdictions, and Planned Parenthood clinics.

6. The Family Planning Program receives 8.9 million dollars in funding from the State of Washington and 3.9 million dollars in federal Title X funding annually.

7. The services provided by the agencies we fund prevented an estimated 18,390 unintended pregnancies and 6,210 abortions, and saved over 143 million dollars in health care costs in 2018.

8. In Calendar Year 2018, the number and percent of clients' source of payment at the time of visit (meaning what they were intending would pay for the visit) was as follows:

| Source of Payment | Number | Percent of Total |
|---|---|---|
| Medicaid & Medicaid Family Planning Waiver | 41,105 | 44% |
| Private Insurance | 34,038 | 37% |
| Sliding Fee and Full Fee (Title X funding) | 13,180 | 14% |
| Other Source of Payment | 4,797 | 5% |

9. I am familiar with the Interim Final Rules issued on October 6, 2017, regarding expansion of the exemptions to the contraceptive mandate under the Affordable Care Act.

10. I understand that employers in Washington took advantage of the religious accommodation under the predecessor rules adopted during President Obama's administration. I expect that at least some of these employers will utilize the new, broader religious exemption created by the new rules.

11. An increase in the number of women who do not receive coverage for contraception through their employer-sponsored health insurance will likely result in an increase in the number of Washington residents eligible for and seeking services funded by the Family Planning Program. This increased need will place greater demand on the finite resources of the providers the Department of Health funds.

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

Executed on June 17, 2019, in Mabton, Washington.

Cynthia N. Harris

CYNTHIA HARRIS
Program Manager

XAVIER BECERRA, State Bar No. 118517
Attorney General of California
KATHLEEN BOERGERS, State Bar No. 213530
Supervising Deputy Attorney General
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IN THE UNITED STATES DISTRICT COURT

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**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF LISA M. HOLLIER, MD, MPH IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Lisa M. Hollier, MD, MPH, FACOG, declare:

1. I am the Interim Chief Executive Officer of the American College of Obstetricians and Gynecologists (ACOG). I have served in my current position since November 1, 2018. As Interim Chief Executive Officer, I oversee the day-to-day operations of ACOG, including the development and publication of ACOG Committee Opinions.

2. 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)(6) 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 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 … 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 710, "Counseling Adolescents About Contraception," released August 2017, a true and correct copy of which is attached as Exhibit B, ACOG states that "[a]t no time should an adolescent patient be forced to use a method chosen by someone other than herself, including a parent, guardian, partner, or health care provider."

9. Per ACOG Committee Opinion 710, "Counseling Adolescents About Contraception," released August 2017, a true and correct copy of which is attached as Exhibit B, ACOG states that "[l]ong-acting reversible contraceptive (LARC) methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives. Because LARC methods are safe, they are excellent contraceptive choices for adolescents" and recommends that "discussions about contraception should begin with information on the most effective methods first."

10. Per ACOG Committee Opinion 710, "Counseling Adolescents About Contraception," released August 2017, a true and correct copy of which is attached as Exhibit B, ACOG asserts that "[d]ual-method use—the use of condoms for STI prevention in combination with more effective contraceptive methods to protect against unintended pregnancy—often is the ideal contraceptive practice for adolescents," and further recommends that "obstetrician-gynecologists write advance prescriptions for oral emergency contraception for their patients to increase awareness and remove barriers, especially for adolescents."

11. Per ACOG Committee Opinion 735, "Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices," released May 2018, a true and correct copy of which is attached as Exhibit C, ACOG finds that "[b]arriers to use of LARC by adolescents include patients' lack of familiarity with or understanding about the methods, potentially high cost of initiation, lack of access, low parental acceptance, and obstetrician-gynecologists' and other health care providers' misconceptions about the safety of LARC use in adolescents," and concludes that "[o]bstetrician-gynecologists should counsel all sexually active adolescents who

do not seek pregnancy on the range of reversible contraceptive methods, including LARC, and should help make these contraceptives readily accessible to them."

12. Per ACOG Committee Opinion 755, "Well-Woman Visit," released October 2018, a true and correct copy of which is attached as Exhibit D, ACOG states that a "key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to ensure that medical testing and treatments provided are aligned with her current and future plans. A discussion of a reproductive life plan may include prepregnancy counseling, infertility assessment, or the full range of contraceptive options."

13. Per ACOG Committee Opinion 762, "Prepregnancy Counseling," which was developed jointly with the American Society for Reproductive Medicine and was released January 2019, a true and correct copy of which is attached as Exhibit E, ACOG states that "[c]ounseling patients about optimal intervals between pregnancies may be helpful to reduce future complications. Woman should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months. Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing labor after cesarean" (citations omitted).

14. Per ACOG Committee Opinion 777, "Sexual Assault," released April 2019, a true and correct copy of which is attached as Exhibit F, ACOG states that "[w]hen the survivor's physical, medical, and legal needs have been addressed, the clinician should discuss with her the degree of injury and the probability of infection or pregnancy. Emergency contraception should be provided, requiring its immediate availability in hospitals and facilities where sexual assault survivors are treated."

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

Executed on 26 of June, 2019, in Washington, D.C.

Lisa M. Hollier, MD, MPH, FACOG
Interim
Chief Executive Officer
American College of Obstetricians
and Gynecologists

# EXHIBIT A

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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# EXHIBIT B

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

# ACOG COMMITTEE OPINION

Number 710 • August 2017

**Committee on Adolescent Health Care**

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Adolescent Health Care in collaboration with committee member Karen R. Gerancher, MD.*

# Counseling Adolescents About Contraception

**ABSTRACT:** Modern contraceptives are very effective when used correctly and, thus, effective counseling regarding contraceptive options and provision of resources to increase access are key components of adolescent health care. Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist routinely should address her contraceptive needs, expectations, and concerns. Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age appropriate and compatible with the patient's health literacy. The American College of Obstetricians and Gynecologists recommends that discussions about contraception begin with information on the most effective methods first. Emergency contraception routinely should be included in discussions about contraception, including access issues. Moreover, the American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists work with their office staff to establish office procedures and routines that safeguard the privacy of adolescent patients whenever possible. Adolescents' right of refusal for initiating or discontinuing a method should be addressed by obstetrician–gynecologists. At no time should an adolescent patient be forced to use a method chosen by someone other than herself, including a parent, guardian, partner, or health care provider. The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for sexually transmitted infections per the Centers for Disease Control and Prevention's guidelines.

## Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist routinely should address her contraceptive needs, expectations, and concerns.
- Statutes on the rights of minors to consent to health care services vary by state, and obstetrician–gynecologists should be familiar with the regulations that apply to their practice.
- Emergency contraception routinely should be included in discussions about contraception, including access issues. The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists write advance prescriptions for oral emergency contraception for their patients.
- Long-acting reversible contraceptive (LARC) methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives. Because LARC methods are safe, they are excellent contraceptive choices for adolescents.
- Discussions about contraception should begin with information on the most effective methods first.
- Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age appropriate and compatible with the patient's health literacy.
- The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for sexually transmitted infections (STIs) per the Centers for Disease Control and Prevention's (CDC) guidelines.

## Background

With a peak incidence of 117 per 1,000 women in 1990 (1), and despite significant decreases in recent years (2), the adolescent pregnancy rate in the United States is the highest among developed countries, according to available data, with a rate in 2010 of 57 per 1,000 girls aged 15–19 years (3). Three-quarters of adolescent pregnancies are unintended (2). Reproductive life planning, including delay of onset of sexual activity and childbirth, is an important element of counseling (4). When comparing the United States with Europe, adolescents have similar rates of sexual activity, but European adolescents are more likely to have access to sexuality education and contraception and are more likely to use the most effective methods, resulting in lower pregnancy rates (5). In the United States, approximately 4.3% of women aged 15–19 years who are currently using a method of contraception use a highly-effective LARC method (eg, intrauterine devices and the implant) (6). Long-acting reversible contraceptive methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives. Because LARC methods are safe, they are excellent contraceptive choices for adolescents. Modern contraceptives are very effective when used correctly and, thus, effective counseling regarding contraceptive options and provision of resources to increase access are key components of adolescent health care.

## The Contraceptive Health Visit

Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist should routinely address her contraceptive needs, expectations, and concerns. Virginal patients may not need contraception immediately, but contraceptive counseling conversations should take place before they are sexually active, and contraception should be made accessible. Ideally, the initial reproductive health visit should take place between ages 13 years and 15 years and should encompass a discussion about contraception and STIs in addition to preventive medicine services such as human papillomavirus vaccination (7). The CDC suggests taking a sexual history that encompasses the 5 Ps: Partners, Practices, Protection from STDs, Past history of STIs, and Prevention of pregnancy (8) (see Box 1). Such a history may elicit whether adolescents are engaged in noncoital activity (eg, oral or anal sex) (9). Guidance from the U.S. Office of Population Affairs and the CDC, Providing Quality Family Planning Services, and the CDC's U.S. Selected Practice Recommendations for Contraceptive Use also offer important information on how best to provide reproductive health services (10, 11). By grade 12, more than one half of females report having had sexual intercourse (12), so speaking to young patients is an opportunity for obstetrician–gynecologists to provide anticipatory guidance. Sexual activity is not required before the discussion or offering of contraceptives. An adolescent-friendly environment is important, as is adequate time for the adolescent patient who may need additional explanation and details compared with an adult patient.

### Confidentiality

Confidentiality is an essential component of health care for all patients. It is even more crucial for adolescents because the lack of confidentiality can be a barrier to the delivery of reproductive health care services (13). The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists work with their office staff to establish procedures and routines that safeguard the privacy of adolescent patients whenever possible. Obstetrician–gynecologists should discuss confidentiality with each adolescent and, as appropriate, with her parent(s) or guardians(s) during the initial visit, to help establish rapport and outline expectations (14). Other organizations, including the Society for Adolescent Health and Medicine and the American Academy of Pediatrics, provide useful guidance on confidentiality in the setting of adolescent health care, including the need to discuss the scope of and limits to confidentiality, while emphasizing its importance (15) and the need for confidentiality around a minor's consent to contraception (16). Statutes on the rights of minors to consent to health care services vary by state, and obstetrician–gynecologists should be familiar with the regulations that apply to their practice. Useful sources of information on state laws include the Guttmacher Institute (www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services) and the Center for Adolescent Health and the Law (www.cahl.org/state-minor-consent-laws-a-summary-third-edition/).

When feasible, obstetrician–gynecologists should work with government agencies and legislative bodies to eliminate or mitigate the effect of laws that unduly restrict confidential health services for minor adolescents. Open communication between obstetrician–gynecologists and patients (this may include a parent or guardian) regarding the current laws and requirements is imperative, and confidentiality protection is consistent with the development of autonomy and maturity of the adolescent patient. Effective communication between adolescents and their parents should be supported and encouraged, but should not be required.

The billing and insurance claims process has a substantial effect on confidentiality (17). Although confidentiality for provision of contraceptive services may be allowed by state statute, violation of confidentiality may occur through insurance claim processes, such as explanation of benefits notifications. Implementation of the Affordable Care Act has increased coverage of some reproductive health services by mechanisms such as no additional cost-sharing for contraceptive methods for those with health insurance and expanded coverage options for young adults through parental policies. However, there has not been a concordant change

protecting health information from other individuals if the patient is not the primary insurance holder or is a minor. The American College of Obstetricians and Gynecologists endorses the Society for Adolescent Health and Medicine and American Academy of Pediatrics recommendation that explanation of benefits notifications or other similar communications should not be sent when individuals insured as dependents obtain sensitive

### Box 1. Sexual History Questions to Ask Patients

**1. Partners**

- Are you currently sexually active? (Are you having sex?)
  - — If no, have you ever been sexually active?
- In recent months, how many sex partners have you had?
- In the past 12 months, how many sex partners have you had?
- Are your sex partners men, women, or both?*
  - — If a patient answers "both" repeat first two questions for each specific gender.

**2. Practices**

- I am going to be more explicit here about the kind of sex you have had over the past 12 months to better understand if you are at risk of sexually transmitted infections (STIs).
- What kind of sexual contact do you have or have you had?
  - — Genital (penis in the vagina)?
  - — Anal (penis in the anus)?
  - — Oral (mouth on penis, vagina, or anus)?

**3. Protection from STIs**

- Do you and your partner(s) use any protection against STIs?
  - — If not, could you tell me the reason?
  - — Are you comfortable asking your partner to use condoms?†
  - — If so, what kind of protection do you use?
  - — How often do you use this protection?
  - — If "sometimes," in what situations or with whom do you use protection?
- Do you have any other questions, or are there other forms of protection from STIs that you would like to discuss today?

**4. History of STIs**

- Have you ever been diagnosed with an STI?
  - — When?
  - — How were you treated?
  - — Have you had any recurring symptoms or diagnoses?
- Have you ever been tested for human immunodeficiency virus (HIV) or other STIs?
  - — Would you like to be tested?‡
    - Has your current partner or have any former partners ever been diagnosed or treated for an STI?
  - — Were you tested for the same STI(s)?
  - — If yes, when were you tested?
  - — What was the diagnosis?
  - — How was it treated?

**5. Prevention of Pregnancy**

- Are you currently trying to become pregnant?
- Are you concerned about getting pregnant?
- Are you using contraception or practicing any form of birth control?
- Is your partner supportive of your using birth control?†
- Do you need any information on birth control?

**Completing the History**

- What other things about your sexual health and sexual practices should we discuss to help ensure your good health?
- What other concerns or questions regarding your sexual health or sexual practices would you like to discuss?

*Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1077–80 *and* Care for transgender adolescents. Committee Opinion No. 685. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e11–6.

†If no, for more information on reproductive coercion see Chamberlain L, Levenson R. Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic and reproductive health care settings. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; San Francisco (CA): Futures Without Violence; 2012. Available at: https://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf. Retrieved April 7, 2017 *and* Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:411–5.

‡Ideally, opt-out HIV screening should be performed, in which the patient is notified that HIV testing will be performed as a routine part of gynecologic care unless the patient declines testing. See Routine human immunodeficiency virus screening. Committee Opinion No. 596. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1137–9.

Data from Centers for Disease Control and Prevention. A guide to taking a sexual history. Atlanta (GA): CDC; 2011. Available at: https://www.cdc.gov/std/treatment/SexualHistory.pdf. Retrieved March 31, 2017.

services (18). Obstetricians–gynecologists should review such processes in their own practice to educate patients and policy holders on confidentiality implications, as well as potentially to revise processes that may increase adolescent confidentiality while maintaining compliance with all state and federal laws. When confidential services cannot be provided, referral to Title X Federal Family Planning program clinics (www.opa-fpclinicdb.com) should be considered.

Engagement of adolescents in their own health care through technology is another way to provide age-appropriate venues for confidential communication. As a core component of meaningful use requirements, the patient portal presents opportunities and challenges for the care of adolescents. When parents have access to adolescent health records, the practice of providing open-access to this information is often in direct conflict with best practices for confidential care of the adolescent patient. Institutionally-individualized electronic health record systems do not allow for easy implementation of technology modifications, such as control over parental access to records. Data demonstrate the ability of the patient portal or similar mobile health technology to advance adolescent health care (19); the challenge is to optimize its potential (20). When providing contraceptive services to adolescents, obstetrician–gynecologists should be aware of their own patient portal logistics and usage requirements and should discuss its limitations and opportunities for confidential communication with patients (21). In a large health care system, confidentiality may not be ensured when electronic health records are shared.

### Coercion

Reproductive coercion is behavior that interferes with a woman's decision making about any aspect of her reproductive health and can be associated with increased rates of physical, sexual, or psychological abuse in relationships. Adolescents may be more susceptible to such abuse than adult counterparts (22). See Committee Opinion No. 554, *Reproductive and Sexual Coercion*, for more information and resources (23). Health care provider bias is another form of coercion, and health care providers are encouraged to self-reflect on their own biases and how to provide patient-centered noncoercive care. Obstetrician–gynecologists have the duty to refer patients in a timely manner to other health care providers if they do not feel that they can provide the standard reproductive services that their patients request (24).

Adolescents' right of refusal for initiating or discontinuing a method should be addressed by obstetrician–gynecologists. At no time should an adolescent patient be forced to use a method chosen by someone other than herself, including a parent, guardian, partner, or health care provider. A patient-centered approach is recommended by the U.S. Office of Population Affairs and the CDC's Providing Quality Family Planning Services (10). Adolescents who are limited in their ability to verbalize or give consent should not be seen as asexual. Obstetrician–gynecologists should provide them, or their caregivers, or both, with the same information on contraception as patients without disabilities, including the option of private time with the obstetrician–gynecologist, if appropriate. At age 18 years, an adolescent can autonomously give consent in most states; however, obstetrician–gynecologists should be aware of their state laws surrounding health care power of attorney documents and consent processes that may apply to patients living with disabilities. Adolescents with intellectual disabilities, or physical disabilities, or both, and special needs comprise a distinct population with unique considerations addressed later in the document (see "Special Considerations").

## Emergency Contraception

Emergency contraception can provide protection from pregnancy as many as 120 hours after unprotected or inadequately protected intercourse and should be made available to all adolescents (25). No physical examination or testing is indicated before the provision of oral emergency contraception. Notably, access to emergency contraception remains challenging for many women, particularly for adolescents, immigrants, non-English speaking women, survivors of sexual assault, those living in areas with few pharmacy choices, young women, and poor women (26). The Guttmacher Institute maintains an up-to-date listing of state policies on emergency contraception (www.guttmacher.org/state-policy/explore/emergency-contraception). The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists write advance prescriptions for oral emergency contraception for their patients to increase awareness and remove barriers, especially for adolescents (26). Thus, emergency contraception routinely should be included in discussions about contraception, including access issues. Because of its efficacy and its advantage as an ongoing contraceptive method, a copper intrauterine device should be considered as an alternative to oral emergency contraception. Based on limited secondary data, obesity has been associated with reduced efficacy of oral emergency contraception; however, it should not be withheld from women who are overweight or obese (25).

## Approach to Counseling

Provision of contraceptive services, including counseling and education, is enhanced using tools such as those provided by the U.S. Office of Population Affairs and the CDC (10). Contraceptive experiences and preferences, pregnancy intention and reproductive life plan, sexual health assessment, and medical history are key elements of the patient history. Obstetrician–gynecologists and other health care providers who treat adolescents should provide anticipatory guidance to patients and their parents or guardians, and they should individualize care to

the patient's developmental stage. Dual method use—the use of condoms for STI prevention in combination with more effective contraceptive methods to protect against unintended pregnancy—often is the ideal contraceptive practice for adolescents.

The counseling script, along with other factors such as cost, may influence contraceptive decisions, as demonstrated by the Contraceptive CHOICE Project (27). In this initiative, which provided access to all methods without cost, the counseling script described the effectiveness, advantages, and disadvantages of currently available reversible contraceptives in the order of method effectiveness. Choice of a LARC method, as well as continuation of the method, was exponentially higher in the CHOICE clinics compared with a cohort of surrounding clinics. The CHOICE Project demonstrated the efficacy of LARC methods. Women who used oral contraceptives, the patch, or ring were 20 times more likely to experience an unintended pregnancy compared with LARC users in the first year of the project (28). Based on the success of the CHOICE Project's structured counseling in order of method effectiveness (27), ACOG recommends that discussions about contraception begin with information on the most effective methods first. Obstetrician–gynecologists should be aware of potential barriers and the methods available to help guide the counseling process for their patients.

Counseling may be better received if the environment is adolescent friendly. This includes attention to details such as an adolescent-friendly waiting room, appointment scheduling at convenient times, and tools and visual aids used in the consultation room. See Committee Opinion No. 598, *The Initial Reproductive Health Visit,* for resources that are useful to create such an environment (7).

## Special Considerations

Serving patients with certain medical conditions, such as a mental health issue or intellectual or physical disability, may require awareness of other barriers and issues and the implementation of additional counseling strategies. Some studies report higher rates of contraceptive nonuse, misuse, and discontinuation among women with symptoms of mental health disorders (eg, depression and anxiety) compared with asymptomatic women (29). More information on contraception and mental health disorders is available in Committee Opinion No. 705, *Mental Health Disorders in Adolescents* (30). Young women with medical comorbidities that may influence their choice of contraceptive method should be counseled about the potential effect their condition could have on a pregnancy or that pregnancy could have on their condition. Obstetrician–gynecologists should consult the CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 for information on contraceptive counseling (31). Among adolescents with intellectual disabilities, or physical disabilities, or both, and other special needs, reproductive health (eg, menstrual suppression) care may overlap with contraceptive choices (32). When working with a patient to choose an appropriate option, the need for menstrual management and anticipatory guidance in special caregiver situations should be considered (33).

## Advantages and Common Misperceptions About Available Methods

Excellent tools exist to help the obstetrician–gynecologist guide a patient through selection and correct use of a contraceptive. Adolescents may have misperceptions and concerns about methods and an obstetrician–gynecologist should be prepared to elicit these concerns and counsel appropriately. Candidacy for use of individual methods is detailed in the U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (31). There are no restrictions on any method based on age alone. Additionally, evidence-based information regarding required testing and follow-up, initiation and timing, missed dosages, and adverse effect management is detailed in the CDC's U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (11). The American College of Obstetricians and Gynecologists endorses and advocates the use of both documents.

Additionally, cultural, social, economic, and educational background can influence an adolescent's perceptions of birth control methods. Common areas of concern for each method, such as weight gain with depot medroxyprogesterone acetate use, are not unique to adolescent patients. However, young patients may not be effective in verbalizing their concerns and may experience intimidation and embarrassment in such discussions. Dialogue that includes open-ended and direct questions may provide an avenue for the patient to express her concerns or beliefs.

Data on unmarried young adults aged 18–29 years in the United States demonstrate that misperceptions are common regarding use of contraceptives—there is a gap between intent and actual behavior in preventing unplanned pregnancy (34). This gap stems from multiple issues, including awareness, fear, myths, underestimation of personal fertility, and access, as well as pregnancy ambivalence (34). Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age-appropriate and compatible with the patient's health literacy (35).

## Follow-Up Visit

Assessing adherence to and satisfaction with an adolescent's chosen method is important. An in-person visit, telephone call, or electronic communication gives her the opportunity to voice any concerns or problems. The availability of follow-up should be explained to the patient and documented in the record, and she should be provided with office phone numbers and email information

(if applicable) for ease of communication. The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for STIs per CDC guidelines (36).

## For More Information

The American College of Obstetricians and Gynecologists 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/Adolescent Contraception.

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 website, or the content of the resource.

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# EXHIBIT C

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

# ACOG COMMITTEE OPINION

Number 735 • May 2018

*(Replaces Committee Opinion Number 539, October 2012)*

**Committee on Adolescent Health Care**
**Long-Acting Reversible Contraception Work Group**

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Adolescent Health Care and the Long-Acting Reversible Contraception Work Group in collaboration with Committee member Ashlyn H. Savage, MD and Sarah F. Lindsay, MD, on behalf of the Long-Acting Reversible Contraception Work Group.*

# Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices

**ABSTRACT:** The phenomenon of adolescent childbearing is complex and far reaching, affecting not only the adolescents but also their children and their community. The prevalence and public health effect of adolescent pregnancy reflect complex structural social problems and an unmet need for acceptable and effective contraceptive methods in this population. In 2006–2010, 82% of adolescents at risk of unintended pregnancy were currently using contraception, but only 59% used a highly effective method, including any hormonal method or intrauterine device. Long-acting reversible contraceptives (LARC) have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives among adolescents who choose to use them. Complications of intrauterine devices and contraceptive implants are rare and differ little between adolescents and women, which makes these methods safe for adolescents. Barriers to use of LARC by adolescents include patients' lack of familiarity with or understanding about the methods, potentially high cost of initiation, lack of access, low parental acceptance, and obstetrician–gynecologists' and other health care providers' misconceptions about the safety of LARC use in adolescents. Because adolescents are at higher risk of sexually transmitted infections (STIs), obstetrician–gynecologists should continue to follow standard guidelines for STI screening. They should advise adolescents who choose LARC methods to use male or female condoms consistently (dual method use) to decrease the risk of STIs, including human immunodeficiency virus (HIV). Obstetrician–gynecologists should counsel all sexually active adolescents who do not seek pregnancy on the range of reversible contraceptive methods, including LARC, and should help make these contraceptives readily accessible to them.

## Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Long-acting reversible contraceptives (LARC) have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives among adolescents who choose to use them.
- Complications of intrauterine devices (IUDs) and contraceptive implants are rare and differ little between adolescents and women, which makes these methods safe for adolescents.
- Patient choice should be the principal factor driving the use of one method of contraception over another, and respect for the adolescent's right to choose or decline any method of reversible contraception is critical. A reproductive justice framework for contraceptive counseling is essential to providing equitable health care, promoting access and coverage for all contraceptive methods, and avoiding potential coercion. Obstetrician–gynecologists should use this framework and offer LARC alongside all other reversible methods to adolescents who wish to prevent pregnancy.
- New-onset abnormal uterine bleeding unrelated to initial placement of a LARC should be evaluated similarly to abnormal bleeding in non-LARC users.
- Because adolescents are at higher risk of sexually transmitted infections (STIs), obstetrician–gynecologists should continue to follow standard guidelines for STI screening. They should advise

adolescents who choose LARC methods to use male or female condoms consistently (dual method use) to decrease the risk of STIs, including human immunodeficiency virus (HIV).

This Committee Opinion has been updated to reflect newer LARC methods and data on the safety and effectiveness of LARC methods in adolescents.

## Sexual Behavior and Contraceptive Use Among American Adolescents

In the United States, 42% of female and 44% of male adolescents aged 15–19 years have had sexual intercourse (1). Although there has been a recent decrease in adolescent pregnancies, 75% of adolescent pregnancies were unplanned in 2011, accounting for one-sixth of all unintended pregnancies in the United States. (2). According to available data, the United States continues to have the highest adolescent pregnancy and birth rates among developed countries (2, 3). The phenomenon of adolescent childbearing is complex and far reaching, affecting not only the adolescents but also their children and their community. The prevalence and public health effect of adolescent pregnancy reflect complex structural social problems and an unmet need for acceptable and effective contraceptive methods in this population (4).

In 2006–2010, 82% of adolescents at risk of unintended pregnancy were currently using contraception, but only 59% used a highly effective method, including any hormonal method or IUD (5, 6). Adolescents who use contraception most often use short-acting methods, such as condoms, withdrawal, or oral contraceptives. These methods have higher discontinuation and pregnancy rates compared with LARC methods (7, 8). Poor continuation coupled with higher failure rates significantly decrease the efficacy of short-acting contraception in young women (9, 10).

Adolescents have high continuation rates with LARC methods. A meta-analysis of 12 studies evaluating LARC method continuation among adolescents and women younger than 25 years found a 12-month continuation rate of 84% for LARC methods (11). The CHOICE project, a prospective cohort study of 9,256 girls and women of reproductive age (ages 14–45 years) designed to promote the use of LARC, found that 81% of adolescents aged 14–19 years continued use of a LARC method at 1 year, whereas 44% of participants continued short-acting contraceptive use (12). Continuation rates were similar among adolescent IUD and implant users. Compared with adult women, adolescents in the CHOICE project had equally high satisfaction rates with LARC methods and were not more likely to discontinue LARC methods (13). Adolescents enrolled in this study were significantly less likely to experience a pregnancy, live birth, or abortion compared with adolescents in the same age group in the general U.S. population (14).

Despite high efficacy and satisfaction rates with LARC methods, relatively few adolescents use an implant or IUD for contraception. Only 5.8% of adolescents and women aged 15–19 years have ever used a LARC method, with 3.0% ever using an IUD and 2.8% ever using a contraceptive implant (1). Age appears to influence LARC method preference, with younger adolescents (14–17 years) most commonly selecting implants and older women (18–20 years) most commonly selecting IUDs (14, 15).

Barriers to use of LARC by adolescents include patients' lack of familiarity with or understanding about the methods, potentially high cost of initiation, lack of access, low parental acceptance, and obstetrician–gynecologists' and other health care providers' misconceptions about the safety of LARC use in adolescents (16). The CHOICE project, which included scripted counseling about contraceptive efficacy and eliminated cost barriers, found that more than two thirds of females aged 14–20 years chose a LARC method (15).

## Long-Acting Reversible Contraceptives

There are several LARC options available for use in the United States. At present, there are four different levonorgestrel-releasing IUDs (LNG-IUD) of varying size, cost, dosage and duration of use, one copper-containing IUD, and one subdermal implant (Table 1)*. Data indicate that the Paragard (the copper IUD), Mirena, and the contraceptive implant all are effective beyond their FDA-approved durations of use (17). Extended-use studies are ongoing for Liletta, and data are not yet available for the newer devices such as Kyleena and Skyla.

## "Quick Start" Initiation

Because delays in contraceptive method initiation may be a barrier to contraception for adolescents, same day initiation ("quick start") should be considered for most adolescents. All contraceptive methods (including LARC) can be started anytime, including on the day of the contraceptive counseling visit, if there is reasonable certainty that the patient is not pregnant. Risk of pregnancy can be assessed using patients' history and urine pregnancy tests (18). When there is uncertainty about pregnancy, the benefits of starting most hormonal contraception (implant, injection, combined hormonal contraceptives, and progestin-only pills) likely exceed any risk, and a pregnancy test should be repeated in 2–4 weeks. If there is uncertainty about a luteal phase pregnancy, an LNG-IUD should not be inserted until the clinician is reasonably certain that the patient is not pregnant. The copper IUD may be inserted within 5 days of unprotected intercourse for emergency contraception (19). Additional information about "quick start" initiation is available in the ACOG-endorsed Center for Disease Control and Prevention's (CDC) *U.S. Selected Practice Recommendations for Contraceptive Use* (18).

*Brand names referenced in the document are used purely for product identification purposes and do not imply endorsement.

**Table 1.** Long-Acting Reversible Contraceptive Methods ⇦

| Brand Name | Medication and Device Type (Dose) | Initial Rate of Release (micrograms/day) | FDA-approved Duration of Use | Potential Efficacy Beyond FDA-approved Duration | Identifying Characteristics | Size of Device (Horizontal x Vertical, mm) | Inserter Tube Diameter (mm) | Percentage of Women Experiencing an Unintended Pregnancy in the First Year of Use (Typical Use)* |
|---|---|---|---|---|---|---|---|---|
| Kyleena | LNG-IUD (19.5 mg) | 17.5 | 5 years | N/A | Blue strings; silver ring | 28 x 30 | 3.8 | 0.20[†] |
| Liletta | LNG-IUD (52 mg) | 19.5 | 4 years | +1 year[‡] | Blue strings | 32 x 32 | 4.4 | 0.20[†] |
| Mirena | LNG-IUD (52 mg) | 20 | 5 years | +2 years[§,‖] | Gray strings | 32 x 32 | 4.4 | 0.20[†] |
| Skyla | LNG-IUD (13.5 mg) | 14 | 3 years | N/A | Gray strings; silver ring | 28 x 30 | 3.8 | 0.20[†] |
| Paragard | Copper T380A IUD (380 $mm^2$) | NA | 10 years | +2 years[¶] | White strings | 32 x 36 | 4.01 | 0.80 |
| Nexplanon/ Implanon | Etonogestrel single-rod contraceptive implant (68 mg) | 60–70 | 3 years | +1-2 years[‖,#] | N/A | 40 x 2 | N/A | 0.05 |

Abbreviations: FDA=U.S. Food and Drug Administration, IUD=intrauterine device, LNG=levonorgestrel.

*Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

[†]For all LNG-IUDs

[‡]Creinin MD, Jansen R, Starr RM, Gobburu J, Gopalakrishnan M, Olariu A. Levonorgestrel release rates over 5 years with the Liletta® 52-mg intrauterine system. Contraception 2016;94:353–6.

[§]Rowe P, Farley T, Peregoudov A, Piaggio G, Boccard S, Landoulsi S, et al. Safety and efficacy in parous women of a 52-mg levonorgestrel-medicated intrauterine device: a 7-year randomized comparative study with the TCu380A. IUD Research Group of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Contraception 2016;93:498–506.

[‖]McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. Am J Obstet Gynecol 2017;216: 586.e1–6.

[¶]Wu JP, Pickle S. Extended use of the intrauterine device: a literature review and recommendations for clinical practice. Contraception 2014;89:495–503.

[#]Ali M, Akin A, Bahamondes L, Brache V, Habib N, Landoulsi S, et al. Extended use up to 5 years of the etonogestrel-releasing subdermal contraceptive implant: comparison to levonorgestrel-releasing subdermal implant. WHO study group on subdermal contraceptive implants for women. Hum Reprod 2016;31:2491–8.

## Counseling, Consent, Confidentiality, and Cost

Adolescent contraceptive counseling may require attention to the unique concerns of adolescents about informed consent, confidentiality, parental involvement, and insurance coverage or cost. A reproductive justice framework for contraceptive counseling is essential to providing equitable health care, promoting access and coverage for all contraceptive methods, and avoiding potential coercion (4). Specifically, obstetrician–gynecologists should use this framework and offer LARC alongside all other reversible methods to adolescents who wish to prevent pregnancy (4). See Committee Opinion No. 710, *Counseling Adolescents About Contraception*, for more information (20).

Obstetrician–gynecologists should engage adolescents who wish to prevent pregnancy in shared decision-making and provide information on the benefits and risks of all contraceptive methods. Contraceptive counseling should include anticipatory guidance for adolescents and their parents or guardians regarding possible menstrual changes, side effects, and noncontraceptive benefits such

as management of irregular or abnormal uterine bleeding and treatment of dysmenorrhea (17).

Coercive provision of LARC has been used as a means of fertility control in marginalized women (21). Patient choice should be the principal factor driving the use of one method of contraception over another, and respect for the adolescent's right to choose or decline any method of reversible contraception is critical. Obstetrician–gynecologists should recognize that potential sources of coercion could include parents, partners, clinicians, and peers. In addition, obstetrician–gynecologists should be cautious that their own enthusiasm for LARC may be an additional source of coercion (22, 23).

Just as adolescents have the right to choose or decline LARC, they also have the right to discontinue LARC without barriers. Initial contraceptive counseling should include anticipatory guidance for discontinuation, including the need for a future visit with an appropriately trained clinician for removal and the costs associated with removal. Additionally, if an adolescent makes an informed decision to discontinue LARC, the obstetrician–gynecologist should facilitate removal.

Protecting adolescents' confidentiality is important because fears around parental disclosure can serve as a barrier to reproductive health care. In a majority of states, adolescents have the right to receive contraceptives, including LARC methods, without parental consent. Obstetrician–gynecologists should be familiar with local laws concerning provision of contraception to minors. Information regarding these laws can be found at www.guttmacher.org/state-policy/explore/overview-minors-consent-law. Obstetrician–gynecologists also should inform patients that some billing practices, such as explanation of benefits notifications, can compromise confidentiality (24). Although some adolescents may not want to use parental insurance benefits for LARC because of confidentiality concerns, others may be uninsured or have insurance that excludes coverage for LARC. In these cases, referral to a clinic with Title X or other public funding (www.opa-fpclinicdb.com) may be appropriate for adolescents in order to improve access and maintain confidentiality.

Because adolescents are at higher risk of STIs, obstetrician–gynecologists should continue to follow standard guidelines for STI screening. They should advise adolescents who choose LARC methods to use male or female condoms consistently (dual method use) to decrease the risk of STIs, including HIV.

## Guidance for Adolescent Health Care Providers to Address Common Misconceptions

Myths and misinformation from patients, parents, and clinicians have been a barrier to adolescent LARC access. Training and continuing education programs should address common misconceptions and review the key safety evidence and benefits of adolescent LARC use.

### Intrauterine Devices

#### *Intrauterine Devices Are Safe to Use Among Adolescents*

Intrauterine devices are safe for adolescents, with very low rates of complications such as pelvic inflammatory disease (PID) or uterine perforation (25). The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Centers for Disease Control and Prevention (CDC), and the Society of Family Planning support the use of LARC by adolescents (26–28) (Table 2). The risk of PID with IUD placement is 0–2% when no cervical infection is present and 0–5% when insertion occurs with an undetected infection (29). The risk of PID is highest in the first 20 days after IUD insertion (relative risk of 9.7 cases per 1000 woman-years of use) but the overall absolute risk of PID is small at 1.6 cases per 1000 woman-years of use (29–31). With long-term use, levonorgestrel IUDs may lower the subsequent risk of PID by thickening cervical mucus and thinning the endometrium (32–34).

Sexually active adolescents should be screened for gonorrhea and chlamydial infection at the time of IUD insertion based on current CDC guidelines (18). It is appropriate to screen for STIs and place an IUD on the same day. Screening and awaiting results before IUD insertion do not decrease the risk of postinsertion PID (35), but could delay initiation of highly effective contraception and increase the risk of unintended pregnancy. Routine antibiotic prophylaxis is not recommended at the time of IUD insertion (17, 18). If an STI is diagnosed after the IUD is in place, it may be treated without removing the IUD (17, 18, 36, 37).

Uterine perforation is a very rare complication of IUD insertion. A systematic review summarizing retrospective cohort data and insurance claims data demonstrated that adolescents are not at higher risk of perforation compared with women. The risk of uterine perforation for adolescents and women is approximately 0.1% (25).

#### *Intrauterine Devices Do Not Increase an Adolescent's Risk of Infertility*

Infertility is not more likely to occur after IUD discontinuation than after discontinuation of other reversible methods of contraception (31). Baseline fecundity returns rapidly after IUD removal (38). In a large case–control study that examined determinants of tubal infertility, the presence of chlamydial antibodies (not previous IUD use) was associated with infertility (39). A prospective study that compared 12-month pregnancy rates of 69 participants aged 18–35 years from the CHOICE project who had discontinued their IUD with 42 former non-IUD users found no difference in pregnancy rates or time to pregnancy between the groups (40).

#### *Intrauterine Devices May Be Inserted Without Difficulty in Most Adolescents and Nulliparous Women*

Intrauterine device insertion has not been shown to be more difficult in adolescents compared with older

**Table 2.** U.S. Medical Eligibility Criteria for Contraceptive Use*

| Condition | Cu-IUD | LNG-IUD | Implants |
|---|---|---|---|
| *Age* | | | |
| Menarche to less than 20 years | 2 | 2 | 1 |
| *Parity* | | | |
| Nulliparous | 2 | 2 | 1 |
| Parous | 1 | 1 | 1 |
| *Postpartum (including cesarean delivery)* | | | |
| Less than 10 minutes after delivery of placenta (breastfeeding) | 1 | 2 | - |
| Less than 10 minutes after delivery of placenta (not breastfeeding) | 1 | 1 | - |
| 10 minutes after delivery of placenta to less than 4 weeks after delivery (breastfeeding or nonbreastfeeding) | 2 | 2 | - |
| 4 weeks or greater after delivery (breastfeeding or nonbreastfeeding) | 1 | 1 | - |
| Postpartum sepsis | 4 | 4 | - |
| *Postpartum* | | | |
| Nonbreastfeeding (any time postpartum) | - | - | 1 |
| Breastfeeding, less than 30 days postpartum | - | - | 2 |
| Breastfeeding, 30 days or more postpartum | - | - | 1 |
| *Postabortion* | | | |
| First trimester (including immediately after spontaneous or induced abortion)† | 1 | 1 | 1 |
| Second trimester (including immediately after spontaneous or induced abortion)† | 2 | 2 | 1 |
| Immediate postseptic abortion | 4 | 4 | 1 |

Abbreviations: Cu-IUD, copper-containing intrauterine device; LNG-IUD, levonorgestrel-releasing intrauterine device.

*Categories: 1 = A condition for which there is no restriction for the use of the contraceptive method; 2 = A condition for which the advantages of using the method generally outweigh the theoretical or proven risks; 3 = A condition for which the theoretical or proven risks usually outweigh the advantages of using the method; 4 = A condition that represents an unacceptable health risk if the contraceptive method is used.

†IUDs can be inserted immediately after spontaneous or induced abortion.

Modified from Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep 2016;65(RR-3):1–103.

women or in nulliparous patients compared with parous women. In a cohort of 1,177 adolescents and women aged 13–24 years, successful IUD placement was achieved on first attempt in 96% of patients. The majority of the IUDs were placed by an advanced practice clinician (41).

Most women experience some degree of discomfort during IUD insertion. Obstetrician–gynecologists should provide anticipatory guidance regarding pain that may occur during and after insertion. Provision of additional analgesia during IUD insertion should be individualized and may include nonsteroidal antiinflammatory drugs (NSAIDs), narcotics, anxiolytics, or paracervical blocks. The most effective method of pain control has not been established yet (42, 43). One study demonstrated that women who received oral naproxen 1 hour before IUD insertion did not have reduced pain with IUD insertion but did have reduced pain after insertion (44). A paracervical block using 1% lidocaine was shown to reduce pain scores among nulliparous adolescents and women aged 14–22 years undergoing IUD insertion, although administration of the block did not improve overall satisfaction with insertion (45). Misoprostol

should not be routinely used before IUD insertion because it has not been shown to reduce pain or enhance ease of insertion and has been shown to increase cramping and nausea (18, 43, 46).

Placement of the Skyla IUD and the Kyleena IUD may be easier and less painful than the Mirena IUD because of a smaller insertion tube diameter (see Table 1). In phase II clinical trials, cervical dilation was performed more frequently for the Mirena IUD compared with the Skyla IUD and the Kyleena IUD (9.4% versus 3.9%, $P$=.004) and participants rated placement of the Skyla IUD and the Kyleena IUD as either "no pain" or "mild pain" more often compared with the Mirena (72.3% versus 57.9%) (47). Participants in this study were aged 21–40 years and approximately 20% of the women were nulliparous (47).

### *Intrauterine Device Expulsion Is Uncommon in Adolescents*

Intrauterine device expulsion rates range from 2% to 10% for all IUD users (48). A retrospective review of 2,138 adolescents and women aged 13–35 years with an IUD showed that younger females (aged 13–19 years) and nulliparous women were not more likely to experience expulsion than older or parous women (overall expulsion rate of 6%). However, when expulsion did occur, the younger females were more likely to experience partial expulsion than the older cohort (49). Another retrospective review of 684 females, 27% of whom were adolescents, did not find a significantly different rate of IUD expulsion between adolescents and adults at 6 months after placement (9% versus 6%, respectively, $P$=.7) (50). A prospective study of 1,117 adolescents who underwent IUD placement at a university clinic found an expulsion rate of 3.0% at 6 months after placement (41).

Among adolescents enrolled in the CHOICE Project, expulsion rates at 12 months and at 36 months were approximately 10% and 19% respectively, which was approximately twice the risk for women older than 20 years. Although expulsion rates were higher in the adolescents, nulliparity did not affect risk of expulsion (51). These expulsion rates for adolescents were notably higher than in most other studies and may be explained partially by the mechanism of data collection in this study. Expulsion rates for the copper IUD are slightly higher than for LNG-IUDs (49, 51). Prior expulsion is a risk factor for repeat expulsion, but should not be considered a contraindication if the adolescent desires another IUD and counseling is provided on the higher risk of expulsion (approximately 30%) of the second IUD (52, 53).

### *Intrauterine Devices Cause Changes in Bleeding Patterns*

Obstetrician–gynecologists should counsel adolescents using IUDs to expect changes in menstrual bleeding, especially in the first months of use. The copper IUD may cause heavier menses. Nonsteroidal antiinflammatory drugs are effective for the treatment of dysmenorrhea or bothersome bleeding from the copper IUD (17).

Many women using one of the LNG-IUDs will have a decrease in bleeding over time that will lead to lighter bleeding, spotting, or amenorrhea. Lower dose devices have lower rates of amenorrhea and also may have higher rates of unscheduled bleeding. As with the copper IUD, evidence supports treating bleeding and spotting associated with LNG-IUD use with NSAIDs (17). In one randomized placebo-controlled trial, naproxen significantly reduced bleeding and spotting days in the first 12 weeks of Mirena IUD use, whereas transdermal estradiol significantly increased bleeding and spotting (54). However, another trial found that tranexamic acid and mefenamic acid did not alleviate nuisance bleeding during the first 90 days of Mirena IUD use (55).

Young women with bleeding concerns that coincide with LARC initiation rarely require extensive evaluation (17). For more information, see Practice Bulletin No. 186, *Long-Acting Reversible Contraception: Implants and Intrauterine Devices* and the CDC's *Selected Practice Recommendations for Contraceptive Use* (17, 18). New-onset abnormal uterine bleeding unrelated to initial placement of a LARC should be evaluated similarly to abnormal bleeding in non-LARC users. The differential diagnosis remains similar, including complications of pregnancy, infection, and gynecologic malignancy. Additionally, a new change in bleeding may indicate partial IUD expulsion in adolescents, and placement should be assessed with examination and possibly ultrasonography. An IUD located within the cervix is partially expelled, and given the increased risk of complete expulsion, the IUD should be removed (and replaced if the patient desires). Ideal management of low-lying IUDs is less clear; a shared decision-making approach between the patient and the obstetrician–gynecologist or other gynecologic care provider based on symptoms and other considerations is most appropriate. For additional information, see Committee Opinion No. 672, *Clinical Challenges of Long-Acting Reversible Contraceptive Methods* (43).

## Contraceptive Implants

### *The Contraceptive Implant Has Minimal or No Effect on Bone Density or Weight*

A prospective study of etonogestrel implant users showed no difference in the change in bone mineral density compared with copper IUD users after 2 years of use (56). Most evidence suggests that implants do not have a significant effect on body weight. A small percentage of women (2.3%) in the clinical trials for the etonogestrel implant discontinued use because of reported weight gain; however, actual weight gain was not documented (57). The mean weight change after 1 year was 2.1 kilograms for 130 women with implants who were monitored in the CHOICE Project. After adjusting for age and race,

this weight change was not statistically different from women using an IUD in this study (58). In contrast, depot medroxyprogesterone acetate injections have been associated with weight gain and with overweight adolescents more susceptible to weight gain than normal-weight adolescents (59).

***Contraceptive Implants Cause Changes in Bleeding Patterns.***

Obstetrician–gynecologists should counsel adolescents who choose an implant for contraception to expect changes in menstrual bleeding patterns throughout the duration of use. In an analysis of 11 clinical trials, including 942 etonogestrel implant users of all ages, the most common bleeding pattern was infrequent bleeding in 33.3% of 90-day cycles, followed by amenorrhea in 21.4% of cycles. Prolonged bleeding occurred in 16.9% of cycles and frequent bleeding occurred in 6.1% of cycles (57). Change in bleeding pattern is the most common reason for implant discontinuation, but early discontinuation rates among adolescents are generally low at approximately 10% within the first year (60). Anticipatory guidance regarding bleeding patterns may improve satisfaction and rates of continuation. There are no clinical parameters or risk factors that aid in predicting bleeding patterns. However, the bleeding pattern women experience in the first 3 months is broadly predictive of future bleeding patterns (61).

There is limited evidence demonstrating that interventions to treat irregular bleeding patterns are of benefit. Oral contraceptive pills have been shown at least to temporarily interrupt bleeding episodes (62). The CDC recommends consideration of the following two treatment options: 1) NSAIDs for short-term treatment (5–7 days), and 2) hormonal treatment (if medically eligible) with low-dose combined oral contraceptives or estrogen for short-term treatment (10–20 days) (18). Limited clinical trial data suggest that, compared with placebo, mefenamic acid, mifepristone in combination with ethinyl estradiol, mifepristone in combination with doxycycline, and doxycycline alone decrease the length of bleeding episodes in implant users (63–65). More research is needed to determine whether these or other interventions affect long-term continuation or the acceptability of the implant and if these regimens are safe for long-term use. New-onset abnormal uterine bleeding not associated with initial placement should be evaluated similarly to abnormal bleeding in non-LARC users and to that of IUD users with abnormal uterine bleeding.

## Postpartum Long-Acting Reversible Contraception Initiation

The American College of Obstetricians and Gynecologists supports immediate postpartum LARC insertion (ie, before hospital discharge) as a best practice, recognizing its role in preventing rapid repeat and unintended pregnancy (17, 66). Adolescents are at high risk of a short interpregnancy interval, which is associated with lower rates of maternal educational achievement and employment and higher rates of preterm birth and small-for-gestational-age infants (67–69). Adolescents who use LARC methods after their first delivery are at significantly lower risk of repeat adolescent pregnancy (70–72). Insertion of an IUD or implant immediately postpartum ensures reliable contraception for adolescents when they are highly motivated to prevent pregnancy and are already in the health care system, and it is cost effective in decreasing rapid repeat pregnancy (73). Lack of insurance coverage for inpatient LARC insertion has been an obstacle to immediate postpartum LARC initiation; however, since 2013 increasing numbers of state Medicaid programs have begun covering this service (74). For additional information, including clinical guidance, see Committee Opinion No. 670, *Immediate Postpartum Long-Acting Reversible Contraception* and Practice Bulletin No. 186, *Long-Acting Reversible Contraception: Implants and Intrauterine Devices.*

## Postabortal Long-Acting Reversible Contraception

Insertion of an IUD immediately after first-trimester or second-trimester uterine aspiration and after completed medication-induced abortion should be offered routinely as a safe and effective option for postabortion contraception (17, 27) (Table 2). Immediate IUD insertion after confirmation of completed medication-induced abortion or after first-trimester uterine aspiration is associated with low expulsion rates, high continuation rates, and low risk of complications. Intrauterine device insertion immediately after second-trimester abortion is associated with higher expulsion rates compared with first-trimester postabortion insertion (17).

Insertion of a contraceptive implant on the same day as first-trimester or second-trimester uterine aspiration or on the initial day of medication-induced abortion should be offered routinely as a safe and effective option for postabortion contraception (17). The risk of abortion failure with placement at the time of mifepristone administration for medication-induced abortion is low and similar to the baseline medication-induced abortion failure rate (75).

## Conclusion

Long-acting reversible contraceptive methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives among adolescents who choose to use them. Complications of IUDs and contraceptive implants are rare and differ little between adolescents and women, which makes these methods safe for adolescents. Obstetrician–gynecologists should counsel all sexually active adolescents who do not seek pregnancy on the range of reversible contraceptive methods, including LARC, and should help make these contraceptives readily accessible to them.

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Adolescents and long-acting reversible contraception: implants and intrauterine devices. ACOG Committee Opinion No. 735. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018; 131:e130–9.

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# EXHIBIT D

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

# ACOG COMMITTEE OPINION

Number 755

*(Replaces Committee Opinion No. 534, August 2012)*

**Committee on Gynecologic Practice**

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice in collaboration with committee member Catherine Witkop, MD, MPH.*

# Well-Woman Visit

**ABSTRACT:** A well-woman visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks. Given the shifting and complex landscape of care, in which many women may not receive all the recommended preventive services, obstetrician–gynecologists have an opportunity to contribute to the overall health and well-being of women throughout the lifespan by providing recommended preventive services and counseling. Taking a comprehensive history (specifically obtaining detailed information on symptoms and past medical and gynecologic history) will inform if certain components of the physical examination, including breast or pelvic examination, are indicated at that visit and will inform shared decision making for these examinations. Family history should be used as a risk assessment tool and should be completed and updated regularly to ensure the most comprehensive assessment of a woman's personal risk factors. Another key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to ensure that medical testing and treatments provided are aligned with her current and future plans. Obstetrician–gynecologists provide care for women across the lifespan, and periodic well-woman visits are appropriate and necessary for perimenopausal women and postmenopausal women as well. This Committee Opinion has been revised to reflect updated guidance on components of the physical examination and new sources for well-woman preventive services.

## Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- A well-woman visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks.
- The periodic well-woman care visit should include screening, evaluation and counseling, and immunizations based on age and risk factors.
- The interval for specific individual services may differ for individual patients, and the scope of services provided may vary in different ambulatory care settings.
- Team-based care, including obstetrician–gynecologists, physician assistants, nurse practitioners, and other health care professionals, may facilitate meeting the needs of preventive care for women.
- A comprehensive history is one of the most important aspects of a well-woman visit.
- Although components of a physical examination may not be required at a well-woman visit, obstetrician–gynecologists can play a critical role in engaging patients in shared decision making, encouraging and facilitating healthy behaviors, and counseling about a wide array of effective preventive health practices.

The purpose of this document is to describe the importance of the periodic women's health visit and provide a general overview of women's preventive services and care. The scope of this Committee Opinion does not allow for a detailed review of all services and examinations that may be covered in a well-woman visit. This document will highlight resources and tools to assist

obstetrician–gynecologists in the provision of comprehensive well-woman care. See Table 1 for sources of specific well-woman preventive health services. This Committee Opinion has been revised to reflect updated guidance on components of the physical examination and new sources for well-woman preventive services.

## Background

Obstetrician–gynecologists have a tradition of providing preventive care to women. A well-woman visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks. Periodic visits for reproductive and well-woman care are recommended, even if individual components of that visit (eg, cervical cancer screening) may not be indicated each year. The periodic well-woman care visit should include screening, evaluation and counseling, and immunizations based on age and risk factors. The interval for specific individual services may differ for individual patients, and the scope of services provided may vary in different ambulatory care settings.

Obstetrician–gynecologists have the opportunity to provide preventive health services to women, in addition to managing reproductive health care. Data from medical records of national representative visits from 2007 to 2010 showed that, although more than 50% of preventive care visits for women (ages 18 years and older) were to obstetrician–gynecologists, these visits were primarily focused on screening for cervical and breast cancer (1). Family medicine clinicians, general practitioners, and internists covered a wider range of clinical preventive services (including screening for colorectal cancer, cholesterol, and diabetes mellitus) and counseling for diet, exercise, and obesity (1).

In a survey of obstetrician–gynecologists, when asked about their role in well-woman care, 61% defined well-woman care as "overall health and primary care"; however, they largely focused on reproductive health issues (2). Another study showed that even though most obstetrician–gynecologists reported that they provided well-woman care, there were gaps in the provision of some clinical preventive services during such visits, such as screening for intimate partner violence and sexual abuse and counseling about folic acid (3).

Because patient preferences may affect use of health care services, it is important to understand where women prefer to get their reproductive, primary, and preventive care. A 2015 study that examined the preferred and usual source of reproductive health care (including cervical cancer screening, contraception, and sexually transmitted infection services) showed that women's health care specialists (including obstetrician–gynecologists and family planning clinics) were the most used, and often the preferred, source of care compared with family medicine, internal medicine, and general medicine clinicians (4). Another 2017 paper suggests changes in cervical cancer screening recommendations and the increase in provision of long-acting reversible contraceptive methods may contribute to women seeking care from obstetrician–gynecologists less frequently (5).

The Patient Protection and Affordable Care Act of 2010 identified essential sources of recommended women's preventive health services and required coverage for these services without cost-sharing (Table 1). Subsequently, the Institute of Medicine (now known as the National Academy of Medicine) was tasked by the U.S. Department of Health and Human Services to identify additional evidence-based clinical preventive services for women (Table 1) (6). Given the shifting and complex landscape of care, in which many women may not receive all the recommended preventive services, obstetrician–gynecologists have an opportunity to contribute to the overall health and well-being of women throughout the lifespan by providing recommended preventive services and counseling.

### Management of Well-Woman Visits

As the number of recommended clinical preventive services increases, it is essential that obstetrician–gynecologists and other health care providers have access to high-quality resources that provide current information regarding these services. Existing repositories of well-woman recommendations are limited in usability and comprehensiveness; ultimately, a framework such as the one *Bright Futures* provides for children and adolescents would be helpful for adult women as well. Obstetrician–gynecologists should offer and recommend clinical preventive services to patients based on their age and risk factors; however, it may not be possible to complete all recommended services in one visit or with one health care provider. Team-based care, including obstetrician–gynecologists, physician assistants, nurse practitioners, and other health care professionals, may facilitate meeting the needs of preventive care for women. Providing patients with visuals, such as infographics (https://www.acog.org/Patients/FAQs/Annual-Well-Woman-Exam-Infographic and https://www.acog.org/Patients/Especially-for-Teens/21-Reasons-Infographic), can help women understand the scope of services obstetrician–gynecologists can provide.

### Comprehensive History and Physical Examination

A comprehensive history is one of the most important aspects of a well-woman visit. This history includes symptoms; medications; allergies; and medical, surgical, family, social, and gynecologic history, including questions on reproductive, sexual, and mental health (using screening tools as indicated). Taking a comprehensive history (specifically obtaining detailed information on symptoms and past medical and gynecologic history) will inform if certain components of the physical examination, including breast or pelvic examination, are indicated at that visit and will inform shared decision making for these examinations. The

**Table 1.** Sources for Recommended Preventive Services Without Patient Cost-Sharing Under the Affordable Care Act*

| Organization | Description of Organization, Group, or Panel | Type of Recommendations | Source |
|---|---|---|---|
| Advisory Committee on Immunization Practices | A panel selected by the Secretary of the U.S. Department of Health and Human Services to develop recommendations on the use of vaccines in the civilian population of the United States. The committee includes members with expertise in medicine and public health and a consumer representative providing the social and community perspective. | Recommended vaccinations for children, adolescents, and adults | https://www.cdc.gov/vaccines/hcp/acip-recs/index.html |
| Bright Futures† | Four multidisciplinary expert panels develop guidelines, led by the American Academy of Pediatrics | Evidence-informed primary care recommendations for children and adolescents aged 11–21 years | https://www.aap.org/en-us/Documents/periodicity_schedule.pdf |
| HRSA and IOM‡ Committee on Preventive Services for Women | A committee of specialists in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines | Coverage recommendations for well-woman care for those aged 10–65 years.<br>• Well-woman visits<br>• Screening for gestational diabetes<br>• Human papillomavirus testing<br>• Counseling for sexually transmitted infections<br>• Counseling and screening for human immunodeficiency virus<br>• Contraceptive methods and counseling<br>• Breastfeeding support, supplies, and counseling<br>• Screening and counseling for interpersonal and domestic violence | https://www.hrsa.gov/womensguidelines/index.html and http://nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx |
| U.S. Preventive Services Task Force§ | An independent panel of clinicians, specialists in health behavior, and methodologists who represent various disciplines and specialties (many with a background in women's health, including primary care physicians and nurses as well as obstetrician–gynecologists); selected through a nominative process. | Evidence-based counseling, screening, and preventive medication recommendations for children, adolescents, and adults.<br>• Grade A: high certainty that the net benefit of a service is substantial<br>• Grade B: high certainty that the net benefit is moderate or, when there is moderate certainty, that the net benefit is moderate or substantial.<br>• Both Grade A and Grade B: recommendations can be translated to mean that the service should be routinely offered as part of primary care for relevant individuals.<br>• Grade C: selectively offer or provide this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/<br>https://epss.ahrq.gov/ePSS/index.jsp |

(*continued*)

**Table 1.** Sources for Recommended Preventive Services Without Patient Cost-Sharing Under the Affordable Care Act* (*continued*)

| Organization | Description of Organization, Group, or Panel | Type of Recommendations | Source |
|---|---|---|---|
| Women's Preventive Services Initiative | Advisory Panel with representatives from the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Physicians, and the National Association of Nurse Practitioners in Women's Health | Recommendations for women's preventive health care services, including an update of HRSA and IOM‡ | https://www.womenspreventivehealth.org/ |

Abbreviations: HRSA, Health Resources and Services Administration; IOM, Institute of Medicine (now known as the National Academy of Medicine).

*Applies to nongrandfathered private insurance plans

†Hagan JF, Shaw JS, Duncan PM. Bright futures: guidelines for health supervision of infants, children, and adolescents, 4th edition. Elk Grove Village (IL): American Academy of Pediatrics; 2017.

‡The name of the Institute of Medicine was changed to the National Academy of Medicine, effective July 1, 2015.

§"Grade A" and "Grade B" recommendations only; The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, uses the U.S. Preventive Services Task Force. Breast cancer: screening, 2002 [archived]. Rockville (MD): USPSTF; 2015.

American College of Obstetricians and Gynecologists recommends that pelvic and breast examinations be performed when indicated by medical history or symptoms (7, 8). Some specific topics that are sometimes overlooked, but that should be addressed at well-woman visits throughout the lifespan, include bone health, vulvovaginal symptoms, and sexual health.

Family history should be used as a risk assessment tool and should be completed and updated regularly to ensure the most comprehensive assessment of a woman's personal risk factors (9). For example, the family history may be used to identify a woman at increased risk of cancer, allowing her to be referred for genetic testing, counseling, or both, and for further preventive care as indicated.

Certain risk factors and behaviors have a profound negative effect on the health of women and should be addressed during a well-woman visit. Smoking, poor diet, and lack of physical activity are associated with cardiovascular disease, type 2 diabetes, and multiple types of cancer, among other conditions that cause significant morbidity and are the leading causes of mortality in the United States (10). These behaviors also can contribute to conditions frequently treated by obstetrician–gynecologists (eg, menstrual irregularities; polycystic ovary syndrome; infertility; and endometrial, breast, and cervical cancer) and can increase the risk of maternal and surgical complications as well as adverse effects to future offspring (11). Obstetrician–gynecologists have the opportunity to counsel women about the effect of lifestyle choices on overall health, specifically reproductive health, and to guide them in decision-making related to behavior change, potential interventions, and treatment options, if indicated. The obstetrician–gynecologist can educate, screen, monitor, and treat women to reduce their risk of morbidity and mortality from cardiovascular disease, such as from myocardial infarction and stroke. All women should be screened for tobacco use and counseled about options for smoking cessation (12) as well as at-risk drinking and alcohol dependence (13). Women also should be screened for overweight and obesity, counseled, and offered treatment options or referral (14–16). The American College of Obstetricians and Gynecologists' Obesity Toolkit offers practical information for the obstetrician–gynecologist (https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Obesity-Toolkit).

Another key component of a well-woman visit for a reproductive-aged woman is the development and discussion of her reproductive life plan to ensure that medical testing and treatments provided are aligned with her current and future plans. A discussion of a reproductive life plan may include prepregnancy counseling, infertility assessment, or the full range of contraceptive options. The Centers for Disease Control and Prevention has published tools to assist health care providers in addressing a woman's family planning needs at all periods in her reproductive life (17). *Providing Quality Family Planning Services*, developed by the Centers for Disease Control and Prevention and the U.S. Office of Population Affairs, provides guidance on contraceptive services, prepregnancy health, achieving pregnancy, basic infertility services, and health care related to sexually transmitted infections (18, 19). Endorsed by the American College of Obstetricians and Gynecologists, the *U.S. Medical Eligibility Criteria for Contraceptive Use* and the *U.S. Selected Practice Recommendations for Contraceptive Use* offer important information on how best to provide patient-specific contraception counseling and management (20, 21). Obstetrician–gynecologists provide

care for women across the lifespan, and periodic well-woman visits are appropriate and necessary for perimenopausal women and postmenopausal women as well.

## Conclusion

Obstetrician–gynecologists have the opportunity to provide holistic care for their patients. This includes taking a comprehensive history, diagnosing and treating conditions that are identified with a comprehensive history and focused examinations, and providing evidence-based and evidence-informed clinical preventive services. Although components of a physical examination may not be required at a well-woman visit, obstetrician–gynecologists can play a critical role in engaging patients in shared decision making, encouraging and facilitating healthy behaviors, and counseling about a wide array of effective preventive health practices. There is great variability in how these services are offered among health care delivery systems, and obstetrician–gynecologists should work within their local systems to promote their role in providing primary and preventive care services for women.

## For More Information

The American College of Obstetricians and Gynecologists 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/WellWoman.

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 website, or the content of the resource. The resources may change without notice.

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Well-woman visit. ACOG Committee Opinion No. 755. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e181–86.

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# EXHIBIT E

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

asrm
American Society for Reproductive Medicine

# ACOG COMMITTEE OPINION

Number 762

**Committee on Gynecologic Practice**
**American Society for Reproductive Medicine**

*This Committee Opinion was developed jointly by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and the American Society for Reproductive Medicine in collaboration with committee member Daniel M. Breitkopf, MD and ASRM member Micah Hill, DO.*

# Prepregnancy Counseling

**ABSTRACT:** The goal of prepregnancy care is to reduce the risk of adverse health effects for the woman, fetus, and neonate by working with the woman to optimize health, address modifiable risk factors, and provide education about healthy pregnancy. All those planning to initiate a pregnancy should be counseled, including heterosexual, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and gender nonconforming individuals. Counseling can begin with the following question: "*Would you like to become pregnant in the next year?*" Prepregnancy counseling is appropriate whether the reproductive-aged patient is currently using contraception or planning pregnancy. Because health status and risk factors can change over time, prepregnancy counseling should occur several times during a woman's reproductive lifespan, increasing her opportunity for education and potentially maximizing her reproductive and pregnancy outcomes. Many chronic medical conditions such as diabetes, hypertension, psychiatric illness, and thyroid disease have implications for pregnancy outcomes and should be optimally managed before pregnancy. Counseling patients about optimal intervals between pregnancies may be helpful to reduce future complications. Assessment of the need for sexually transmitted infection screening should be performed at the time of prepregnancy counseling. Women who present for prepregnancy counseling should be offered screening for the same genetic conditions as recommended for pregnant women. All patients should be routinely asked about their use of alcohol, nicotine products, and drugs, including prescription opioids and other medications used for nonmedical reasons. Screening for intimate partner violence should occur during prepregnancy counseling. Female prepregnancy folic acid supplementation should be encouraged to reduce the risk of neural tube defects.

## Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) and the American Society for Reproductive Medicine (ASRM) make the following recommendations and conclusions:

- Any patient encounter with nonpregnant women or men with reproductive potential (eg, not post-hysterectomy or poststerilization) is an opportunity to counsel about wellness and healthy habits, which may improve reproductive and obstetric outcomes should they choose to reproduce.
- Counseling can begin with the following question: "*Would you like to become pregnant in the next year?*"
- The goal of prepregnancy care is to reduce the risk of adverse health effects for the woman, fetus, and neonate by working with the woman to optimize health, address modifiable risk factors, and provide education about healthy pregnancy.
- Women should be counseled to seek medical care before attempting to become pregnant or as soon as they believe they are pregnant to aid in correct dating and to be monitored for any medical conditions in which treatment should be modified during pregnancy.
- Many chronic medical conditions such as diabetes, hypertension, psychiatric illness, and thyroid disease

have implications for pregnancy outcomes and should be optimally managed before pregnancy.

- All prescription and nonprescription medications should be reviewed during prepregnancy counseling. This review also should include nutritional supplements and herbal products that patients may not consider to be medication use but could affect reproduction and pregnancy.
- Women who present for prepregnancy counseling should be offered screening for the same genetic conditions as recommended for pregnant women.
- Women of reproductive age should have their immunization status assessed annually for tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap); measles–mumps–rubella; hepatitis B; and varicella.
- All patients should receive an annual influenza vaccination; those women who are or will be pregnant during influenza season will have additional benefits.
- Assessment of the need for sexually transmitted infection (STI) screening should be performed at the time of prepregnancy counseling.
- Patients with potential exposure to certain infectious diseases, such as the Zika virus, should be counseled regarding travel restrictions and appropriate waiting time before attempting pregnancy.
- All patients should be routinely asked about their use of alcohol, nicotine products, and drugs, including prescription opioids and other medications used for nonmedical reasons.
- Screening for intimate partner violence should occur during prepregnancy counseling.
- Female prepregnancy folic acid supplementation should be encouraged to reduce the risk of neural tube defects (NTDs).
- Patients should be screened regarding their diet and vitamin supplements to confirm they are meeting recommended daily allowances for calcium, iron, vitamin A, vitamin $B_{12}$, vitamin B, vitamin D, and other nutrients.
- Patients should be encouraged to try to attain a body mass index (BMI) in the normal range before attempting pregnancy, because abnormal high or low BMI is associated with infertility and maternal and fetal pregnancy complications.

## Introduction

Obstetrician–gynecologists have a prime opportunity to improve maternal and fetal outcomes through prepregnancy counseling. Like a well-woman visit, the prepregnancy visit (when the patient presents to discuss a potential future pregnancy) provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks (1). The goal of prepregnancy care is to reduce the risk of adverse health effects for the woman, fetus, and neonate by working with the woman to optimize health, address modifiable risk factors, and provide education about healthy pregnancy. Prepregnancy counseling should include a review of a patient's immunizations, an assessment for immunity, and other screenings and tests, as appropriate. All those planning to initiate a pregnancy should be counseled, including heterosexual, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and gender nonconforming individuals. Pregnancy complications may be reduced by appropriate identification and mitigation of risk factors, while genetic screening may allow a couple to make informed decisions regarding family planning. Management of preexisting medical conditions may be optimized during the prepregnancy period, reducing the chances of pregnancy-related complications. Additionally, understanding aspects of patients' social context during prepregnancy counseling may identify ways to help improve prenatal care usage, including understanding barriers that patients may face when accessing health care.

## Timing of Prepregnancy Counseling

Direct screening for a patient's pregnancy intentions, as stated in the "One Key Question Initiative," is a core component of high-quality, primary preventive care services (2). Any patient encounter with nonpregnant women or men with reproductive potential (eg, not posthysterectomy or poststerilization) is an opportunity to counsel about wellness and healthy habits, which may improve reproductive and obstetric outcomes should they choose to reproduce. Counseling can begin with the following question: "*Would you like to become pregnant in the next year?*" Prepregnancy counseling is appropriate whether the reproductive-aged patient is currently using contraception or planning pregnancy. Because health status and risk factors can change over time, prepregnancy counseling should occur several times during a woman's reproductive lifespan, increasing her opportunity for education and potentially maximizing her reproductive and pregnancy outcomes. Additionally, prepregnancy counseling can be performed by the obstetrician–gynecologist of an infertile patient before referral to a reproductive endocrinologist, further streamlining patient education. The American College of Obstetricians and Gynecologists and ASRM support coverage for and access to recommended prepregnancy counseling and services as a core component of women's health care.

## Family Planning and Pregnancy Spacing

Family planning is a foundational aspect of prepregnancy counseling. Approximately 45% of the pregnancies

in the United States are unintended, and unintended pregnancy increases the risk of pregnancy complications (3). Education and enhanced awareness of the effect of age on fertility (4) and planning for family size are essential in counseling the patient who desires pregnancy. Counseling patients about optimal intervals between pregnancies may be helpful to reduce future complications. Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months (5, 6). Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing labor after cesarean (also referred to as trial of labor after cesarean) (7). The Centers for Disease Control and Prevention's (CDC) *U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use* (8, 9) can be used to facilitate evidence-based contraception counseling to meet an individual patient's family planning and pregnancy spacing needs. For infertile women planning to use assisted reproductive technology to become pregnant, a pregnancy interval less than 18 months but greater than 6 months may be advisable (10).

An ovulatory woman who is younger than 35 years who desires pregnancy and who does not have a clearly identifiable risk factor for infertility should be expeditiously evaluated if she has not become pregnant after 12 months of unprotected intercourse. A woman who is 36 years and older should be evaluated after 6 months. A comprehensive evaluation should be conducted and treatment initiated by a heath care provider with adequate training and expertise. For anovulatory women and those with a clearly identifiable risk factor for infertility, strong consideration should be given to evaluation and treatment upon presentation.

Referral to a fertility specialist for males and females may be considered at any point if the infertility etiology, indicated treatment, or attempted treatment failures exceeds the expertise of the obstetrician–gynecologist. Monthly ovulation is likely in women with regular and predictable menses with no greater than 2–3-day variance within a range of 25–35 days. For example, a woman with cycles every 26–28 days is likely ovulatory, while a woman with cycles of 25, 34, 26, then 35 days is likely not ovulatory. Patients desiring pregnancy should be counseled that the fertile window is having sexual intercourse in the 3–4 days before ovulation and that intercourse every 1–2 days yields the highest pregnancy rates (11). Patients may inquire about ovulation predictor kits or electronic apps for fertility. These tools vary in quality, and data on their usefulness are limited (12).

## Review of Medical, Surgical, and Psychiatric Histories

Many chronic medical conditions such as diabetes, hypertension, psychiatric illness, and thyroid disease have implications for pregnancy outcomes and should be optimally managed before pregnancy (Table 1). Consideration may be given to referral to a maternal–fetal medicine specialist. Data are insufficient to recommend for or against universal screening for subclinical thyroid disease; however, screening may be appropriate for patients with risk factors (eg, age greater than 30 years, morbid obesity, history of pregnancy loss, preterm delivery, or infertility) (13).

## Review of Current Medications

All prescription and nonprescription medications should be reviewed during prepregnancy counseling. This review also should include nutritional supplements and herbal products that patients may not consider to be medication use but could affect reproduction and pregnancy. The pregnancy safety of each medication and supplement should be discussed. Medications with potential teratogenicity should be reviewed and the specific risks of each individual medication discussed in detail. The importance of reliable contraception should be emphasized when a patient is taking potentially teratogenic medications. For a patient who desires pregnancy, potentially teratogenic medication should be adjusted in collaboration with the prescribing health care provider before the patient discontinues contraception. The lowest effective doses of the safest medications should be used whenever it is medically reasonable to do so. For information on the effects of medications used to manage depression during pregnancy, see *The Management of Depression During Pregnancy*, a report jointly developed by ACOG and the American Psychiatric Association (14). Male partners should be screened for the use of androgens, such as testosterone. Androgen use is associated with azoospermia and infertility in males, which may be reversible in some cases with cessation (15, 16).

## Review of Family and Genetic History

A genetic and family history of the patient and her partner should be obtained (17–20). This may include family history of genetic disorders, birth defects, mental disorders, and breast, ovarian, uterine, and colon cancer. When any genetic disease carrier status is diagnosed in one or both partners, full medical records review and genetic counseling are recommended to educate the patient on the effects of the disease and the potential options for prepregnancy and early pregnancy screening of offspring. Women who present for prepregnancy counseling should be offered screening for the same genetic conditions as recommended for pregnant women, though insurance coverage for screening may be lacking and may be a barrier for some patients. Screening in the prepregnancy period offers the additional advantages of identifying, before pregnancy, couples at risk of having children with genetic diseases and offering appropriate testing to optimize patient education, counseling, and options for achieving pregnancy. Couples at risk of having children with specific genetic

**Table 1.** Major Medical Conditions That Affect Pregnancy

| Condition | Associated Risks | Treatment | Goals |
|---|---|---|---|
| Pregestational diabetes mellitus | Congenital anomalies and pregnancy-related complications | The importance of euglycemic control before and during pregnancy should be emphasized. Optimal weight management also should be discussed in the context of managing blood sugars. Consideration should be given to testing for underlying vasculopathy with retinal examination, 24-hour urine protein testing, and electrocardiography. Thyroid dysfunction is common in women with pregestational diabetes; therefore, screening for thyroid function should be performed. | $HbA_{1c}$ <6.5% (48 mmol/mol), to reduce the risk of congenital anomalies* |
| Chronic hypertension | Preeclampsia and intrauterine growth restriction | Assessment of the teratogenic risk of hypertensive medications should be performed. Angiotensin converting enzyme inhibitors and angiotensin receptor blockers are contraindicated in pregnancy. Consideration should be given to testing for ventricular hypertrophy, retinopathy, and renal disease for women with longstanding or uncontrolled hypertension.† | — |
| Hypothyroidism (untreated) | Spontaneous abortion, preeclampsia, preterm birth, placental abruption, and fetal death | Screening based on risk factors, rather than universal screening, should be considered for patients who are planning pregnancy.†‡ | Treat if thyrotropin (previously thyroid-stimulating hormone) is above the upper level of normal. |
| Bariatric surgery | A period of rapid weight loss typically occurs in the first 12–24 months postoperatively. During this period, pregnancy is less desirable because of potential effects on fetal growth. | Contraceptive counseling during the postoperative period is important because the risk of oral contraceptive failure in patients who have bariatric surgery with a malabsorptive component is increased. Counseling regarding the benefits of nonoral contraceptive or LARC methods is recommended.§ | — |
| Mood disorders | Impaired maternal infant bonding, risk of maternal self-harm, or neglect. Antidepressants and antipsychotic medications increase anovulation and decrease fecundability.‖¶ | Women with established depression or anxiety should be counseled regarding the risks of these conditions in pregnancy and the risks and benefits of treatment. The risk of relapse for bipolar disorder is higher in pregnancy, thus women with this condition should establish a strategy for managing relapse while planning for a pregnancy. Women with schizophrenia should receive counseling regarding the risks of the condition on pregnancy and the importance of establishing a plan for managing the condition during pregnancy. | — |

(*Continued*)

**Table 1.** Major Medical Conditions That Affect Pregnancy (*continued*)

| Condition | Associated Risks | Treatment | Goals |
|---|---|---|---|
| Human immunodeficiency virus (HIV) | Vertical transmission | Women with HIV should receive prepregnancy counseling, including a discussion of interventions to reduce vertical transmission, methods for optimizing long-term health, and the few potential effects of antiretroviral medications on the fetus.[#] Antiretroviral therapy should be instituted before pregnancy and continued during pregnancy. Medications should not be discontinued during the first trimester. Women should continue seeing their HIV health care providers.<br><br>Serodiscordant couples should receive information about the risk of sexual and perinatal transmission and about safer methods for achieving pregnancy.[**]<br><br>Women at the highest risk of acquiring HIV infection (eg, a woman not infected with HIV with a male sexual partner who is known to be infected with HIV) should be considered candidates for preexposure prophylaxis. The use of daily oral preexposure prophylaxis during pregnancy and lactation for women without HIV with HIV-infected partners has had limited study; however, the drug combination of tenofovir and emtricitabine is commonly used during pregnancy and has a reassuring safety profile.[††] | Viral load should be undetectable and patients should be co-managed with an HIV health care provider. |
| Thrombophilia | DVT or PE during pregnancy or in the postpartum period | Consider and plan for thromboprophylaxis during pregnancy.[‡‡] | — |
| Previous pregnancy complications | Recurrence in future pregnancies | Assess and counsel on risk of recurrence. | — |

Abbreviations: DVT, deep vein thrombosis; $HbA_{1c}$, hemoglobin $A_{1c}$; HIV, human immunodeficiency virus; LARC, long-acting reversible contraception; PE, pulmonary embolism.

*Management of diabetes in pregnancy: standards of medical care in diabetes—2018. American Diabetes Association. Diabetes Care 2018;41:S137–43.

†Garber JR, Cobin RH, Gharib H, Hennessey JV, Klein I, Mechanick JI, et al. Clinical practice guidelines for hypothyroidism in adults: cosponsored by the American Association of Clinical Endocrinologists and the American Thyroid Association. American Association of Clinical Endocrinologists and American Thyroid Association Taskforce on Hypothyroidism in Adults. [published errata appear in Thyroid 2013;23:251; Thyroid 2013;23:129]. Thyroid 2012;22:1200–35.

‡Subclinical hypothyroidism in the infertile female population: a guideline. Practice Committee of the American Society for Reproductive Medicine. Fertil Steril 2015;104:545–53.

§Bariatric surgery and pregnancy. ACOG Practice Bulletin No. 105. American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;113:1405–13.

‖Casilla-Lennon MM, Meltzer-Brody S, Steiner AZ. The effect of antidepressants on fertility. Am J Obstet Gynecol 2016;215:314.e1–5.

¶Besnard I, Auclair V, Callery G, Gabriel-Bordenave C, Roberge C. Antipsychotic-drug-induced hyperprolactinemia: physiopathology, clinical features and guidance. Encephale 2014;40:86–94.

#Gynecologic care for women and adolescents with human immunodeficiency virus. Practice Bulletin No. 167. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e89–110.

**Recommendations for reducing the risk of viral transmission during fertility treatment with the use of autologous gametes: a committee opinion. Practice Committee of American Society for Reproductive Medicine. Fertil Steril 2013;99:340–6.

††Preexposure prophylaxis for the prevention of human immunodeficiency virus. Committee Opinion No. 595. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1133–6.

‡‡Inherited thrombophilias in pregnancy. Practice Bulletin No. 138. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:706–17.

diseases can be counseled about the disease inheritance and course and offered referral for potential interventions, such as preimplantation genetic testing. See Table 2 for counseling and screening recommendations.

## Immunizations

Women of reproductive age should have their immunization status assessed annually for Tdap, measles–mumps–rubella, hepatitis B, and varicella. All patients should receive an annual influenza vaccination; those women who are or will be pregnant during influenza season will have additional benefits (21). Adult women who have never received a dose of Tdap or whose Tdap vaccination status is unknown should receive a single dose, as recommended for nonpregnant adults by the CDC. Additionally, Tdap vaccine should be given to all women during each pregnancy between 27–36 weeks regardless of prepregnancy immunization history. Human papillomavirus vaccination (HPV) and cervical cancer screening should be performed in accordance with current guidelines. The HPV vaccination currently is not recommended during pregnancy but should not be avoided or delayed because a woman may want to become pregnant or may be actively trying to become pregnant. If the HPV vaccine series is started and a patient then becomes pregnant, completion of the vaccine series should be delayed until that pregnancy is completed (22, 23). Vaccinations for rubella and varicella should be given at least 28 days before pregnancy, or in the postpartum period if not previously given. Because two doses of the varicella vaccine are recommended, and the CDC recommends that women not become pregnant for 1 month after being vaccinated, a woman who desires pregnancy should begin vaccination 2 months before attempting pregnancy (24). Some advanced-reproductive-age patients may wish to reproduce, and those age 50 years and older should also be vaccinated against herpes zoster (25). The need for other immuni-

**Table 2.** Family and Genetic History Counseling and Screening Recommendations

| Condition | Who to Counsel | Considerations |
|---|---|---|
| Canavan disease | Carrier screening for those of Ashkenazi Jewish descent.<br><br>When only one partner is of Ashkenazi Jewish descent, that individual should be offered screening first. If it is determined that this individual is a carrier, the other partner should be offered screening.* | — |
| Cystic fibrosis | All women who are considering pregnancy* | — |
| Familial dysautonomia | Carrier screening for those of Ashkenazi Jewish descent.<br><br>When only one partner is of Ashkenazi Jewish descent, that individual should be offered screening first. If it is determined that this individual is a carrier, the other partner should be offered screening.* | — |
| Fragile X | Any woman with a family history of fragile X-related disorders or intellectual disability suggestive of fragile X syndrome and any woman younger than the age of 40 with unexplained ovarian insufficiency.* | Women without risk factors who request fragile X screening may be tested after informed consent. |
| Hemoglobinopathies | Couples at risk of having a child with thalassemia or sickle cell disease should be offered genetic counseling to review prenatal testing and reproduction options.† | — |
| Spinal muscular atrophy | All women who are considering pregnancy | — |
| Tay–Sachs disease | If either member of the couple is of Ashkenazi Jewish, French-Canadian, or Cajun descent; those with a family history consistent with Tay-Sachs disease also should be offered screening.* | Biochemical testing can be altered in women who are pregnant or using oral contraceptive pills, so leukocyte testing must be used in these patients.* |

*Carrier screening for genetic conditions. Committee Opinion No. 691. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e41–55.

†Hemoglobinopathies in pregnancy. Practice Bulletin No. 78. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;109:229–37.

zations should be assessed during a prepregnancy visit by reviewing health, lifestyle, and occupational risks of other infections and administering required doses as indicated (26). The CDC's Advisory Committee on Immunization Practice immunization schedules provide the most current information on immunization recommendations (27).

## Infectious Disease Screening

Assessment of the need for STI screening should be performed at the time of prepregnancy counseling. Guidance on recommended STI screening is available from the CDC (28) and ASRM (29). Gonorrhea, chlamydial infection, syphilis, and human immunodeficiency virus (HIV) should be screened for based on age and risk factors. Counseling to reduce STI risk should be provided (26). For current guidance on hepatitis C screening for nonpregnant women, see the CDC's recommendations (30). Those at high risk of tuberculosis should be screened and treated appropriately before pregnancy (26). Exposure to toxoplasmosis should be assessed and avoidance counseled. Much attention has been given to educational programs to reduce maternal *Toxoplasma gondii* infection and, thus, congenital toxoplasmosis. However, despite the successes demonstrated in some observational studies, several reviews (including a Cochrane review) suggest that weaknesses in study design prevent the conclusion that such strategies effectively reduce congenital toxoplasmosis (31). Patients with potential exposure to certain infectious diseases, such as the Zika virus, should be counseled regarding travel restrictions and appropriate waiting time before attempting pregnancy. Obstetrician–gynecologists may ask the patient about recent or upcoming travel history for herself and her partner. The CDC offers up-to-date guidance on Zika precautions (32) and other infectious diseases (33). Information and guidance on the Zika virus also is available from ACOG (34) and ASRM (35).

## Individuals with Human Immunodeficiency Virus

All reproductive-aged patients living with HIV should receive prepregnancy counseling if considering pregnancy (36). Prepregnancy counseling should include a detailed discussion of interventions to reduce the risk of perinatal transmission, ways to optimize long-term health, and the possible effects of antiretroviral medications on the fetus. Any HIV-infected patients who are contemplating pregnancy should be counseled that they should be receiving treatment with antiretroviral therapy, with the goal of a plasma viral load suppressed to an undetectable level before achieving pregnancy. Artificial insemination is the safest way for an HIV-infected couple to become pregnant while minimizing the risk of HIV transmission to an HIV-negative partner (37). Prepregnancy administration of antiretroviral preexposure prophylaxis for HIV-uninfected partners may offer an additional tool to reduce the risk of sexual transmission (38). A non-HIV-infected woman with an HIV-infected male partner with whom she wants to achieve pregnancy should be offered a referral to a subspecialist with the requisite training and experience in infectious disease or reproductive endocrinology and infertility for counseling. Like prepregnancy counseling for non-HIV-infected women, the goals for HIV-infected women are to improve the health of the women before pregnancy and to identify risk factors for adverse maternal and fetal outcomes. Safe sex practices and avoidance of STIs should be discussed, and both partners should be screened for STIs, which should be treated if present. The choice of antiretroviral therapy in women of childbearing capacity should take into consideration the regimen's effectiveness, the women's hepatitis B status, the teratogenic potential of the medications, potential drug interactions, and possible maternal and fetal adverse outcomes (37). See ACOG's Practice Bulletin No. 167, *Gynecologic Care for Women and Adolescents With Human Immunodeficiency Virus*, for more information.

## Substance Use Assessment

All patients should be routinely asked about their use of alcohol, nicotine products, and drugs, including prescription opioids and other medications used for nonmedical reasons (39, 40). Adverse effects associated with smoking during pregnancy include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function (41, 42), preterm prelabor rupture of membranes (also referred to as premature rupture of membranes) (43, 44), low birth weight, perinatal mortality (41), and ectopic pregnancy (41). Children born to women who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity (45–47). Pregnancy appears to motivate women to stop smoking; 46% of prepregnancy smokers quit smoking directly before or during pregnancy (48); however, women who are unable to quit during pregnancy likely have a tobacco use disorder (49). Effective strategies for tobacco cessation should be employed, such as the 5A's intervention model (40).

Alcohol use patterns should be determined and patients counseled that there is no safe level or type of alcohol use during pregnancy. Fetal alcohol spectrum disorders are the most severe result of prenatal drinking and are associated with central nervous system abnormalities, growth defects, and facial dysmorphia. Alcohol-related birth defects include growth deformities, facial abnormalities, central nervous system impairment, behavioral disorders, and impaired intellectual development (50). Alcohol can affect a fetus at any stage of pregnancy, and the cognitive defects and behavioral problems that result from prenatal alcohol exposure are lifelong. Brief behavioral counseling interventions can reduce the risk of alcohol-exposed pregnancies (50–52).

Marijuana is used by an estimated 2–5% of pregnant women. Several states have recently legalized marijuana for recreational use or medicinal purposes. Marijuana may have harmful effects on reproduction and the effect of smoking marijuana during pregnancy may be as harmful as tobacco (53). Patients who are contemplating pregnancy should be encouraged to discontinue marijuana use. Patients contemplating pregnancy should be screened for opioid use and opioid use disorder. See ACOG Committee Opinion No. 711, *Opioid Use and Opioid Use Disorder in Pregnancy*, for validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger) (39).

## Exposure to Violence, Intimate Partner Violence, and Reproductive and Sexual Coercion

More than one in three women in the United States have experienced rape, physical violence, or stalking by an intimate partner in their lifetime (54). Screening for intimate partner violence should occur during prepregnancy counseling. The discussion regarding intimate partner violence should be framed by indicating that all patients in the practice are screened. Assurances of privacy and confidentiality are important components of intimate partner violence screening; however, some state laws place mandatory reporting requirements on health care providers for certain types of injuries or disclosures and for certain groups of patients. Therefore, it also is important to inform patients about what it is necessary, under state laws, for physicians to disclose to authorities. Sample questions to begin the conversation are provided in ACOG Committee Opinion No. 518, *Intimate Partner Violence* (54). Self-administered questionnaires are as effective as a physician interview in screening for intimate partner violence and reproductive coercion. Sexual coercion includes a range of behavior that a partner may use related to sexual decision making to pressure or coerce a person to have sex without using physical force (55). The most common forms of reproductive coercion include sabotage of contraceptive methods, pregnancy coercion, and pregnancy pressure (56). If ongoing abuse is identified, assessment of the immediate safety of the patient and her family should be ascertained and community resources for victims should be provided.

## Assess Nutritional Status

Fruits, vegetables, and daily multivitamins are good sources of antioxidants and vitamins that may assist in reproductive health for males and females. Female prepregnancy folic acid supplementation should be encouraged to reduce the risk of NTDs. All women of reproductive age (15–45 years) should take folic acid supplementation. For average-risk women, supplementation with 400 micrograms per day is adequate. Women at increased risk of NTDs, including women with a prior pregnancy with an NTD or women with seizure disorders, should be counseled to take 4 mg of folic acid daily (57). Because of the risk of vitamin A toxicity, women who need additional folic acid should not take additional prenatal vitamins; instead, women at higher risk of NTDs should be prescribed additional folic acid supplements. Most prenatal multivitamins contain adequate amounts of folic acid for average-risk-women (58). Prenatal vitamins use also is associated with a lower risk of miscarriage (59). Moderate caffeine consumption (less than 200 mg per day) does not appear to be a major contributing factor in miscarriage or preterm birth (60).

Patients should be screened regarding their diet and vitamin supplements to confirm they are meeting recommended daily allowances for calcium, iron, vitamin A, vitamin $B_{12}$, vitamin B, vitamin D, and other nutrients. The U.S. Department of Agriculture offers tools for self-dietary assessment (61), and the Office of Disease Prevention and Health Promotion offers clinical guidance (62). Recommended daily allowances are available in *Guidelines for Perinatal Care*, Eighth Edition, from ACOG and the American Academy of Pediatrics (63). Consumption of fish with high mercury levels should be discouraged (64, 65) and the U.S. Food and Drug Administration provides a patient resource for fish to avoid (66). Maternal listeria infection has been associated with preterm delivery and other obstetric and neonatal complications, and pregnant women should be advised to avoid eating foods with a high risk of listeria contamination. See the CDC guidance for foods to avoid (67). Patients who are at risk of eating disorders should be screened and counseled (63). Patients with malabsorptive gastrointestinal disease, bariatric surgery, or those on a vegan diet may require vitamin and mineral supplementation.

## Achieving and Maintaining a Healthy Body Weight

Patients should be encouraged to try to attain a BMI in the normal range before attempting pregnancy because abnormal high or low BMI is associated with infertility and maternal and fetal pregnancy complications (68). The reproductive risks of obesity include, but are not limited to, infertility, miscarriage, birth defects, preterm delivery, gestational diabetes, gestational hypertension, cesarean delivery, and thromboembolic events (69, 70). Obesity also increases the risk of nonreproductive diseases, including stroke, heart disease, certain types of cancer, arthritis, high cholesterol, hypertension, and diabetes (71). Pregnant women with low BMI are at risk of having small-for-gestational-age fetuses and low-birthweight infants (72). Ideally, weight should be optimized before a woman attempts to becoming pregnant (70), although the health benefits of postponing pregnancy need to be balanced against reduced fecundity with female aging (4, 69).

## Assess Exercise and Physical Activity

Regular physical exercise improves cardiovascular health, reduces obesity and associated medical comorbidities, and improves longevity. Patients should exercise moderately at least 30 minutes a day, 5 days a week, for a minimum of 150 minutes of moderate exercise per week (73). These levels of exercise are recommended prepregnancy, during pregnancy, and in postpartum women. Dietary modifications in concert with exercise produce greater weight loss than exercise alone (73). Compared with their nonathlete peers, competitive athletes require frequent and closer supervision because they tend to maintain a more strenuous training schedule throughout pregnancy and resume high-intensity postpartum training sooner. Competitive athletes should pay particular attention to avoiding hyperthermia, maintaining proper hydration, and sustaining adequate caloric intake to prevent weight loss that may adversely affect fetal growth (73).

## Assess for Teratogens and Environmental and Occupational Exposures

Mounting and robust evidence suggests there are reproductive and pregnancy risks associated with environmental pollutants, workplace teratogens, and endocrine disruptors. By the time a woman presents with pregnancy, disruptions of organogenesis may have already occurred. For these reasons, prepregnancy patient history and identification of exposures are encouraged (74). If exposures are identified, patients can be educated regarding the avoidance of exposure to toxic agents and, when necessary, referred to occupational medicine programs. Exposures can occur both at home (eg, plastics with bisphenol-A, pesticides, lead paint, asbestos) and at work. Employment sectors at particular risk of potentially hazardous exposures during pregnancy include agriculture (pesticides), manufacturing (organic solvents and heavy metals), dry cleaning (solvents), and health care (biologics and radiation) (75). See the For More Information section for additional resources.

## Pregnancy Dating

Women should be counseled to seek medical care before attempting to become pregnant or as soon as they believe they are pregnant to aid in correct dating and to be monitored for any medical conditions in which treatment should be modified during pregnancy. Correct first-trimester pregnancy dating provides value in managing potential subsequent pregnancy complications and indications for delivery.

## For More Information

The American College of Obstetricians and Gynecologists 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/PrepregnancyCounseling.

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 website, or the content of the resource. The resources may change without notice.

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Prepregnancy counseling. ACOG Committee Opinion No. 762. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e78–89.

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# EXHIBIT F

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

# ACOG COMMITTEE OPINION

Number 777

*(Replaces Committee Opinion Number 592, April 2014)*

**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 in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD.*

# Sexual Assault

**ABSTRACT:** Sexual violence continues to be a major public health problem affecting millions of adults and children in the United States. Medical consequences of sexual assault include sexually transmitted infections; mental health conditions, including posttraumatic stress disorder; and risk of unintended pregnancy in reproductive-aged survivors of sexual assault. Obstetrician–gynecologists and other women's health care providers play a key role in the evaluation and management of sexual assault survivors and should screen routinely for a history of sexual assault. When sexual violence is identified, individuals should receive appropriate and timely care. A clinician who examines sexual assault survivors in the acute-care setting has a responsibility to comply with state and local statutory or policy requirements for the use of evidence-gathering kits. This document has been updated to include model screening protocols and questions, relevant guidelines from other medical associations, trauma-informed care, and additional guidance regarding acute evaluation of survivors and evidence-gathering kits.

## Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions regarding sexual violence:

- Sexual assault and rape are pervasive problems in the United States, creating a major effect on public health.
- Obstetrician–gynecologists and other women's health care providers should screen all women for a history of sexual assault.
- Clinicians who evaluate survivors of sexual assault in the acute phase must comply with certain medical and legal requirements.
- Clinicians should recognize the short-term and long-term health consequences of sexual assault, such as infection, pregnancy, and mental health conditions and manage them appropriately.
- Clinicians should incorporate a trauma-informed care framework when assessing the needs of sexual assault survivors.

## Definitions

The terms "rape" and "sexual assault" are sometimes used interchangeably, and the legal definitions of both terms vary from state to state. Specifically, sexual assault is a crime of violence and aggression and encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape (1). *Rape*, as re-defined by the Federal Bureau of Investigation in 2013, is the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. This definition notably excludes any gender of victim and perpetrator and any reference to force. The definition acknowledges that rape and sexual assault occur in situations in which consent is not given, such as situations of intoxication or when individuals are otherwise mentally or physically incapable of demonstrating consent (2). Sexual assault and rape often further are characterized to include acquaintance rape, date rape, statutory rape, child sexual abuse, and incest. These terms generally relate to the age of the victim and the relationship to the abuser.

Acquaintance rape and date rape refer to sexual assaults committed by someone the victim knows. When the perpetrator is a family member of the victim, the assault is defined as *incest*. Statutory rape refers to consensual sexual intercourse with an individual younger

than a specific age. The age at which an adolescent may consent to sexual intercourse varies by state and generally is 16–18 years. Some states allow for consent at ages younger than 16 years when the partner is close in age. Sexual assault that occurs in childhood, defined by most states as younger than 14 years, is considered child abuse. *Sexual abuse* is further defined by the Child Abuse and Prevention Act as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children" (3). The scope of this Committee Opinion does not include childhood sexual assault. Please refer to guidelines from the American Academy of Pediatrics, *The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected* (http://pediatrics.aappublications.org/content/132/2/e558.long) (4); North American Society for Pediatric and Adolescent Gynecology's *Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused* (https://www.sciencedirect.com/science/article/pii/S1083318815000303); and the American College of Obstetricians and Gynecologists' Committee Opinion No. 498, Adult Manifestations of Childhood Sexual Abuse, for more information (4–6).

## Incidence and Prevalence

Sexual assault and rape are pervasive problems in the United States, creating a major effect on public health. An estimated 1.47 million rape-related physical assaults occur against women annually (7). Approximately one in five U.S. women (19%, or an estimated 23 million women) surveyed reported that they had been victims of a completed or attempted rape during their lifetime (7). Nearly 80% reported that they were first raped before age 25 years, and 41% reported that they were raped before age 18 years (7). Adolescents are more likely to be assaulted repeatedly and victimized in incestuous relationships (6). Minority women experience a higher prevalence of estimates of rape. A total of 32% of multiracial women, 29% of American Indian/Alaska Native women, 21% of non-Hispanic black women, 20% of non-Hispanic white women, 15% of Hispanic women, and 10% of Asian/Pacific Islander women have experienced rape at some point during their lifetime. Among female sexual assault survivors, 47% reported that at least one perpetrator was a current or former intimate partner, 45% reported an acquaintance, 13% reported a family member, and 13% reported a stranger (7). Female veterans experience increased rates of sexual assault during their time in the military, as well as during civilian life, compared with their civilian counterparts. They are eligible to receive lifetime care at any Veterans Health Administration facility for health problems related to military sexual assault (8).

## Medical Consequences of Sexual Assault

Negative health consequences from sexual victimization can be short-term and long-term. Acute traumatic injuries of sexual assault include scratches, bruises, and welts. Some women sustain more extensive injuries such as fractures, head and facial trauma, lacerations, bullet wounds, or even death. Survivors of sexual assault may sustain traumatic injuries to the vulva or vagina severe enough to require surgical intervention. The risk of injury increases for adult female rape survivors in the following situations: the perpetrator is a current or former intimate partner; the rape occurs in the victim's or perpetrator's home; the rape is completed; the perpetrator threatens harm to the victim or another; a gun, knife, or other weapon is used during the assault; or the perpetrator is using drugs or alcohol at the time of the assault (9).

Sexual assault may lead to pregnancy. The national rape-related pregnancy rate is approximately 5% per rape among women aged 12–45 years, or approximately 32,000 pregnancies resulting from rape each year (10). Pregnancy rates are especially high among adolescent sexual assault survivors because of their relatively low use of contraception and higher baseline fertility. When rape results in pregnancy, women are more likely to choose pregnancy termination than continuation (10).

Various long-term health effects are associated with female sexual assault. Increases in patient-reported physical symptoms, diminished levels of social function, alterations in health perceptions, and decreased quality of life are sequelae of childhood and adult sexual abuse (11–12). Many women do not discuss a history of sexual assault spontaneously but may present with chronic pelvic pain, dysmenorrhea, and sexual dysfunction more often than those without such a history (13). Additional information on adult manifestations of childhood sexual abuse is available elsewhere (6). Clinicians should recognize the short-term and long-term health consequences of sexual assault, such as infection, pregnancy, and mental health conditions and manage them appropriately.

## Psychological and Mental Health Consequences of Sexual Assault

An individual who is sexually assaulted loses control over her life during the period of the assault. After the assault, a rape-trauma syndrome often occurs. The acute, or disorganization phase (the first phase), may last for days to weeks and is characterized by physical reactions such as generalized pain throughout the body, eating and sleeping disturbances, and emotional reactions such as anger, fear, anxiety, guilt, humiliation, embarrassment, self-blame, and mood swings (1, 14). The delayed, or organization, phase (the next phase), is characterized

by flashbacks, nightmares, and phobias as well as somatic and gynecologic symptoms. This phase often occurs in the weeks and months after the event and may involve major life adjustments (1, 14).

Posttraumatic stress disorder is a long-term consequence of sexual assault. Posttraumatic stress disorder is characterized by a symptom cluster involving re-experiencing the trauma, avoidance, and a state of hyperarousal (15). Symptoms may not appear for months or even years after a traumatic experience.

Alcohol abuse, including binge drinking, and illicit drug use and dependence have long-term associations with sexual assault. In a survey of women seeking substance use disorder treatment, prevalence rates of completed rape or other types of sexual assault were 64.2% and 44.8%, respectively (16).

## Incorporation of Trauma-Informed Care

Traumatic life events are widespread and encompass exposure to a variety of interpersonal violence scenarios, including sexual assault. The trauma experienced by individuals can have lasting adverse effects on their functioning and mental, physical, social, and emotional well-being (17). The trauma-informed approach to care uses a framework that acknowledges the effect of trauma, recognizes signs and symptoms of trauma, responds by integrating knowledge about trauma into practices, and seeks to resist retraumatization. The key principles of trauma-informed care include ensuring physical and emotional safety, maximizing trustworthiness, prioritizing individual choice and control, empowering individuals, and encouraging peer support (17). This framework is particularly relevant to provision of care to sexual assault survivors and can help optimize the patient–provider relationship, improve health outcomes, and reduce long lasting burdens of trauma. Clinicians should incorporate a trauma-informed care framework when assessing the needs of sexual assault survivors.

## Roles and Responsibilities of Clinicians

The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other women's health care providers screen all women for a history of sexual assault, paying particular attention to those who report pelvic pain, dysmenorrhea, or sexual dysfunction (18). Model screening protocols and questions have been developed to assist clinics (see Box 1 and Box 2).

Early identification of survivors of sexual assault can lead to prevention of long-term and persistent physical and mental health consequences of abuse. When a history of sexual abuse is disclosed, the clinician can expect that various health care procedures, such as pelvic, rectal, breast, and endovaginal ultrasonographic examinations, may trigger panic and anxiety. Such reactions may stem from posttraumatic stress disorder and may have a connection with more remote events. Clinicians should screen women with a history of sexual assault for substance use disorder and, conversely, also should screen women with a history of substance use disorder for a history of sexual assault. Counseling can help sexual assault survivors understand their psychologic and physical responses, thereby diminishing the associated symptoms (14).

Many hospitals have implemented programs to provide acute medical and evidentiary examinations for sexual assault victims by Sexual Assault Nurse Examiners (SANEs) or Sexual Assault Forensic Examiners (SAFEs). These individuals receive specialized education and clinical preparation in the care of survivors of sexual assault and can perform medical forensic examinations that meet standard criteria of assessment. When there is no designated hospital program, a specialized examiner can be located through the International Association of Forensic Nurses at https://www.forensicnurses.org/search/custom.asp?id=2093 (19).

In some settings obstetrician–gynecologists remain the first point of contact for the evaluation and care of sexual assault survivors. Clinicians who evaluate survivors of sexual assault in the acute phase must comply with certain medical and legal requirements (see Box 3). When called on to perform a sexual assault examination,

**Box 1. SAVE Model Protocol**

SCREEN all patients for sexual violence
ASK direct questions in a nonjudgmental way
VALIDATE the patient
EVALUATE, educate, and refer

Modified from Florida Council Against Sexual Violence. How to screen your patients for sexual assault: a guide for health care professionals. Tallahassee (FL): FCASV; 2012.

**Box 2. Sample Sexual Assault Screening Questions**

- Has anyone ever touched you against your will or without your consent?
- Have you ever been forced or pressured to engage in sexual activities when you did not want to?
- Have you ever had unwanted sex while under the influence of alcohol or drugs?
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to sexual activities?
- Is your visit today because of a sexual experience you did not want to happen?

the clinician who has no experience or limited experience should request assistance from trained hospital personnel to ensure appropriate evidence collection. If trained personnel are unavailable, a detailed protocol from the U.S. Department of Justice's Office of Violence Against Women titled "A National Protocol for Sexual Assault Medical Forensic Examinations of Adults/Adolescents" may be consulted at https://www.forensicnurses.org/search/custom.asp?id=2093 (20). Technical assistance and clinical guidance also are available for clinicians serving assault victims through the SAFE Technical Assistance program at https://www.safeta.org (21). Innovative alternatives, such as the use of video conferencing technology, also are being developed to assist clinicians in remote areas or with limited resources. Improper evidence collection, including a break in the chain of custody and incorrect handling of samples, virtually eliminates the option to prosecute the case, so care must be taken.

The clinician conducting an evidentiary evaluation of a sexual assault victim must comply with state and local statutory or policy requirements involving the use of evidence gathering collection kits. These requirements can be found by contacting local law enforcement agencies. In the event such regulations cannot be found, national best practices for sexual assault kits have been developed by the U.S. Department of Justice (22). Sexual assault survivors who communicate with a physician's office, emergency department, or clinic before evaluation should be encouraged to go to a medical facility immediately and told not to bathe, change clothes, douche, urinate, defecate, wash out the mouth, clean fingernails, smoke, eat, or drink. Many jurisdictions use a 72-hour cutoff time for collection of evidence in a sexual assault case, whereas some have extended the time to 1 week. When collecting evidentiary materials, clinicians should comply with the required timeframe within their jurisdiction (20); however, if an assault is reported outside of the time limit of a particular jurisdiction, clinicians still should perform an examination and provide subsequent clinical management, as appropriate.

Before initiating a medical forensic examination, consent for the medical evaluation and for evidence collection and release must be obtained from the sexual assault victim. A complete history of pertinent information is imperative. Details of the assault, including time between the assault and the evaluation and specifics of any injuries, should be documented. Relevant medical history, including obstetric and gynecologic conditions and current pregnancy or risk of pregnancy, should be recorded (1). A detailed examination of the entire body should be performed, and injuries should be photographed or drawn.

The clinician should document the emotional condition of the survivor as assessed by direct observation and examination (1). If the individual is a minor or a vulnerable adult (those unable to care for their daily needs because of mental or physical disabilities), the clinician should report the incident to the appropriate authorities as required by state law. Efforts should be made to encourage involvement of a trusted adult.

When the survivor's physical, medical, and legal needs have been addressed, the clinician should discuss with her the degree of injury and the probability of infection or pregnancy. Emergency contraception should be provided, requiring its immediate availability in hospitals and facilities where sexual assault survivors are treated. The most common sexually transmitted infections reported in sexual assault victims include trichomoniasis, gonorrhea, and *Chlamydia trachomatis* (23–24). The Centers for Disease Control and Prevention (CDC) recommends testing and empiric antimicrobial treatment

**Box 3. Evaluation and Management of Sexual Assault Survivors**

**Medical Issues**

- Obtain informed consent
- Assess and treat physical injuries
- Obtain past gynecologic history
- Perform physical examination, including pelvic examination, with appropriate chaperone
- Obtain appropriate specimens and serologic tests for STI testing
- Provide appropriate infectious disease prophylaxis as indicated
- If the assailant's HIV status is unknown, evaluate the risks and benefits of postexposure prophylaxis
- Provide or arrange for provision of emergency contraception as indicated
- Provide counseling regarding findings, recommendations, and prognosis
- Arrange follow-up medical care and referrals for psychosocial needs

**Legal Issues***

- Document events
- Document injuries with drawings or photographs
- Collect samples as indicated by local protocol or regulation
- Identify the presence or absence of sperm in vaginal fluids and make appropriate slides
- Report to authorities as required
- Ensure security of chain of evidence

*Many jurisdictions have prepackaged kits for the initial forensic examination of a sexual assault survivor that provide specific containers and instructions for the collection of physical evidence and for written and pictorial documentation of the victim's subjective and objective findings. See https://www.rainn.org/articles/rape-kit for more information on rape kits.

Abbreviations: HIV, human immunodeficiency virus; STI, sexually transmitted infection.

for these sexually transmitted infections as well as testing for additional relevant infections such as human immunodeficiency virus (HIV), hepatitis B, and syphilis. Vaccination for hepatitis B and human papillomavirus also are recommended, as indicated (25).

Cases of HIV transmission after sexual assault have been described, although infrequently (26). Multiple characteristics of sexual assault increase the risk of HIV transmission, including genital or rectal trauma leading to bleeding, multiple traumatic sites involving lacerations or deep abrasions, and the presence of preexisting genital infection or ulcers in the victim (27). Postexposure prophylaxis (PEP) is a 28-day course of highly active antiretroviral therapy that, when initiated soon after high-risk exposure, can reduce risk of HIV infection significantly. If the assailant's HIV status is unknown, clinicians should evaluate the risks and benefits of PEP on a case-by-case basis. If indicated, PEP should be initiated as soon as possible but no later than 72 hours after potential exposure to HIV. The CDC provides guidance on factors to consider in decision making around PEP, information to be shared with individuals about PEP usage, and appropriate management plans (24).

Other health personnel, particularly those trained to respond to rape-trauma victims, should be consulted to provide immediate intervention if necessary and to facilitate counseling and follow-up. Clinicians are urged to assemble and maintain a list of individuals and other resources for patient referral. The CDC maintains a list of national resources to assist clinicians in their efforts that can be found at https://www.cdc.gov/violenceprevention/sexualviolence/resources.html (28).

Because of the emotional intensity of the experience, a sexual assault survivor may not recall all the information provided during an office visit. Therefore, it is helpful to provide all instructions and plans in writing. Generally, a visit for clinical and psychologic follow-up should take place within 1–2 weeks with additional encounters scheduled thereafter as indicated by results and assessments.

## Evidence Collection Kits

Sexual assault evidence collection kits, also known as rape kits, are packages used to collect evidence from a survivor during a medical forensic examination. These containers usually include checklists, materials used for specimen collection, documents, and instructions. Many jurisdictions develop their own kits, but premade kits can be purchased through commercial vendors (22).

To maintain evidence integrity, jurisdictional policies must be followed (20). These policies include details on packaging, labeling, and sealing evidence and specifics on transfer, storage, management, and distribution of evidence (20). In addition, the U.S. Department of Justice recommends that the time between the collection of a kit and its transfer and storage be minimized, the transfer of evidence be done only by law enforcement officials or authorized agents, storage only occur at a crime laboratory or other law enforcement facility, and chain-of-custody information be documented to ensure no loss or alteration of evidence before a trial (20).

Currently, in many parts of the United States there is a significant backlog of unanalyzed rape kits, which presents a major obstacle to prosecution of perpetrators. In multiple states, this backlog includes thousands of untested kits. A national campaign to address this problem has resulted in passage of laws in several states, increased availability of funding for processing evidence, and technical assistance and support to cities and states. Obstetrician–gynecologists and other health care providers should support efforts to address rape kit backlogs.

## Conclusion

Sexual violence affects millions of individuals in the United States and has a major effect on public health. For sexual assault survivors, the physical, psychological, and emotional effects can be devastating and have long-term consequences. Obstetrician–gynecologists and other women's health care providers have a unique opportunity, and a responsibility, to screen all patients for sexual violence and, when identified, to provide competent, compassionate, and appropriate care.

## For More Information

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/SexualAssault.

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 website, or the content of the resource. The resources may change without notice.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF LISA C. IKEMOTO IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Lisa C. 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, the Feminist Research Institute, and the Religious Studies Department. 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 final rules on religious and moral

exemptions to contraception coverage (Final Rules), published in the *Federal Register* on November 15, 2018.

4. Upon reviewing the Final Rules and the interim final rules that preceded them, I gathered data to determine their impacts on California women. Specifically, I reviewed and assessed the impact of the Final Rules on employees and their dependents receiving coverage from self-insured plans in California.

The Final Rules 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.[1] Because the state benefit mandate does not apply to self-funded plans, the Final Rules 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.[2] In California, an estimated 3.7 million to 6.6 million employees and dependents were enrolled in self-insured plans in 2018.[3] The majority of women have health benefits through employment-based plans.[4] That suggests that a substantial proportion, if not a majority, of the

[1] Cal. Health & Saf. Code §1367.25.

[2] KAISER FAMILY FOUND., *2018 Employer Health Benefits Survey* at 168 (October 3, 2018), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.

[3] 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.

[4] 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.

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 2018, 50% of employees of firms with 200-999 workers were enrolled in self-funded plans; 87% of employees of firms with 1,000-4,999 workers, and 91% of firms with 5,000 or more workers were enrolled in self-funded plans.[5] 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 the thousands, if not tens of thousands. That group of Californians are at risk of losing access to comprehensive health care if employers are able to use the Final Rules' 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 Final Rules will allow employers to impose their beliefs on employees through the exemptions. Many employees who seek access to contraceptives are likely to turn to state-funded family planning services.

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 Final Rules 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

[5] KAISER FAMILY FOUND., 2018 *Health Benefits Survey*, *supra* note 2.

(LARC), are the four most commonly used methods of contraception.[6] The pill, sterilization, the IUD and implantable rods are also among the most effective forms of birth control.[7] Cost is one of the major access barriers to effective contraception. The ACA has eliminated or reduced the out-of-pocket costs of the most effective contraceptives, and thus improved women's access to those methods.[8] 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.[9] 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."[10] These studies show that insurance coverage enables women to choose methods that are more effective.

The Final Rules 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

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[6] *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).

[7] U.S. FOOD &DRUG ADMIN., BIRTH CONTROL GUIDE, (last visited June 24, 2019), https://www.fda.gov/media/99605/download

[8] Ranji, et al, *Barriers to Care Experienced by Women in the United States*, JAMA INFOGRAPHIC, at 2154 (June 11, 2019)[Attached hereto as Exhibit A is a true and correct copy of the JAMA Infographic], https://jamanetwork.com/journals/jama/fullarticle/2735482?utm_campaign=KFF-2019-Womens-Health-Policy-WHP&utm_source=hs_email&utm_medium=email&utm_content=73566256&_hsenc=p2ANqtz-_rgpEtPX6-RhuZHXZOCGHIvpqsKl6heW55xxc5VxLbr0hurHNncZOJBQHUpWLJ2dnIp6UXfhv6iTe8Gbep4pSfuSN2itivjkKSQyztY8fuk_G-GW4&_hsmi=73566256; Snyder, et al, *The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women*, WOMEN'S HEALTH ISSUES, at 221, https://www.whijournal.com/article/S1049-3867(17)30527-3/pdf.

[9] Kavanaugh & Jerman, *Contraceptive Method Use in the United States*, *supra note 6*, at 6.

[10] 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).

object to methods they believe interfere with conception, including IUDs. Employers who follow Catholic doctrine would claim exemption for coverage of all eighteen FDA-approved contraceptive methods. If employers are able to use the Final Rules, 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. Employer exemptions, in fact, will impose a number of barriers. As noted, cost is a substantial barrier to contraceptive use, as well as to effective contraceptive use. A 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."[11] Loss of coverage also adds barriers to access to education and counseling about family planning, as well as to contraceptives. Family planning counseling can address the ways in which the burdens of family planning disproportionately affect women.[12]. The elimination of coverage for counseling services will prevent the equalization of the responsibilities for family planning.[13]

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.[14] Women who lose contraceptive coverage will face many of these barriers.

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[11] 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).

[12] *Id*. at 8.

[13] Katrina Kimport, *More Than a Physical Burden: Women's Mental and Emotional Work in Preventing Pregnancy*, J. SEX RESEARCH 1 (2017), http://www.tandfonline.com/doi/full/10.1080/00224499.2017.1311834

[14] COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMMITTEE OPINION: ACCESS TO CONTRACEPTION, AM. COLL. 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).

Loss of coverage will impose the need to seek information, obtain funding, change providers, decide whether to switch to a less expensive contraceptive method, switch from a pharmacy to a family planning clinic, and so on. Disruption of services, even if temporary, both creates a risk of unintended pregnancy and 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.

Numerous studies have documented the social and economic benefits of women's access to effective contraception. The benefits include improvements in women's educational attainment, workforce participation, economic stability, formation of stable relationships, mental health, and the well-being of children.[15] "It is clear that consistent access to effective and affordable contraception has indeed served as a catalyst of opportunity. It has helped revolutionize women's expectations about their educational and career prospects and their roles in the home and workplace, and it has helped reshaped societal expectations of and opportunities for women."[16] 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."[17]

Failure to cover some or all prescription contraceptives discriminates on the basis of gender. The Final Rules authorize employers to claim exemption from coverage of eighteen FDA approved

[15] Adam Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, GUTTMACHER INSTITUTE REPORT (March 2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf

[16] Id. at 4.

[17] 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).

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.[18] Twenty-nine states have addressed concerns about gender equality and access to comprehensive health care with state benefit mandates.[19] Several state mandates, including the California Women's Contraceptive Equity Act, provide broader coverage than federal law requires.[20] Thus, the majority of states, like the EEOC, the Institutes of Medicine (now the National Academies of Science, Engineering and Medicine), and leading health policy and health professional organizations recognize that access to safe and effective contraception is necessary to enable women to protect their own health and achieve equality.

7. Based on over twenty-years of research on women's health and rights, my review of the Final Rules, and a review of data and other research conducted for this Declaration, I conclude that the Final Rules will have significant negative impact on women in California by imposing barriers to contraceptive access for women enrolled in self-insured plans sponsored by employers. The Final Rules authorize employers to exclude contraceptive and family planning services coverage. In so doin, the Final Rules authorize employers to impose reproductive control over women in self-funded plans. Lack of access to safe and effective contraception will expose women to risks and attendant effects of unintended pregnancy, and will create barriers to opportunities, to which women are

[18] 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.

[19] Guttmacher Institute, States Laws and Policies: Insurance Coverage of Contraceptives (as of June 1, 2019), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives

[20] Id.

entitled, to fully participate in higher education, political participation, career attainment, and economic stability.

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

Executed on Jun 18, 2019, 2019, in Davis, California.



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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MARTY JOHNSON IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**
Defendant-Intervenors.

I, Marty Johnson, declare:

1. I make this declaration from personal knowledge and would testify to the following facts if called as a witness at hearing or trial.

2. I am the Acting Chief Economist and Research Director for the Illinois Department of Revenue. In this capacity, I am responsible for researching and quantifying the impact of proposed legislation and federal policy changes on tax revenues in the State.

3. Currently, a significant number of Illinois residents work in neighboring states. Using estimates based on the most recent Census Bureau Population Data (by county), the Illinois Department of Revenue estimates that approximately 68,300 residents work in Indiana, 28,500 work in Wisconsin, 17,500 work in Missouri, 6,000 work in Iowa, and 720 work in Kentucky (U.S. Census Bureau: Annual estimates of the resident population – 2018 population estimates).

Executed on July 1, 2019 in SPRINGFIELD, ILLINOIS.

MARTY JOHNSON, MBA
Research Director
Illinois Department of Revenue

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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.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF DAVE JONES, INSURANCE COMMISSIONER OF CALIFORNIA**

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 final rules on religious and moral exemptions to the coverage of contraceptives ("Final Rules") 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 5.7 million covered lives in employer self-funded health plans in California.

5. Californians have a constitutionally guaranteed right to privacy. The Final Rules 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 5.7 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 available without co-pays or deductibles, there were months when they had been unable to afford to fill their prescriptions for contraceptives. If the Final Rules 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[3] 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

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[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.

[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] Senate Bill 999 added subdivision (f) to Insurance Code section 10123.196 in 2016.

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").[4]

18. Unplanned or unintended pregnancy can lead to many adverse medical outcomes for both the woman and the baby.[5,6,7]

19. Some women who lose access to insurance coverage for contraceptives due to the Final Rules will seek contraceptive services from a Family PACT[8] provider. However, these services are not without cost to the woman, and they are limited only to low-income women, with incomes at or below 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.[9]

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

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[4] 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.

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

[6] 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.

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

[8] Family PACT is a state program that provides comprehensive family planning services to low-income women and men. See http://www.familypact.org/Home/home-page.

[9] 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.

significant: 93% for emergency contraceptives, 84% for barrier methods, 72% for the implant, and 68% for the injection.[10]

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.[11] These 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 interim final rules that preceded the Final Rules, 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.

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[10] 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-actmakes-impact-on-costs-of-many-forms-of-birth-control.

[11] Rebecka Rosenquist, University of Pennsylvania Leonard Davis Institute of Health Economics, *The ACA and Contraceptive Coverage*, July 7, 2015. Available online at https://ldi.upenn.edu/aca-and-contraceptive-coverage.

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 Final Rules 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.

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

Executed on December 7, 2018 in Sacramento, California.

Dave Jones
Insurance Commissioner of California

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF KEVIN KISH IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Kevin Kish declare:

1. I am the Director of the California Department of Fair Employment and Housing (DFEH). I was appointed in December 2014 by Governor Jerry Brown to lead DFEH.

2. DFEH is the state agency charged by the California Legislature with enforcing California's civil rights laws. The mission of DFEH is to protect the people of California from unlawful discrimination in employment, housing, and public accommodations and from hate violence and human trafficking. Cal. Gov't Code § 12930.

3. DFEH is responsible for enforcing state laws that make it illegal to discriminate against an employee because of certain protected categories, including sex and gender (e.g. pregnancy, childbirth, breastfeeding, or related medical conditions). Among other laws, DFEH enforces the California Fair Employment and Housing Act (FEHA) (Cal. Gov't Code § 12900 et seq.) and the Unruh Civil Rights Act (Cal. Civil Code § 51).

4. FEHA applies to public and private employers, labor organizations, and employment agencies. Under FEHA, it is illegal for employers of five or more employees to discriminate against employees because of a protected category (including sex and gender), or to retaliate against them because they have asserted their rights under the law.

5. The Unruh Civil Rights Act prohibits discrimination by business establishments.

6. To carry out its responsibilities, DFEH facilitates a complaint process, whereby an

individuals who feels that they were the victim of discrimination, may file a complaint with DFEH, which is called an intake form. The submission of the intake form initiates an intake interview with a department representative to determine whether a formal complaint will be accepted for investigation. The DFEH investigator contacts the individual complainant and the investigator seeks specific facts and any records about the incident(s) and copies of any documents supporting the complaint. DFEH then evaluates the facts and decides whether the case alleges facts within DFEH's jurisdiction. DFEH does not have discretion to decline to investigate cases within its jurisdiction. If a case is within its jurisdiction, DFEH will prepare a complaint form for the individual's signature under penalty of perjury and when the individual returns the complaint, it is delivered to the person or entity that the person believes discriminated against him/her/them, which is the respondent.

7. After a complaint is signed and issued, the respondent is required to answer the complaint. DFEH reviews the answers with the complainant. It conducts an investigation by obtaining documents and interviewing witnesses. Cases are evaluated for complexity and merit at every stage of the investigation.

8. DFEH offers free dispute resolution services to encourage parties to resolve the complaint, when appropriate. A voluntary resolution can be negotiated at any time during the complaint process. When parties cannot resolve a complain, DFEH continues an investigation to determine if a violation of California law occurred. If it did not, the case is closed. If DFEH finds there were probable violations of the law, the case moves into DFEH's Legal Division. At that time, the parties are required to go to mediation. At mediation, the parties have the opportunity to reach an agreement to resolve the dispute and close the case. If mediation fails, DFEH may file a lawsuit in court.

9. If an individual prefers not to use the DFEH investigation process, the individual may instead file their own lawsuit. In the context of employment discrimination, a complainant must first obtain a Right-to-Sue notice from DFEH before filing a lawsuit in court.

10. DFEH does not take sides when a complaint is first filed. Rather, DFEH investigates

the facts and encourages the parties to resolve the dispute in appropriate cases. DFEH considers taking legal action if evidence supports a finding of discrimination and the dispute is not resolved.

11. I have reviewed and am familiar with the two final exemption 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 November 15, 2019 (exemption rules). Under the exemption rules, I understand that any employer could claim a religious or moral objection to providing contraceptive coverage and leave their employees without no-cost contraceptive coverage. I understand that this expanded exemption would effectively make contraceptive coverage optional.

12. When an employer excludes healthcare coverage that only affects women employees but demands that women employees continue to pay the same as their male colleagues, the employer is creating a gender-based classification in the workplace.

13. If an employee were to file a complaint asserting that her employer excluded essential healthcare benefits from the healthcare plan for women, but not for men, that complaint would fall under DFEH's jurisdiction as a gender-based workplace classification and DFEH would have a legal obligation to investigate the claim.

14. After considering the rules, I believe that they will impact the analysis that DFEH must engage in to carry-out its required responsibilities under the law, including analysis of the scope and application of California's own religion-based exemptions from anti-discrimination principles of general applicability. See e.g., Cal. Gov't Code § 12926.2.

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

Executed on June 14, 2019, in Los Angeles, California.

KEVIN KISH

DIRECTOR,
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FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

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**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF KATHRYN KOST IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
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**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Kathryn Kost, declare:

1. I am the Acting Vice President for Domestic Research at the Guttmacher Institute. I have worked for the Guttmacher Institute in a full-time or consulting capacity for nearly 30 years since joining the Institute as a Senior Research Associate in 1989. I received my BA in sociology from Reed College and my PhD in sociology from Princeton University, where I specialized in demography at the Office of Population Research.

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 30 years, I have designed, executed, and analyzed numerous quantitative and qualitative research studies in the field of reproductive health care, including those on contraceptive use and failure, unintended pregnancy, maternal and child health, and the impact on public health and fisc associated with particular reproductive health care policies or

trends. My peer-reviewed research has been published in dozens of articles, including first-authored work in *Demography*, *Perspectives on Sexual and Reproductive Health*, *Contraception*, *Studies in Family Planning* and other public health, medical and demographic journals. 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 reproductive health care, family planning, and unintended pregnancy, and the impact on individuals, families, and the public health from access to contraception and related care, or interference with that care, in the United States.

4. I understand that this lawsuit involves a challenge to the federal government's Final Rules ("Final Rules") regarding the Affordable Care Act's ("ACA") contraceptive coverage mandate. In my expert opinion, the Final Rules would 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]

[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.

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

**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); other 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

[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.
[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 (FDA) and must be shown to be safe and effective through rigorous scientific testing. Thus, the federal government itself provides the oversight to ensure that contraception is safe and effective in preventing pregnancy.

12. The government's effort to imply that there is doubt about whether contraception reduces the risk of unintended pregnancy is simply unfounded, as the data above illustrate. Though the Final Rules cite "conflicting evidence" for the effects of a contraceptive coverage requirement,[10] in the previous interim final rules, the government made positive arguments that contraceptive access did not reduce the risk of unintended pregnancy. This argument is flawed. For example, in the interim final rules the government argued, "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."[11]

13. However, the government's assertion in the interim final rules that unintended pregnancy rates rose between 1972 and 2002 was 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

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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, Aiken A, "Contraceptive Efficacy" pp. 829–928. In Hatcher RA et al., eds., *Contraceptive Technology,* 21st ed., New York: Ayer Company Publishers, 2018.

[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*, 83(221):57536–57590, https://www.gpo.gov/fdsys/pkg/FR-2018-11-15/pdf/2018-24512.pdf

[11] 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.

incidence of *intended* pregnancy. Second, the 1972 figure includes only *births* (not all pregnancies), and then only those births that were to married women.[12] 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, 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),[13] and 43.6 million women of reproductive age (15–44),[14] 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.[15] Even when including miscarriages in the later rate, it is lower than the earlier rate; because miscarriages typically represent about 14% of all pregnancies,[16] 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 being able to choose from among the full range of methods to find the *best* methods for a given point in a woman's 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.[17] IUDs and implants, for example, are effective for years after they are inserted by a health care provider, and do not

[12] 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.
[13] Tietze C, Unintended pregnancies in the United States, 1970–1972, *Family Planning Perspectives,* 1979, 11(3):186–188.
[14] 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.
[15] 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.
[16] 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.
[17] 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.

require women using them to think about contraception on a day-to-day basis.[18] 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 their pills and 10% ran out).[19] 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.[20] 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.[21]

17. Being able to select the methods that best fulfill a woman's needs and priorities is an important way to ensure that she will be 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

[18] Winner B et al., Effectiveness of long-acting reversible contraception, *New England Journal of Medicine*, 366(21):1998–2007.
[19] 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.
[20] 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.
[21] 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.

gap in use, compared with 12% of completely satisfied users.[22] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[23]

18. Consistent contraceptive in turn 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 a 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.[24]

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. 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 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.

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[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.

[23] 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.

[24] 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.

[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.

[26] Martin JA, Hamilton BE and Osterman MJK, Births in the United States, 2016, *NCHS Data Brief*, 2017, No. 287,

21. 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]

22. 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 22% in 2011–2013; there was no significant change in sexual activity during this time.[32] And in a 2010

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.

[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.

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]

23. 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**

24. Extensive empirical evidence demonstrates what common sense would predict: eliminating costs leads to more effective and continuous use of contraception. That 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 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]

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[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.

[38] Trussell J, Aiken A, "Contraceptive Efficacy" pp. 829–928. In Hatcher RA et al., eds., *Contraceptive Technology,* 21st ed., New York: Ayer Company Publishers, 2018.

[39] Trussell J et al., Cost effectiveness of contraceptives in the United States, *Contraception*, 2009, 79(1):5–14.

25. 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 have monthly costs. And although some stores offer certain pill formulations at steep discounts, access to those cost savings can require a woman to change to a different formulation than the one prescribed by her clinician and increases her risk of adverse health effects.

26. 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. This is not true. For example, a national study found that about one-third of uninsured people and lower-income people in the United States 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.[44]

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[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] 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.

27. 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 want them, driving them 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.[45] This figure was particularly high among women relying on male condoms and other less effective methods such as withdrawal. A study conducted after the enactment of 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 for them; 48% also agreed that it would be easier to use contraception consistently if they had coverage.[46] 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 contraceptives,[47] and are more likely than insured women to report using no contraceptive method at all.[48,49]

28. Reducing financial barriers is critical to increasing access to effective contraception. Before the ACA provision went into effect, 28 states required private insurers that cover

[45] 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.

[46] 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.

[47] 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.

[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, 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.

prescription drugs to provide coverage of most or all FDA-approved contraceptive drugs and devices.[50] 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.[51] 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.[52]

29. 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 does—have even greater potential to increase women's ability to use methods effectively. For example, when Kaiser Permanente Northern California 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.[53] 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.[54] Three-quarters of those

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[50] Guttmacher Institute, Insurance coverage of contraceptives, *State Policies in Brief (as of July 2012)*, 2012.

[51] The government argued in the interim final rules that the state mandates have not been effective, asserting 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 relied 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 mandates 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, contraceptive coverage quickly became the norm in the insurance industry—even in states without mandates—thus minimizing potential differences between states with laws and states without them. [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.]

[52] Magnusson BM et al., Contraceptive insurance mandates and consistent contraceptive use among privately insured women, *Medical Care*, 2012, 50(7):562–568.

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

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

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.[55]

30. 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.[56] 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.[57]

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

31. 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.[58] Similarly, another study found that since

[55] 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.

[56] 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.

[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] 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.

implementation of the ACA, the share of women of reproductive age (regardless of whether they were using contraception) who had out-of-pocket costs for oral contraceptives decreased from 21% in 2012 to just 4% in 2014.[59] 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.[60]

32. Before the ACA, contraceptives accounted for between 30–44% of out-of-pocket health care spending for women.[61] 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 for them.[62]

33. Demonstrating the population-level impact of the ACA's coverage provision (e.g., a change in unintended pregnancy rates) is complicated, because the provision affects only a subset of U.S. women, and because there are so many additional variables that affect women's pregnancy intentions, contraceptive use and ultimately the unintended pregnancy rate in the population. 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.

[59] 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/.

[60] 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.

[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] 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. 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.[63] 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).[64]

35. 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.[65,66] 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 a proportional decline in sterilization.[67] 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

[63] 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.
[64] 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.
[65] 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.
[66] 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.
[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.

or use a method such as the pill for noncontraceptive reasons after implementation of the contraceptive coverage guarantee.[68]

36. 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%.[69] Study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[70] Similarly, when access to both contraception and abortion increased in Iowa, the abortion rates actually declined.[71] 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 Would Harm Women**

37. The Final Rules would make it more difficult, once again, for those receiving insurance coverage through companies or schools that use the exemption (i.e., employees, students and dependents) to access the methods of contraception that are most acceptable and effective for them. That, in turn, would 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.

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[68] 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.

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

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

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

38. 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—would 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.

39. Allowing employers to restrict access to the full range of contraceptive methods and to approve coverage only for those they deem acceptable would place 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).

40. 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.[72,73] 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.

41. 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

[72] Leeman L, Medical barriers to effective contraception, *Obstetrics and Gynecology Clinics of North America,* 2007, 34(1):19–29.

[73] 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.

woman's chosen provider should be able to manage all health conditions and needs at the same time.[74,75]

42. To the extent that expanding the exemptions would burden women's contraceptive use in these ways, it would be harmful to women's health. Contraception allows women to avoid unintended pregnancies and to time and space wanted pregnancies, which has been demonstrated to improve women's health and that of their families. Specifically, pregnancies that occur too early in a woman's life or that are spaced too closely are associated with negative maternal health outcomes and/or adverse birth outcomes, including preterm birth, low birth weight, stillbirth, and early neonatal death.[76,77,78,79] 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.[80] Unintended pregnancy also affects women's mental health; notably, it is a risk factor for depression in adults.[81,82] For these reasons, the Centers for Disease Control and Prevention (CDC) included the development of and improved access to methods of family planning among the 10 great public health achievements of the 20th century.[83]

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[74] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.

[75] 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.

[76] 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.

[77] 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.

[78] 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.

[79] 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.

[80] 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.

[81] 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.

[82] 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.

[83] Centers for Disease Control and Prevention, Achievements in public health, 1900–1999: family planning, *Morbidity and Mortality Weekly Report,* 1999, 48(47): 1073–1080.

43. In the Final Rules, the government implies that there is debate about whether contraception may have negative health consequences that outweigh its benefits. In the previous interim final rules, the government implied that putative negative health consequences of contraception may outweigh its benefits. On the contrary, the government itself provides the oversight to ensure that the health benefits of contraception outweigh any potential negative consequences. Notably, the FDA's approval processes require that drugs and devices, including contraceptives, be proven safe and effective through rigorous controlled trials. In addition, the CDC publishes extensive recommendations to help clinicians and patients identify potential contraindications and decide which specific contraceptive methods are most appropriate for each patient's needs and health circumstances.[84,85] 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 risks.[86]

44. Expanding the exemptions to the contraceptive coverage requirement would 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.[87] Economic analyses have found 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.[88] Moreover, the primary reasons women give for why they use and value contraception are

[84] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.
[85] 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.
[86] 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.
[87] 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.
[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.

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%).[89]

45. The government contends that expanding the exemption would 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. That argument is misleading. Low-income women, women of color and women aged 18–24 are at disproportionately high risk for unintended pregnancy,[90] and millions of these women rely on private insurance coverage—particularly following implementation of the ACA. In fact, from 2013 to 2017, the proportion of women overall and of women below the poverty level who were uninsured dropped by more than one-third nationwide, declines driven by substantial increases in both Medicaid and private insurance coverage.[91] 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.

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

46. State and federal programs and laws—such as the Title X national family planning program, Medicaid, and state contraceptive coverage requirements—cannot replicate or replace the gains in access made by the contraceptive coverage guarantee. In the interim final rules, the government claimed that "[i]ndividuals who are unable to obtain contraception coverage through

[89] 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.

[90] 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.

[91] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, *News in Context,* Dec. 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

their employer-sponsored health plans because of the exemptions created in these interim final rules…have other avenues for obtaining contraception…."[92]

47. 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),[93] 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.

48. Funding for Title X has not increased sufficiently for the program even to keep up with the increasing number of women in need of publicly funded care;[94] therefore, Title X cannot sustain additional beneficiaries as a result of the Final Rules. From 2010 to 2014, even as the number of women in need of publicly funded contraceptive care grew by 5%, representing an additional one million women in need,[95] Congress cut funding for Title X by 10%.[96] With its current resources, Title X is able to serve only one-fifth of the nationwide need for publicly funded contraceptive care.[97] Still, the government has proposed diverting already insufficient

[92] 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.

[93] 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.

[94] 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.

[95] 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] 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.

[97] 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.

Title X funding to help cover the cost of care for any women affected by the Final Rules,[98] an action that would inevitably hurt patients who rely on publicly funded services.

49. 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 states that have not expanded Medicaid eligibility under the ACA. In almost all of those 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 Alabama and Texas.[99] Several of these 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, by contrast, the federal contraceptive coverage guarantee applies regardless of income. And because the U.S. Supreme Court has ruled that states cannot be compelled by the federal government to expand Medicaid eligibility, the federal government cannot rely on Medicaid to fill in gaps in coverage that would result from expanding the exemption.

50. The federal government's assertion that Title X and Medicaid can replace or replicate the ACA's contraceptive coverage guarantee is additionally problematic given that the government itself is at the same time moving to undermine Title X and Medicaid. For example, the government's recent budget proposals have sought to exclude Planned Parenthood Federation of America and its affiliates from Title X, Medicaid and other federal programs,[102] and have called

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[98] Department of Health and Human Services, Compliance with statutory program integrity requirements, *Federal Register*, 83(106):25502–25533, https://www.gpo.gov/fdsys/pkg/FR-2018-06-01/pdf/2018-11673.pdf.

[99] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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 December 2018),* 2018, 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, 2018, 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.

for massive cuts to Medicaid.[103] The Department of Health and Human Services has promulgated sweeping changes to Title X regulations that would undermine quality of care and access to providers,[104] and it 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] The administration has strongly backed similar congressional proposals for cutting and limiting access to Title X and Medicaid.

51. In addition, the promulgated changes to Title X would make it even more unsuitable as a substitute for contraceptive coverage under the ACA. The recent rule for Title X removes the requirement that the contraceptive methods offered by a Title X provider be "medically approved."[106] At the same time, the rule encourages participation in Title X by entities that prioritize their own religious or moral beliefs over patient-centered care and by entities that offer only a single contraceptive method (such as fertility awareness–based methods). These changes, if implemented, would shift the Title X program away from its mission of offering access to a broad range of family planning methods.[107]

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.[108]

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-one have no such laws at all.[109] Of the 29 states and the District of Columbia that do have

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[103] 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.
[104] Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, March 4, 2019.
[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] Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, March 4, 2019.
[107] Hasstedt K, What the Trump Administration's Final Regulatory Changes Mean for Title X, *Health Affairs* Blog, March 4, 2019, https://www.guttmacher.org/article/2019/03/what-trump-administrations-final-regulatory-changes-mean-title-x.
[108] 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.
[109] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of December 2018),*

contraceptive coverage requirements, only 10 currently bar copayments and deductibles for contraception (and another four states have new requirements not yet in effect). Additionally, the federal requirement limits the use of formularies and other administrative restrictions on women's use of contraceptive services and supplies, by making it clear that health plans may seek to influence a patient's choice only 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 state requirements do not specifically require coverage of all the distinct methods that the federal requirement encompasses. For example, only eight 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 Final Rules would have public health and fiscal consequences in states across the country. If unable to access contraceptive coverage through their employer or university, some lower-income women who meet the strict income requirements of public programs would 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, would 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 would be at increased risk of unintended pregnancy. The costs of the resulting unintended pregnancies often then fall to the states because

2018, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[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 December 2018),* 2018, 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/.

the federal government cannot or will not withstand these costs. Examples of this impact are included below for the plaintiff states. Data for all 50 states and the District of Columbia are included in a table as Exhibit B.

**California**

55. In California, some women impacted by the Final Rules would not qualify for Medicaid, the state's Medicaid family planning expansion (Family PACT) or Title X because they would 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 would 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 would force them to forgo contraception use entirely.

58. Other women would 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

[113] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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 December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

would 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 would increase the strain on 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, 2.6 million women were in need of publicly funded family planning in California, and the state's family planning network was able to only 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.[117] Unintended pregnancies cost the state approximately $689 million and the federal government approximately $1.06 billion in 2010. The Final Rules 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.

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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.

**Connecticut**

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

64. For example, in Connecticut, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[118] and individuals are eligible for coverage of family planning services specifically up to 263% of poverty.[119] This means that affected women who lose coverage as a result of the rules may not be eligible.

65. As a result, some women would 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 would force them to forgo contraception use entirely.

66. Other women would 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 would 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 would increase the strain on the state's family planning programs and providers, making it more difficult for

[118] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

them to meet the existing need for publicly funded care. In 2014, 183,000 women were in need of publicly funded family planning in Connecticut, and the state's family planning network was able to only meet 38% of this need.[120]

68. Another indicator of the existing unmet need for contraception in Connecticut is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 32,000 unintended pregnancies occurred among Connecticut residents, a rate of 46 per 1,000 women aged 15–44.[121]

69. Of those unintended pregnancies that ended in birth, 61% were paid for by Medicaid and other public insurance programs.[122] Unintended pregnancies cost the state approximately $80 million and the federal government approximately $128 million in 2010. The Final Rules 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 Connecticut or its residents.

[120] 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.

[121] 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.

[122] 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.

**Delaware**

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

72. For example, in Delaware, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[123] (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.

73. As a result, some women would 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 would force them to forgo contraception use entirely.

74. Other women would 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 would 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 would increase the strain on 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

[123] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

publicly funded family planning in Delaware, and the state's family planning network was able to only meet 30% of this need.[124]

76. 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, 11,000 unintended pregnancies occurred among Delaware residents, a rate of 62 per 1,000 women aged 15–44.[125]

77. Of those unintended pregnancies that ended in birth, 71% were paid for by Medicaid and other public insurance programs.[126] Unintended pregnancies cost the state approximately $36 million and the federal government approximately $58 million in 2010. The Final Rules 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 Delaware or its residents.

**District of Columbia**

79. In the District of Columbia, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

[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.

[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.

80. For example, in the District of Columbia, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 215% or 221%, respectively, of the federal poverty level.[127] (The District of Columbia 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.

81. As a result, some women would 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 would force them to forgo contraception use entirely.

82. Other women would 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 would 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 would increase the strain on the district's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 45,000 women were in need of publicly funded family planning in the District of Columbia, and the district's family planning network was able to only meet 84% of this need.[128]

[127] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[128] 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. Another indicator of the existing unmet need for contraception in the District of Columbia is that substantial numbers of residents experience unintended pregnancy each year. In 2010, 10,000 unintended pregnancies occurred among District of Columbia residents, a rate of 58 per 1,000 women aged 15–44.[129]

85. Of those unintended pregnancies that ended in birth, 85% were paid for by Medicaid and other public insurance programs.[130] Unintended pregnancies cost the district approximately $13 million and the federal government approximately $51 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by district 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 the District of Columbia or its residents.

**Hawaii**

87. In Hawaii, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

88. For example, in Hawaii, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[131] (Hawaii has not

[129] 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.

[130] 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.

[131] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

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.

89. As a result, some women would 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 would force them to forgo contraception use entirely.

90. Other women would 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 would 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 would increase the strain on 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, 73,000 women were in need of publicly funded family planning in Hawaii, and the state's family planning network was able to only meet 25% of this need.[132]

92. Another indicator of the existing unmet need for contraception in Hawaii is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 16,000 unintended pregnancies occurred among Hawaii residents, a rate of 61 per 1,000 women aged 15–44.[133]

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[132] 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.

[133] 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-

93. Of those unintended pregnancies that ended in birth, 50% were paid for by Medicaid and other public insurance programs.[134] Unintended pregnancies cost the state approximately $38 million and the federal government approximately $77 million in 2010. The Final Rules 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 Hawaii or its residents.

**Illinois**

95. In Illinois, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

96. For example, in Illinois, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[135] (Illinois 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.

97. As a result, some women would 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 would force them to forgo contraception use entirely.

2010-and-trends-2002.

[134] 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.

[135] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

98. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

99. The increase in the number of women relying on publicly funded services would increase the strain on 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, 773,000 women were in need of publicly funded family planning in Illinois, and the state's family planning network was able to only meet 20% of this need.[136]

100. Another indicator of the existing unmet need for contraception in Illinois is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 128,000 unintended pregnancies occurred among Illinois residents, a rate of 49 per 1,000 women aged 15–44.[137]

101. Of those unintended pregnancies that ended in birth, 78% were paid for by Medicaid and other public insurance programs.[138] Unintended pregnancies cost the state approximately $352 million and the federal government approximately $572 million in 2010. The Final Rules

[136] 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.

[137] 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.

[138] 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.

are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

102. 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 Illinois or its residents.

**Maryland**

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

104. For example, in Maryland, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[139] and individuals are eligible for coverage of family planning services specifically up to 200% of poverty.[140] This means that affected women who lose coverage as a result of the rules may not be eligible.

105. As a result, some women would 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 would force them to forgo contraception use entirely.

106. Other women would 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

[139] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[140] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

107. The increase in the number of women relying on publicly funded services would increase the strain on 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 able to only meet 25% of this need.[141]

108. 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, 71,000 unintended pregnancies occurred among Maryland residents, a rate of 60 per 1,000 women aged 15–44.[142]

109. Of those unintended pregnancies that ended in birth, 58% were paid for by Medicaid and other public insurance programs.[143] Unintended pregnancies cost the state approximately $181 million and the federal government approximately $285 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

[141] 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.

[142] 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.

[143] 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.

110. 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.

**Minnesota**

111. In Minnesota, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

112. For example, in Minnesota, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[144] and individuals are eligible for coverage of family planning services specifically up to 200% of poverty.[145] This means that affected women who lose coverage as a result of the rules may not be eligible.

113. As a result, some women would 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 would force them to forgo contraception use entirely.

114. Other women would 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 would

[144] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[145] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

115. The increase in the number of women relying on publicly funded services would increase the strain on 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, 295,000 women were in need of publicly funded family planning in Minnesota, and the state's family planning network was able to only meet 29% of this need.[146]

116. Another indicator of the existing unmet need for contraception in Minnesota is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 38,000 unintended pregnancies occurred among Minnesota residents, a rate of 36 per 1,000 women aged 15–44.[147]

117. Of those unintended pregnancies that ended in birth, 67% were paid for by Medicaid and other public insurance programs.[148] Unintended pregnancies cost the state approximately $129 million and the federal government approximately $204 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

118. 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 Minnesota or its residents.

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[146] 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.

[147] 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.

[148] 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.

**New York**

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

120. For example, in New York, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[149] and individuals are eligible for coverage of family planning services specifically up to 223% of poverty.[150] This means that affected women who lose coverage as a result of the rules may not be eligible.

121. As a result, some women would 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 would force them to forgo contraception use entirely.

122. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

123. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult

[149] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[150] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, 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, 1.2 million women were in need of publicly funded family planning in New York, and the state's family planning network was able to only meet 32% of this need.[151]

124. 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, 246,000 unintended pregnancies occurred among New York residents, a rate of 61 per 1,000 women aged 15–44.[152]

125. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs.[153] Unintended pregnancies cost the state approximately $601 million and the federal government approximately $938 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

126. 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.

[151] 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.

[152] 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.

[153] 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.

**North Carolina**

127. In North Carolina, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

128. For example, in North Carolina, parents are eligible for full-benefit Medicaid only if they have incomes at or below 43% of the federal poverty level, and childless adults are ineligible for full-benefit Medicaid at any income.[154] Individuals are eligible for coverage of family planning services specifically up to 200% of poverty.[155] This means that affected women who lose coverage as a result of the rules may not be eligible.

129. As a result, some women would 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 would force them to forgo contraception use entirely.

130. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

131. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult

[154] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[155] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, 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, 668,000 women were in need of publicly funded family planning in North Carolina, and the state's family planning network was able to only meet 20% of this need.[156]

132. Another indicator of the existing unmet need for contraception in North Carolina is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 95,000 unintended pregnancies occurred among North Carolina residents, a rate of 49 per 1,000 women aged 15–44.[157]

133. Of those unintended pregnancies that ended in birth, 75% were paid for by Medicaid and other public insurance programs.[158] Unintended pregnancies cost the state approximately $215 million and the federal government approximately $644 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

134. 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 North Carolina or its residents.

[156] 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.

[157] 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.

[158] 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.

**Oregon**

135. In Oregon, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

136. For example, in Oregon, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[159] and individuals are eligible for coverage of family planning services specifically up to 250% of poverty.[160] This means that affected women who lose coverage as a result of the rules may not be eligible.

137. As a result, some women would 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 would force them to forgo contraception use entirely.

138. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

139. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult

[159] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[160] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, 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, 271,000 women were in need of publicly funded family planning in Oregon, and the state's family planning network was able to only meet 39% of this need.[161]

140. Another indicator of the existing unmet need for contraception in Oregon is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 31,000 unintended pregnancies occurred among Oregon residents, a rate of 41 per 1,000 women aged 15–44.[162]

141. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs.[163] Unintended pregnancies cost the state approximately $47 million and the federal government approximately $123 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

142. 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 Oregon or its residents.

[161] 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.

[162] 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.

[163] 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.

**Rhode Island**

143. In Rhode Island, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

144. For example, in Rhode Island, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[164] (Rhode Island 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.

145. As a result, some women would 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 would force them to forgo contraception use entirely.

146. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

147. The increase in the number of women relying on publicly funded services would increase the strain on 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, 71,000 women were in need

[164] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

of publicly funded family planning in Rhode Island, and the state's family planning network was able to only meet 35% of this need.[165]

148. Another indicator of the existing unmet need for contraception in Rhode Island is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 9,000 unintended pregnancies occurred among Rhode Island residents, a rate of 43 per 1,000 women aged 15–44.[166]

149. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs.[167] Unintended pregnancies cost the state approximately $28 million and the federal government approximately $49 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

150. 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 Rhode Island or its residents.

**Vermont**

151. In Vermont, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

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[165] 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.

[166] 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.

[167] 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.

152. For example, in Vermont, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[168] (Vermont 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.

153. As a result, some women would 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 would force them to forgo contraception use entirely.

154. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

155. The increase in the number of women relying on publicly funded services would increase the strain on 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, 36,000 women were in need of publicly funded family planning in Vermont, and the state's family planning network was able to only meet 59% of this need.[169]

[168] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[169] 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.

156. Another indicator of the existing unmet need for contraception in Vermont is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 4,000 unintended pregnancies occurred among Vermont residents, a rate of 36 per 1,000 women aged 15–44.[170]

157. Of those unintended pregnancies that ended in birth, 74% were paid for by Medicaid and other public insurance programs.[171] Unintended pregnancies cost the state approximately $10 million and the federal government approximately $22 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

158. 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 Vermont or its residents.

**Virginia**

159. In Virginia, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would 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 Final Rules because the state does not have its own policy requiring some level of contraceptive coverage among private insurance plans.

160. For example, in Virginia, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level (starting in

[170] 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.

[171] 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.

January 2019),[172] and individuals are only eligible for coverage of family planning services specifically up to 205% of poverty.[173] This means that affected women who lose coverage as a result of the rules may not be eligible.

161. As a result, some women would 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 would force them to forgo contraception use entirely.

162. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

163. The increase in the number of women relying on publicly funded services would increase the strain on 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 able to only meet 17% of this need.[174]

[172] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

[173] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[174] 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.

164. 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, 84,000 unintended pregnancies occurred among Virginia residents, a rate of 51 per 1,000 women aged 15–44.[175]

165. Of those unintended pregnancies that ended in birth, 45% were paid for by Medicaid and other public insurance programs.[176] Unintended pregnancies cost the state approximately $195 million and the federal government approximately $312 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

166. 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.

**Washington State**

167. In Washington State, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

168. For example, in Washington, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[177] and

[175] 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.

[176] 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.

[177] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, 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.

individuals are eligible for coverage of family planning services specifically up to 260% of poverty.[178] This means that affected women who lose coverage as a result of the rules may not be eligible.

169. As a result, some women would 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 would force them to forgo contraception use entirely.

170. Other women would 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 would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

171. The increase in the number of women relying on publicly funded services would increase the strain on 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, 429,000 women were in need of publicly funded family planning in Washington, and the state's family planning network was able to only meet 26% of this need.[179]

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

[178] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[179] 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.

61,000 unintended pregnancies occurred among Washington residents, a rate of 45 per 1,000 women aged 15–44.[180]

173. Of those unintended pregnancies that ended in birth, 63% were paid for by Medicaid and other public insurance programs.[181] Unintended pregnancies cost the state approximately $177 million and the federal government approximately $291 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

174. 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 Washington or its residents.

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

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

[180] 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.

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Executed on June 13, 2019, in Washington, DC.



Kathryn Kost
Acting Vice President for Domestic Research
The Guttmacher Institute

# Exhibit A

# Kathryn Kost

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(212) 248-1111 · kkost@guttmacher.org

## EDUCATION

**Princeton University**, Princeton, New Jersey
Ph.D., Sociology, 1990; Area of Specialization: Demography

**Reed College,** Portland, Oregon
Bachelor of Arts, Sociology, 1982

## PROFESSIONAL EXPERIENCE

**The Guttmacher Institute, New York, New York**
Acting Vice President of Domestic Research 2018 - present
Director of Domestic Research 2016-2018
Principal Research Scientist 2015-2016
Senior Research Associate, 1989-1998, 2009-2014
Consultant, 2004-2009

**Gynuity Health Projects, New York, New York**
Consultant, 2009

**Princeton University, Princeton, New Jersey**
Teaching Assistant, Introductory Statistics (graduate-level), Woodrow Wilson School, 1986-1987

**East-West Population Institute, Population Research Division, University of Hawaii, Honolulu, HI**
Research Intern, 1987

**Princeton University, Princeton, New Jersey**
Teaching Assistant, Introductory Statistics (graduate-level), Woodrow Wilson School, 1986

**National Academy of Sciences, Institute of Medicine, Washington, D.C.**
Research Intern, Committee on Contraceptive Development, 1986

**Princeton University, Princeton, New Jersey**
NICHD Trainee, Office of Population Research, 1985-1989

**American Health Foundation, New York, New York**
Head of Data Management, Division of Child Health, 1983-1985

## AREAS OF SPECIALIZATION

Sexual and Reproductive Health; Unintended Pregnancy and Childbearing; Pregnancy Surveillance and Statistics; Contraceptive Effectiveness.

**PEER-REVIEWED PUBLICATIONS**

Sundaram A, Vaughan B, Kost K, Bankole A, Finer LB, Singh S. (2017). Contraceptive failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth. *Perspectives on Sexual and Reproductive Health, 49(1)*:7-16.

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**GUTTMACHER PAPERS**

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Curtin SC, Abma JC, Kost K. Pregnancy rates for U.S. women continue to drop: an update. NCHS Health E-stat, November 2015. Available at: http:/ / www.cdc.gov/ nchs/ data/ hestat/ pregnancy/ rates_1990_2010.

**HONORS, AWARDS AND FELLOWSHIPS**

East-West Center, University of Hawaii, Summer Fellowship (1987)

**PROFESSIONAL ASSOCIATIONS**

Population Association of America
American Sociological Association
PRAMS Steering Committee, New York City Department of Health & Mental Hygiene
Editorial Board, International Journal of Population Research
Full Fellow, Society of Family Planning
Member, Social Science and Population Studies Review Panel, National Institutes of Health (2012-2015)

# Exhibit B

**Exhibit B: State-Specific Data on Impact**

| | Medicaid eligibility, as % of federal poverty level (as of January 2018) | | | Women needing publicly supported contraceptive services and supplies, 2014 | | Unintended pregnancies, 2010 | | % of unplanned births paid for by public insurance programs, 2010 | Public costs for unintended pregnancies, 2010 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Childless adults | Parents | Family planning specific | Number | % of need met by publicly supported providers | Number | Rate per 1,000 women 15–44 | | State (in millions) | Federal (in millions) |
| Alabama | — | 18% | 146% | 332,750 | 31% | 46,000 | 48 | 61.6% | $72.6 | $250.5 |
| Alaska | 138% | 139% | — | 41,200 | 63% | 8,000 | 54 | 64.3% | 42.9 | 70.8 |
| Arizona | 138% | 138% | — | 465,450 | 15% | 61,000 | 49 | 64.6% | 161.5 | 509.4 |
| Arkansas | 138% | 138% | — | 204,850 | 29% | 29,000 | 50 | 72.3% | 61.9 | 266.8 |
| California | 138% | 138% | 200% | 2,643,580 | 50% | 393,000 | 50 | 64.3% | 689.3 | 1,062.1 |
| Colorado | 138% | 138% | — | 326,490 | 38% | 43,000 | 42 | 63.8% | 91.1 | 146.1 |
| Connecticut | 138% | 138% | 263% | 183,070 | 38% | 32,000 | 46 | 60.8% | 80.1 | 128.4 |
| Delaware | 138% | 138% | — | 50,100 | 30% | 11,000 | 62 | 71.3% | 36.0 | 58.2 |
| District of Columbia | 215% | 221% | — | 44,910 | 84% | 10,000 | 58 | 84.6% | 13.3 | 50.9 |
| Florida | — | 33% | — | 1,216,520 | 17% | 207,000 | 58 | 70.6% | 427.1 | 892.8 |
| Georgia | — | 36% | 200% | 695,120 | 16% | 119,000 | 57 | 80.5% | 229.7 | 687.7 |
| Hawaii | 138% | 138% | — | 73,090 | 25% | 16,000 | 61 | 49.9% | 37.8 | 76.7 |
| Idaho | — | 26% | — | 113,020 | 21% | 12,000 | 38 | 60.4% | 18.5 | 70.2 |
| Illinois | 138% | 138% | — | 772,510 | 20% | 128,000 | 49 | 78.3% | 352.2 | 571.5 |
| Indiana | 139% | 139% | 146% | 446,230 | 19% | 55,000 | 43 | 64.6% | 91.4 | 284.6 |
| Iowa | 138% | 138% | — | 190,270 | 29% | 23,000 | 39 | 61.5% | 48.3 | 127.6 |
| Kansas | — | 38% | — | 188,100 | 17% | 24,000 | 43 | 47.2% | 50.4 | 115.7 |
| Kentucky | 138% | 138% | — | 284,530 | 24% | 34,000 | 40 | 66.8% | 75.0 | 302.8 |
| Louisiana | 138% | 138% | 138% | 321,480 | 15% | 53,000 | 57 | 78.7% | 120.6 | 530.4 |
| Maine | — | 105% | 214% | 78,880 | 33% | 9,000 | 37 | 74.7% | 14.6 | 43.6 |
| Maryland | 138% | 138% | 200% | 298,190 | 25% | 71,000 | 60 | 58.2% | 180.9 | 285.4 |
| Massachusetts | 138% | 138% | — | 373,060 | 25% | 54,000 | 40 | 56.4% | 138.3 | 219.6 |
| Michigan | 138% | 138% | — | 635,660 | 16% | 93,000 | 49 | 71.9% | 177.0 | 485.1 |
| Minnesota | 138% | 138% | 200% | 294,680 | 29% | 38,000 | 36 | 66.7% | 128.7 | 203.9 |
| Mississippi | — | 27% | 199% | 213,930 | 28% | 35,000 | 57 | 81.9% | 40.4 | 226.7 |
| Missouri | — | 22% | — | 391,510 | 18% | 54,000 | 46 | 72.2% | 132.6 | 385.9 |
| Montana | 138% | 138% | 216% | 66,380 | 41% | 7,000 | 42 | 47.8% | 9.1 | 31.7 |
| Nebraska | — | 63% | — | 118,170 | 20% | 14,000 | 41 | 63.1% | 41.7 | 91.9 |
| Nevada | 138% | 138% | — | 194,430 | 10% | 29,000 | 54 | 60.0% | 37.1 | 65.8 |
| New Hampshire | 138% | 138% | 201% | 65,530 | 29% | 8,000 | 32 | 52.7% | 10.3 | 16.5 |
| New Jersey | 138% | 138% | — | 455,260 | 22% | 97,000 | 56 | 52.4% | 186.1 | 291.0 |
| New Mexico | 138% | 138% | 255% | 151,950 | 28% | 22,000 | 56 | 77.1% | 47.9 | 191.2 |
| New York | 138% | 138% | 223% | 1,227,170 | 32% | 246,000 | 61 | 70.2% | 601.1 | 937.7 |
| North Carolina | — | 43% | 200% | 667,910 | 20% | 95,000 | 49 | 74.8% | 214.7 | 643.5 |
| North Dakota | 138% | 138% | — | 44,180 | 26% | 5,000 | 41 | 36.8% | 7.7 | 17.9 |
| Ohio | 138% | 138% | — | 730,110 | 14% | 109,000 | 49 | 68.7% | 218.8 | 605.8 |
| Oklahoma | — | 45% | 138% | 256,880 | 31% | 36,000 | 49 | 80.7% | 77.0 | 254.0 |
| Oregon | 138% | 138% | 250% | 270,990 | 39% | 31,000 | 41 | 69.9% | 47.2 | 122.7 |
| Pennsylvania | 138% | 138% | 220% | 745,550 | 29% | 115,000 | 47 | 53.5% | 248.2 | 478.6 |
| Rhode Island | 138% | 138% | — | 71,320 | 35% | 9,000 | 43 | 70.1% | 27.5 | 48.7 |
| South Carolina | — | 67% | 199% | 323,140 | 31% | 42,000 | 46 | 78.6% | 84.0 | 327.3 |
| South Dakota | — | 50% | — | 52,610 | 27% | 7,000 | 46 | 46.2% | 14.4 | 35.0 |
| Tennessee | — | 98% | — | 434,440 | 26% | 62,000 | 49 | 73.7% | 130.7 | 400.0 |
| Texas | — | 18% | — | 1,795,160 | 10% | 298,000 | 56 | 73.7% | 842.6 | 2,056.8 |
| Utah | — | 60% | — | 207,350 | 22% | 24,000 | 40 | 53.3% | 30.4 | 127.6 |
| Vermont | 138% | 138% | — | 35,810 | 59% | 4,000 | 36 | 73.5% | 9.6 | 21.8 |
| Virginia | — | 38% | 205% | 447,970 | 17% | 84,000 | 51 | 45.4% | 194.6 | 312.0 |
| Washington | 138% | 138% | 260% | 429,300 | 26% | 61,000 | 45 | 63.1% | 177.1 | 290.7 |
| West Virginia | 138% | 138% | — | 110,910 | 47% | 15,000 | 43 | 76.0% | 24.9 | 120.5 |
| Wisconsin | 100% | 100% | 306% | 353,620 | 22% | 42,000 | 38 | 62.0% | 92.1 | 221.4 |
| Wyoming | — | 55% | — | 34,630 | 30% | 4,000 | 42 | 67.4% | 21.3 | 34.1 |

*Sources:* References 113–117.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MYRON BRADFORD "MIKE" KREIDLER IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Myron Bradford "Mike" Kreidler, declare:

1. I am over the age of eighteen years old, have personal knowledge of all facts and matters herein, and am competent to testify to the matters below.

2. I am the elected Insurance Commissioner for the State of Washington. I was first elected to this position in 2000. I was reelected to my fifth four-year term in 2016.

3. As Insurance Commissioner, I am charged with the regulation of the insurance market in Washington State through the enforcement of the Insurance Code, Title 48, Revised Code of Washington, and enforcement of applicable federal statutes that affect insurance. Wash. Rev. Code § 48.02.060.

4. Based on my knowledge and experience as the State's Insurance Commissioner, I believe that the Final Rules issued on November 15, 2018 will result in women in Washington losing access to contraceptives and an increase in unintended pregnancies, abortions, and increased social and economic costs.

5. The Office of the Insurance Commissioner (OIC) regulates individual, small group and large group fully insured health plans in Washington.

6. Since 1991, our state has recognized that each individual possesses a fundamental right to privacy in personal reproductive decisions, including the right to refuse or accept contraceptives. See Wash Rev. Code § 9.02.100. In 2001, my office clarified by rule that plans providing comprehensive prescription coverage are also required to cover contraceptives.

7. In addition to enforcing Washington State's Insurance Code, my responsibilities as Insurance Commissioner also include implementing and enforcing the federal Patient Protection and Affordable Care Act (ACA) and related state laws and regulations in Washington's health insurance market.

8. I have directed my staff to ensure that health plans filed with my office comply with 42 U.S.C. 300 gg-13(a)(4), which requires all health plans (individual, small group, large group, and even self-insured health plans) to cover women's preventive health care services, including contraceptive coverage, with no cost-sharing. These federal requirements were recently codified into state law in Wash Rev. Code § 48.43.072.

9. I have directed my staff to enforce state laws and rules addressing contraceptive coverage. Washington Administrative Code 284-43-5642, provides that a health benefit plan must cover certain essential health benefits, such as "[p]rovider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices" and "[a]ll FDA-approved contraceptive methods, and prescription-based sterilization procedures for women with reproductive capacity." Wash. Admin. Code §§ 284-43-5642(1)(a)(vii), (6)(a)(iii).

10. My staff also administers Washington Revised Code § 48.43.065, the Washington State Conscience Clause, which allows individual health care providers, religiously-sponsored health carriers, health care facilities, and employers that object to providing a particular service for reasons of conscience or religion from being forced to do so. The exemption applies to any health care service, not just contraception. However, the Conscience Clause prohibits allowing one person's personal objection to be the basis for denial of timely access to critical services. Wash. Rev. Code §§ 48.43.065(1), (2)(b). To that end, health carriers are required to let enrollees know, in writing, which services the carrier or employer refuses to cover, and provide written information describing how the enrollee may directly access those services. Wash. Rev. Code § 48.43.065(2)(b)(i)(ii). In allowing individuals who are providing services to object, but still requiring access to the individuals seeking

those services, the Conscience Clause strikes an appropriate balance between the individual objecting to a service, and the right of health plan enrollees to receive contraceptive coverage.

11. To ensure this process works appropriately, my office has also issued rules implementing our Conscience Clause which require carriers who choose to sell plans to employers objecting to a critical service, such as contraceptive coverage, to demonstrate how enrollees will have access to critical services at the time the carrier submits their plan to my staff for review. Wash. Admin. Code § 284-43-5020.

12. Washington's contraceptive parity rules and Conscience Clause requirements may ensure that contraceptive coverage remains in place for many women in Washington, even if the Final Rules are not overturned. However, there are many women in Washington who remain at risk of suffering some harm from the rule, even though state law will still require access to contraceptive coverage.

13. For example, our contraceptive parity rules cannot be enforced against employer self-funded plans, which are governed by the Employee Retirement Income Security Act of 1974. If the Final Rules are not invalidated, women in Washington State who are enrolled in self-insured employer health plans will be at great risk of losing insurance coverage for preventive contraceptive care.

14. 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 Washington State contraceptive mandate.

15. Some women who lose access to insurance coverage for contraceptives due to the Final Rules may seek contraceptive services from state programs that offer contraceptive service. However, these services are not without a cost to the state, and are often limited, based on income. Women with incomes above those program thresholds will have to bear the increased cost of contraceptive services, or forgo using contraception all together.

16. My office has heard from numerous advocacy groups that imposing any cost-sharing requirements on contraceptives, even very low copays, can prevent many women from having meaningful access to contraceptive coverage.

17. Since the announcement of the Interim Final Rules, the OIC has already received calls asking which health insurance policies will be impacted and when women will lose their contraceptive coverage.

18. Women's access to contraceptives and the potential of unintended pregnancy can impact nearly every aspect of a woman's life including her education, employment and economic security. The Final Rules permit self-insured employers in Washington State to reject contraceptive coverage for their employees for any reason, without any mechanism to balance the needs of those employees and their dependents to receive meaningful access to federally mandated care. This will negatively affect women's health, well-being, economic security, and productivity. More importantly, it flies in the face of the fundamental right that women in Washington State have to make their own choices concerning their reproductive health.

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

Executed on June 20, 2019, in Olympia, Washington.

MYRON BRADFORD "MIKE" KREIDLER
Insurance Commissioner

XAVIER BECERRA, State Bar No. 118517
Attorney General of California
KATHLEEN BOERGERS, State Bar No. 213530
Supervising Deputy Attorney General
NELI PALMA, State Bar No. 203374
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF SHANNON LIGHTNER IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, SHANNON LIGHTNER, declare:

1. I make this declaration from personal knowledge and based on records from Illinois Department of Public Health (IDPH) and would testify to the following facts if called as a witness at hearing or trial.

2. I am the Deputy Director at IDPH charged with overseeing the Office of Women's Health and Family Services (OWHFS), which has a number of programs aimed at improving the health of women and children of Illinois, including the Title X program. Prior to this position, I also served as the Senior Health Policy Advisor to the Governor of Illinois, where I worked across state agencies and with constituent and advocacy groups to craft, implement, and manage broad health care initiatives. I have also served on the staffs of multiple U.S. senators in health care advisory capacities.

3. In my professional opinion, the two Final Rules published by the Departments of Health and Human Services, Treasury, and Labor on November 15, 2018, entitled "Religious Exemptions and Accommodations for Coverage of Certain Preventative Services Under the Affordable Care Act" and "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act" will cause a strain on public funding for contraceptive care in the State of Illinois, including the Illinois Medicaid and Title X programs.

**Access to Contraceptive Coverage in Illinois**

4. Illinois law requires all individual or group health insurance policies amended, delivered, issued, or renewed in Illinois to provide contraceptive coverage that matches the federal guarantee provided by the Affordable Care Act (Public Health Service Act 2713(c)). Illinois Insurance Code, 215 ILCS 5/356z.4. The law specifically requires coverage for all contraceptive drugs, devices, and other products approved by the United States Food and Drug Administrative, including all over-the-counter drugs, devices, and products. *Id.* However, the law does not cover women or covered dependents who have coverage through an employer that uses a self-insured plan. Therefore, Illinois women in self-insured employer-sponsored health insurance plans are at risk of losing contraceptive coverage if their employer uses the new accommodations or exemptions in the Final Rule.

5. The State of Illinois also ensures access to contraceptive coverage to Illinois women through its Medical Assistance (Medicaid) program. Illinois Public Aid Code, 305 ILCS 5/5-5. Illinois women with incomes of up to 138% of the federal poverty level are eligible for the Illinois Medicaid program. 305 ILCS 5/5-2. Illinois Medicaid provides coverage for "reproductive health care that is otherwise legal in Illinois." 305 ILCS 5/5-5.

**6.** The State of Illinois also provides contraceptive coverage through IDPH's Family Planning Program. IDPH is a grantee in the federal Title X National Family Planning Program, administered by the U.S. Department of Health and Human Services. Title X is a federal grant program developed to provide funding for a broad range of high-quality family planning services for underserved individuals.

**The Title X Family Planning Program in Illinois**

7. IDPH's Title X funding currently provides direct support to a network of 28 family planning Delegate Agencies. These agencies run 63 clinic sites throughout Illinois that consist of local health departments, health centers, school-based health centers, and hospitals.

8. In Illinois, IDPH's Title X Family Planning Program grants are used to provide voluntary comprehensive family planning services to low-income women and men who are underinsured, uninsured, or otherwise lack access to health care. Through this effort, the program seeks to improve the well-being of communities by lowering the incidence of unintended pregnancy and improving maternal and infant health. IDPH also seeks to reduce the incidence of abortion. The program also aims to reduce the health costs and social impact of unintended pregnancies and the transmission of STIs. Delegate Agencies provide a range of services, including basic infertility services, pregnancy diagnosis, nondirective pregnancy counseling that includes all options, STI diagnosis and treatment, HIV education, and screenings for breast, cervical, and testicular cancer. Delegate Agencies also offer a broad range of effective and medically approved family planning methods and services.

9. Federal law requires Title X clinics to bill private insurance or Medicaid before seeking reimbursement for services. Otherwise, the Delegate Agencies offer sliding scale fees for individuals. Title X regulations make Title X funds last resort funds that are accessed only if all other possible sources of funds are not available. 42 CFR § 59.5(a)(9).

10. IDPH's Delegate Agencies serve 43 counties in Illinois. Those clinics provide services related to family planning and contraception, including physician exams, prescriptions, laboratory tests, and contraceptive supplies, as well as referrals to other facilities when medically needed. Title X services also include related preventive-health services, such as breast and

cervical cancer screenings, and education, testing, and referral for treatment for sexually transmitted diseases (STDs) and HIV.

**Impact of Regulatory Changes on Illinois Title X Program**

11. In my professional experience, women who do not have health insurance coverage for contraceptives will likely still seek such care from Title X providers. I expect that the number of Illinois women seeking contraceptive care from the Title X program will increase if the Final Rules goes into effect. At least some of these women seeking contraceptive care will be financially unable to afford doing so, and such services will then be publicly funded or otherwise go uncompensated.

12. Similarly, women who receive dependent coverage through a spouse's or parent's plan; a decision by the policyholder's employer to exclude contraceptive coverage may leave them without alternatives to coverage. Women may be limited in their ability to obtain alternative insurance (public or private) that includes contraceptive care coverage. These women are likely to continue to seek contraceptive care from a Title X provider if they are excluded from a policyholder's insurance.

13. It is also likely that some women who are denied contraceptive coverage by their employer, or the employer of their spouse or parent, will forego such insurance and enroll in Illinois' Medicaid Program if their incomes are less than 138% of the federal poverty level. This shifts the cost of contraceptive care for these women from their employer to the State of Illinois. In other instances, women with incomes below 250% of the federal poverty level will seek services compensated by Title X. At least some of these women will seek a Title X provider.

14. In 2017, approximately 101,619 women received family planning services from a Title X provider in Illinois, either through an IDPH provider or with Planned Parenthood or Aunt Martha's Youth Service Center. Of those, 38% had publicly funded insurance, 28% had private

insurance, and 33% were uninsured. If these numbers expand because of a loss of employer-sponsored coverage under the Final Rules, this will constrain the resources of Title X funding throughout the State of Illinois and put additional financial burdens on reduced- and no-cost contraceptive services and programs in Illinois, as well as an emotional and financial strain on the women who are now seeking contraceptive care without the benefit of employer-sponsored insurance coverage.

15. Family planning and the use of contraceptives is the most effective way to avoid unintended pregnancies. If it is more difficult for women to access contraceptives, unintended pregnancies will naturally increase. In my professional experience, it is likely that women who lose contraceptive coverage as a result of the Final Rules may not receive contraceptive care and experience unintended pregnancies. Those unintended pregnancies are likely to increase costs for Illinois Medicaid and other publicly funded programs. According to one study, 78.3% of unplanned pregnancies were publicly funded in Illinois, at least in part with state funds. Guttmacher Institute, "Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010," Feb. 2015, Table 1.

Executed on June 27, 2019, in CHICAGO, ILLINOIS.

SHANNON LIGHTNER
Deputy Director of the Office of Women's Health and Family Services
Illinois Department of Public Health

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF RUTH LYTLE-BARNABY IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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 that provide healthcare 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 seven 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 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 November 15, 2018 (Final Rules) 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 Final Rules 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 provided 11,253 patient visits in 2018, more than 30% of the Delaware women of reproductive age who are in need of publicly funded family planning services. 6,251 (77.4%) 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 calendar

year 2018, these affiliates served more than 8,000 unique patients; 77.4% were at or below 200% of the federal poverty line. Of those, 84% are below 138% of the federal poverty line. PPDE affiliates provided contraception to more than 5,700 patients, conducted more than 3,000 pregnancy tests, and provided nearly 18,000 tests and treatments of sexually transmitted infections. PPDE also provided sexual health education programs to 5,128 youth in Delaware in 2018.

## 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.

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 recently started offering prenatal care. This is an overview of the primary services received by unduplicated patients at a Planned Parenthood of Delaware health center: STI tests (78.5%); contraception (70.7%); pregnancy tests (37.6%); abortion (16.6%); breast exams (19.3%); Pap tests (8.7%); HIV tests (17.8%); emergency contraception (2.8%).

14. In calendar year 2018, Planned Parenthood saw over 8,000 unique patients in over 11,000 appointments. In calendar year 2018 we served Delaware with:

a. Contraception to more than 5,700 patients
b. Almost 300 emergency contraception tests
c. Over 3,000 pregnancy tests
d. Over 800 cervical cancer screenings
e. Over 1,500 breast cancer exams and BRSQ Screening Questionnaires
f. Over 20,000 tests and treatments for sexually transmitted infections
g. Sexual health education programs reaching 5,128 youth.

15. Planned Parenthood primarily serves low income patients in Delaware who have limited access to health care services.

a. Approximately 83% of our patients are women, of those 83.5% are in the prime reproductive age range of 18 to 39;
b. 77.4% are below 200% of the federal poverty level ($24,281 for one person). Of those, 69% are below 100% of the federal poverty level ($12,140) 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, and 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 2018, our sexual health education programs reached 5,128 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 30% of Planned Parenthood's patients receive their health care through DMMA. 28.3% are enrolled in the Managed Care Program, described in greater detail below. Approximately two percent (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. 71.3% of PPDE's patients are Title X eligible.

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 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. Ninety-nine percent (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 FINAL RULES

26. I have reviewed and am familiar with the new contraceptive coverage Final Rules. Under them, any employer that claims a religious or moral objection to providing contraceptive

[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).

[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

coverage would be exempt. In addition, the Final Rules 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 Final Rules. 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, 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 true and correct and of my own personal knowledge.

Executed on June 17, 2019 in New Castle County, DE.

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

[4] Guttmacher Institute

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF HEATHER MAISEN IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Heather Maisen, MSW, MPH, declare:

1. I am currently the Family Planning Program Manager for Public Health – Seattle & King County (PHSKC). I have been employed by PHSKC in the Family Planning Program for over thirteen (13) years.

2. I earned a Master of Social Work and a Master of Public Health from the University of Washington, and I have spent my career working in the field of family planning across various agencies, including non-profit, university and local government.

3. King County is the most populous county in Washington State, and the 13th-most populous county in the United States. Of the two million plus residents in King County, WA, almost a quarter are women of reproductive age (13-44 years old). King County has one of the lowest teen birth rates (9.7 per 1,000) compared to peer counties across the country.

4. Washington State's Medicaid program, Apple Health, has expanded Medicaid and a state-sponsored Medicaid program for women who are pregnant and low-income. The Apple Health for Pregnant Women program covers all pregnancy-related costs, including termination and birth related costs.

5. PHSKC is one of the largest metropolitan health departments in the United States. The health department provides critical health care to some of the most vulnerable populations in the county.

6. Clinics operated by PHSKC serve approximately 10,000 women of reproductive

age, and provide contraceptive services across various programs in 20 different clinical locations throughout King County. PHSKC's primary contraception provision is through the Family Planning Program.

7. The Family Planning Program at PHSKC works specifically to decrease teen pregnancy, unintended pregnancy, and sexually transmitted infections (STIs) in King County. Family planning services provided by PHSKC prevented an estimated 1,040 unintended pregnancies and 350 abortions, and saved over $6.5 million in health care costs in 2018 alone.

8. The Family Planning Program offers comprehensive family planning services at no or low cost to low-income people. These services include all FDA-approved forms of contraception, emergency contraception, pregnancy testing and counseling, preconception counseling, sterilization, certain infertility services, STD testing and treatment, cancer screening, HIV screening, and individualized reproductive health education and counseling. The Family Planning Program is funded, in part, from insurance reimbursement and federal Title X and state family planning grants provided by Washington State's Department of Health. However, these revenue sources do not cover the full cost of services.

9. The final rules issued by the federal government would harm King County because women would be at risk of losing Affordable Care Act required contraceptive coverage. There are over 400,000 women of reproductive age in King County, approximately 100,000 of whom are in need of publicly funded contraception.

10. Currently, 10% of King County's population is enrolled in Medicaid, whereas approximately 70% have employer-based health insurance. Under the final rule, if women lose their contraceptive coverage benefits, they are uninsured for these services.

11. As a result of these rules, women will either (a) utilize and seek coverage through our Public Health family planning clinics at a cost to our program without additional revenue to offset these costs, or (b) they will forgo coverage and experience an unintended pregnancy. In both scenarios, the County will bear the burden of increased costs and its residents will be harmed.

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

Executed on June 20 2019, in Seattle, WA.

Heather Maisen, MSW, MPH
Family Planning Program Manager for
Public Health – Seattle & King County

XAVIER BECERRA, State Bar No. 118517
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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.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF LAURA MEYERS, Ph.D.**

Pursuant to 28 U.S.C. § 1746, I, Dr. Laura Meyers, declare and state as follows:

1. I am the President & CEO of Planned Parenthood of Metropolitan Washington, D.C. ("PPMW"). I have been the President & CEO of PPMW since 2008. Prior to joining PPMW in 2008, I was the CEO of Planned Parenthood of Western New York.

2. I received my Bachelor of Arts from the State University of New York at Albany in 1978. I then earned my Masters in Counseling from University at Buffalo in 1981. In 1996, I earned my Ph.D. in Social Foundations of Education from the University at Buffalo. I was a graduate of the Jacobs School of Management Center for Entrepreneurial Leadership Program at the University at Buffalo as well as the Community Health Foundation of Western and Central New York's Community Healthcare Leadership Fellowship program.

3. In addition to my role at PPMW, I also currently serve as the Chair of the Board of Directors of the National Family Planning and Reproductive Health Association. Previously, I co-chaired the Health, Human Services and Homelessness Committee as part of D.C. Mayor Muriel Bowser's Transition Team.

4. This declaration is based on my personal knowledge, my review of PPMW's business records, and the knowledge I have acquired in the course of my over fifteen years of service and duties with Planned Parenthood affiliates, including PPMW. If called and sworn as a witness, I could and would testify competently to the information in this declaration.

5. PPMW is the Planned Parenthood affiliate for the District of Columbia, Northern Virginia, and Maryland's Prince George's and Montgomery Counties. It provides services to approximately 18,000 patients annually at three health center locations in the District of Columbia; in Gaithersburg, Maryland; and in Suitland, Maryland and through associated online health services.

6. As discussed more fully below, the two 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 November 15, 2018 ("FRs") would have devastating consequences for the people of the District of Columbia who rely on PPMW for a variety of reproductive health and family planning care.

7. In Fiscal Year 2018 ("2018"), PPMW provided services to over 10,000 patients over the course of nearly 14,000 visits to its health center in the District of Columbia. These services included, for example, (a) contraceptive services for approximately 5,360 patients, (b) nearly 500 Pap tests, (c) over 600 breast health exams, and (d) approximately 14,300 tests for sexually transmitted infections.

8. Each year, PPMW serves thousands of low-income patients in the District of Columbia who have limited access to health care services. In 2018, forty-four percent (44%) of patients were below 200% of the federal poverty level, which is an annual income of less than $24,280 for one person. Of those patients, twenty-seven percent (27%) were below the federal poverty level, which is an annual income of less than $12,140 for one person.

9. In 2018, approximately ninety-two percent (92%) of our patients at the District of Columbia health center identified as women, almost all of whom were in the prime reproductive age range of 18 to 39. Our patients are racially and ethnically diverse: approximately 37% of our patients at our District of Columbia health center in 2018 were Black; 35% white; 10% Latinx; 7% Asian/Pacific Islander; and 11% multi-racial, other, or unknown.

10. Our District of Columbia health center is staffed with experienced practitioners at multiple levels. We employ physicians, advanced practice clinicians (nurse practitioners, registered nurses) and health center assistants. Each operates within their particular, authorized scope of practice so that health care services are delivered as efficiently and cost-effectively as possible.

11. PPMW provides reproductive health care services including wellness exams, contraception counseling, breast health exams, cancer screenings, birth control, HPV vaccinations, sexually transmitted infection testing and treatment, PEP and PReP for HIV prevention, pregnancy testing and option counseling, emergency contraception, sterilization, and abortion services.

12. Patients come to PPMW for the accurate, nonjudgmental, compassionate and confidential care and information they need and deserve. Providers are trained to be culturally competent, which is essential with our diverse patient base.

13. PPMW also engages in advocacy and public education activities. In 2018, our sexual health education programs reached 1,276 youth in the District of Columbia.

14. PPMW provides services to individuals who are uninsured, participate in a Medicaid program, or are covered by private insurance.

15. When patients at PPMW's District of Columbia health center do not have Medicaid or private insurance coverage, or have insurance without contraceptive coverage, patients must self-pay for services and contraceptive supplies. Of the 13,875 patient visits to PPMW's District of Columbia health center in 2018: (a) 1,563, or about 11%, of patients used Medicaid to pay for services (including Medicaid Managed Care); (b) 6,684, or about 48%, of patients used self-pay to pay for services, including abortion; and (c) 5,628, or about 41%, of patients used private insurance to pay for services.

16. When patients do not have Medicaid or private insurance coverage, have insurance without contraceptive coverage, or have insurance with high deductibles, patients are often unable to afford the services they need. PPMW often covers a portion of the cost, such as when the medically appropriate contraceptive choice for a patient is unaffordable for that patient.

17. As noted above, 5,628 of patient visits to the District of Columbia health center in 2018 were covered by private insurance. PPMW patients who are covered by insurance plans which the employer self-funds are at risk for losing contraception coverage under the FRs because their employers could claim a religious or moral exemption and discontinue coverage. Since 2018, the District of Columbia has mandated that D.C.-regulated health plans cover contraception. However, self-funded insurance plans are governed by the federal Employee Retirement Security Act (ERISA).

18. Since the FRs permit an individual to refuse insurance coverage of contraception, even more of PPMW's insured patients are at risk. Some patients are not the policyholders 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 of the policyholder. Women facing domestic violence within their families are also at risk for loss of contraceptive coverage. If the policyholder is the abuser, that person could discontinue

contraceptive coverage, which is a tactic to block access to contraception as part of controlling, abusive behavior.

19. Further, across all three PPMW health centers, in 2018 PPMW saw 773 patients from 44 states other than our service areas of D.C., Maryland and Virginia. Since we are based in the Metropolitan Washington, D.C. area, an area with many students and temporary residents with out-of-state health plans, I believe that individuals who lose contraceptive coverage under out-of-state health plans may come to PPMW, and PPMW would face additional costs of trying to cover services.

20. 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 PPMW's District of Columbia health center for services. Women know that Planned Parenthood's mission is "Care. No matter what."

21. PPMW provides services to a significant number of Medicaid and Medicaid Managed Care participants: 1,563 patient visits in 2018 alone. As a result of the FRs, I believe that some eligible women may forgo employer coverage and enroll in Medicaid. As a result, the cost of coverage would shift from the employer to the District of Columbia and the federal government.

22. Contraceptive services are basic, preventive health care for women, improve the lives of families, and should be part of insurance coverage. If women who lose contraceptive coverage do not qualify for or are unable to obtain coverage under Medicaid, or face disruptions in obtaining contraceptive coverage, 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% (Lawrence B. Finer, Ph.D. and Mia R. Zolna, M.P.H., Declines in Unintended Pregnancy in the United States, 2008-2011, New Eng. J. Med 374: 843-52 (2016)).

23. The FRs will interfere with individuals' ability to access contraception, which is not in the best interests of our community in the District of Columbia.

24. Women who obtain services at PPMW frequently tell us that contraception 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.

25. PPMW is dedicated to serving all individuals regardless of income level or insurance status. PPMW, 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 private or public markets. If contraceptive coverage is not provided by an employer, only publicly-funded programs, such as 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.

26. I believe the FRs could create financial risk to the District of Columbia. The District of Columbia would have to decide whether to 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 District of Columbia cannot or decides not to increase funding, women will be at greater risk for unintended pregnancies, and the District of Columbia will face the potential economic consequences of associated disruption to these women's educational and career progress, as well as the public expenses associated with an increased number of live births.

27. I also believe the FRs will impede efforts to improve the reproductive health of women in the District of Columbia.

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

Executed on April 18, 2019, in Washington, DC.

Laura Meyers, Ph.D.
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Planned Parenthood of Metropolitan Washington, D.C.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF TRINIDAD NAVARRO, INSURANCE COMMISSIONER OF DELAWARE, IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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 Final Rules that affect contraceptive coverage (the "Final Rules"), which are the basis for the Second Amended Complaint. As drafted, the Final Rules would allow any employer or insurer that asserts a religious or moral objection to providing contraceptive coverage to claim a coverage exemption. The Final Rules 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 Final Rules 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, consistent with the ACA's coverage mandate, passed in 2018 legislation requiring all individual, group and blanket health insurance policies delivered or issued for delivery in the State 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. *See* 18 *Del. C.* §§ 3342A and 3559 (the "2018 Delaware Contraceptive Equity Act"). This legislation also applies to the State employee health plan and public assistance plans. *See* 29 *Del. C.* § 5203A; 31 *Del. C.* § 526.

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 2018 Delaware Contraceptive Equity Act apply, may impose cost sharing in certain circumstances, "as long as at least 1 drug, device, or other product for that [contraceptive] method is available without cost-sharing." *See* 18 *Del. C.* §§ 3342A(b)(1)b. and 3559(b)(1)b.

10. For group plans, 18 *Del. C.* § 3559(f) includes a religious employer exemption as follows: "[a] religious employer may request and an entity subject to this section shall grant an

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

exclusion from coverage under the policy, plan, or contract for the coverage required under this section for the insertion and removal and medically necessary examination associated with the use of FDA-approved drugs or devices 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 2018 Delaware Contraceptive Equity Act will provide some protection to Delawareans in maintaining their contraceptive coverage in the event of changes to federal law. However, because the State does not have regulatory authority over self-insured plans, other than its own State employee health plan, the Act does not protect the Delawareans covered under these self-insured 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 Final Rules include not only female employees of self-insured 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 Final Rules 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 Final Rules 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

[2] https://www.guttmacher.org/sites/default/files/factsheet/de_8_0.pdf

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 Final Rules are not stricken.

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

Executed on June 11th, 2019 in Kent County, Delaware.

T. L. Navarro

Trinidad Navarro
Delaware Insurance Commissioner

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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.**

4:17-cv-05783-HSG

**DECLARATION OF KAREN NELSON IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**DEPARTMENT OF THE TREASURY; DOES 1-100,**
Defendants,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**
Defendant-Intervenors.

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 24 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 33,000 family planning 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 Final Rules, as published on November 15, 2018 by the U.S Health and Human Services Department, in conjunction with the U.S. Department of Labor and the U.S

Department of Treasury, would have a devastating impact on some women in Maryland who rely on PPM and PPMW for health care services, including contraceptive services. The Final Rules 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 2017, Planned Parenthood of Maryland provided family planning services to 27,527 patients in Maryland at its health centers in Annapolis, Baltimore, Easton, Frederick, Owings Mills, Towson, and Waldorf. In 2017, Planned Parenthood of Metropolitan Washington, DC provided family planning services to 5,480 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 2018, PPM received $2,313,835 in Title X funds, and in Fiscal Year 2018, PPMW received $150,000 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

[1] Response to Inquiry Concerning the Availability of Publicly Funded Contraceptive Care to U.S. Women, Guttmacher Institute, May 2017

vaccinations, sexually transmitted infection testing and treatment, pregnancy testing and option counseling, emergency contraception, sterilization, and abortion services.

11. Of the 33,007 patients to whom PPM and PPMW provided services in 2017, 30,138 were female. The payor mix for this group was:

a. 10,197 Medicaid patients (including Medicaid, MCHP, and Medicaid Family Planning Program), representing 33% of PPM and 18% of PPMW's patients at Maryland health centers;

b. 8,562 Title X patients, representing 22% of PPM and 46% of PPMW's patients at Maryland health centers;

c. 3,939 patients who receive services, including abortion, not covered under Title X or who fall into a miscellaneous eligibility category, representing 12% of PPM and 14% of PPMW's patients at Maryland health centers; and

d. 10,309 commercially insured patients, representing 33% of PPM and 22% of PPMW's patients at Maryland health centers.

**Risk to Planned Parenthood's Insured Patients**

12. As noted above, over 10,000 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 Final Rules 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] In 2018, Maryland again improved coverage by requiring coverage of 12-months dispensing of contraception.[4] However, self-funded insurance plans are not required to comply with State law,

[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

as these plans are exempt from State insurance laws by the federal Employee Retirement Security Act (ERISA).

13. Since the Final Rules 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 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 Final Rules, women in insurance plans which the employer self-funds will be at risk of losing contraceptive coverage. Since approximately 1.49 million Marylanders are covered through self-funded insurance plans, a substantial number of women are at risk for losing contraception coverage.[5] 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**

[4] House Bill 1283 - Health Insurance - Prescription Contraceptives - Coverage for Single Dispensing, 2018, http://mgaleg.maryland.gov/2018RS/bills/hb/hb1283T.pdf

[5] Maryland Insurance Administration, *2017 Maryland Covered Lives Report* (December 2017), https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2017-Report-on-the-Number-of-Insured-and-Self-Insured-Lives-MSAR7797.pdf

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 $2,463,835 (PPM and PPMW Fiscal Year 2018). 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 in Fiscal Year 2020 is $9.2 million, with $6 million in State funds and $3.2 million in federal funds.[6] Under legislation enacted by the Maryland General Assembly in 2017 and 2019, the State of Maryland may have to bear significantly greater financial responsibility for the Title X program using State general funds.[7] If Title X providers lose federal funding because of a federal prohibition on the provision or referrals for abortion services, the State will have to provide substitute funding.

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.[8]

18. Women with incomes up to 250% of the federal poverty level are eligible for the Title X program whether they are uninsured or have commercial insurance. Under the final rule from the U.S. Department of Health and Human Services published on November 15, 2018, commercially insured women over 250% of the federal poverty level would also be eligible for contraceptive services if their employer-sponsored plan does not cover the contraceptive services sought by the woman because of a sincerely held religious or moral objection to providing such coverage.[9] 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

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[6] Fiscal Note for House Bill 1272 – Family Planning Program - Funding, Department of Legislative Services, 2019, http://mgaleg.maryland.gov/2019RS/fnotes/bil_0002/hb1272.pdf

[7] House Bill 1083 – Family Planning Services – Continuity of Care, 2017, http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_28_hb1083T.pdf and House Bill 1271 – Family Planning Program – Funding, http://mgaleg.maryland.gov/2019RS/bills/hb/hb1272E.pdf

[8] *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

[9] 83 Fed. Reg. at 25530.

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 Final Rules, 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.[10] 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 Final Rules, insurance plans have been required to provide contraceptive counseling and most contraceptive options without copayment. If women lose contraception coverage and turn to Title X, under the current regulatory scheme, 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

[10] 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

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.[11] The average monthly enrollment was 12,852.[12] 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 250% 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 Final Rules, 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.

**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 2015, HealthChoice spent $33.7 million on family planning services with 10% from State funds and 90% in federal funds.[13]

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[11] 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

[12] 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

[13] 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

27. Planned Parenthood provides services to a significant number of Medicaid and MCHP participants - over 10,000 in 2017 alone.

28. As a result of the Final Rules, 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.[14]

30. If women who lose contraceptive coverage do not qualify for 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%.[15] 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**

[14] 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

[15] 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).

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 Final Rules allow employers, individuals, and insurers to separate contraceptive coverage from health care coverage. As a result, the Final Rules 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.

**Overall Impact on the State**

34. I believe the Final Rules 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 Final Rules 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 June 24 2019 in Baltimore, Maryland.

Karen Nelson

Karen Nelson
President and CEO
Planned Parenthood of Maryland

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF PHUONG H. NGUYEN, M.D., INTERIM ENTERPRISE CHIEF MEDICAL OFFICER FOR SANTA CLARA VALLEY MEDICAL CENTER, O'CONNOR HOSPITAL AND ST. LOUISE REGIONAL HOSPITAL IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Phuong H. Nguyen, declare:

1. I submit this Declaration in support of the State of California's Motion for Summary Judgment. I have personal knowledge of the facts stated herein and, if called as a witness, I could testify to them competently under oath.

2. I currently serve as Interim Enterprise Chief Medical Officer for Santa Clara Valley Medical Center (SCVMC), O'Connor Hospital (OCH), and St. Louise Regional Hospital (SLRH) (collectively the "Hospitals and Clinics") which are a part of the health care delivery system within the County of Santa Clara Health System (CSCHS). I have been employed by the County of Santa Clara (County) in various capacities for a total of nineteen (19) years, and I have practiced as an obstetrician/gynecologist in a clinical capacity throughout my employment with the County at SCVMC. As of March 1, 2019, when the County assumed operations of OCH and SLRH, I became Interim Enterprise Chief Medical Officer of the Hospitals and Clinics.

3. Santa Clara County is located at the southern end of the San Francisco Bay and is home to 1.9 million residents who rely on the County to provide essential services such as health care, assistance for youth and the elderly, and a wide array of social services.

4. The County of Santa Clara Health System operates SCVMC, OCH, and SLRH under a single consolidated hospital license and with a single consolidated medical staff. The consolidated medical staff currently includes 1202 physicians and advance practice providers at SCVMC, 681 physicians and advance practice providers at OCH, and 262 physicians and

advance practice providers at SLRH. As Interim Enterprise Chief Medical Officer, I supervise the consolidated medical staff for the three hospitals, including overseeing the recruitment, hiring, training, scheduling, and supervision of physicians and advanced practice providers (APP).

5. CSCHS (is the only public safety-net healthcare provider in Santa Clara County, and the second largest such provider in California. SCVMC operates a 731 licensed bed hospital, eleven ambulatory care clinics, medical and dental mobile units, along with specialized centers that provide trauma, burn, rehabilitation, renal, acute inpatient psychiatric, and ambulatory care. It has approximately 6,500 employees, including more than 350 physicians who train more than 180 residents and fellows per year as a graduate medical education provider and teaching institution. SCVMC is a Level 1 Adult Trauma Center and Level 2 Pediatric Trauma Center. Its burn and rehabilitation centers have been nationally recognized, and its ambulatory specialty center and renal care center are state of the art.

6. SCVMC provides a full range of inpatient and outpatient health services, including emergency and urgent care, adult and pediatric primary care services, behavioral health services, comprehensive adult and pediatric specialty services, Level III neonatal intensive pediatric services, women's health services, comprehensive oncology services, and other critical health care services for any resident of the County, regardless of ability to pay.

7. SCVMC provides the vast majority of the health care services available to poor and underserved patients in the County. In fiscal year 2017-18, there were more than 800,000 outpatient visits to SCVMC's primary care, express care, specialty clinics, and emergency department, and over 120,000 days of inpatient stays in the hospital. Patients who are uninsured, reliant on Medi- Cal, or on Medicare were responsible for approximately 88% of outpatient visits and approximately 85% of inpatient days. In 2018, SCVMC's hospital had an average daily census of 363 patients admitted to inpatient care and handled 3,087 births and 88,856 emergency department visits.

8. OCH, also located in San José, provides emergency medical services, urgent care services, primary care, hospital care, and reproductive-health services. OCH operates a nationally

recognized acute care hospital with 334 licensed acute beds; 24 licensed skilled nursing (SNF) beds; an estimated 681 physicians and advance practice providers and 1,446 employees. The hospital handled an estimated 51,948 emergency visits, 4,311 surgical cases, and 1,631 births in 2018. OCH is the home of one of the only family medicine residency programs in the Bay Area. In addition, the hospital has clinical specialties, including but not limited to, cancer, cardiology and cardiac rehabilitation, maternal child health services, orthopedics and joint replacement, rehabilitation and sports therapy, spine care and pain management, stroke prevention and treatment, and wound care.

9. SLRH, located in the City of Gilroy, provides a wide range of high-quality inpatient and outpatient medical care. SLRH operates the only acute care hospital in the southern, rural part of the County, providing maternal child health services, emergency services, women's health, imaging, surgical and specialty procedures, medical intensive care services and wound care. The hospital operates 72 licensed, acute beds, and has an estimated 262 physicians and advance practice providers and 500 employees. In 2018, SLRH had 29,635 emergency room visits.

10. Altogether, the County's three hospitals dealt with 160,000 emergency room visits in 2018.

11. The County also provides health care and related services through its Public Health Department. The mission of the County Public Health Department is to promote and protect the health of the county's entire population. None of Santa Clara County's fifteen cities and towns have a health department. All fifteen cities and towns, and all the County's residents, rely on the Public Health Department to perform essential public health functions including preventing and controlling the spread of infectious diseases such as STDs.

12. The County provides contraceptive services to county residents regardless of their ability to pay.. For example, SCVMC's Ambulatory Care Clinics provide a full range of reversible contraceptive services, including family planning counseling, prescriptions for barrier contraception, birth control pills, intrauterine device and birth control implant insertions,

emergency contraceptives, and abortion services. In addition, SCVMC provides female and male sterilization procedures to patients who request them. Free condoms are distributed by the Public Health Department by its STD/HIV Prevention & Control program through the program's clinical sites as well as through outreach events to the community.

13. The County also provides safety-net services as a provider for California's Family Planning, Access, Care, and Treatment (PACT) Program. Through the Family PACT Program, a network of 2,200 providers—including the County—offer comprehensive family planning services at no cost to low-income people. These services include all FDA-approved forms of contraception, emergency contraception, pregnancy testing and counseling, preconception counseling, sterilization, certain infertility services, STD testing and treatment, cancer screening, HIV screening, and individualized reproductive health education and counseling. Funding for Family PACT services is provided by California and the federal government as part of California's Medicaid program, but the reimbursements paid to Family PACT providers do not cover the full costs of providing these services.

14. Thousands of Santa Clara County residents are insured through self-funded employer health plans. Under the final rules, employers offering self-funded health plans can drop contraceptive coverage with minimal or even no notice to employees and beneficiaries, potentially leaving thousands of County residents without coverage for necessary contraceptive services.

15. This loss of coverage would likely strain the County's already thinly stretched family planning resources, require the County (at significant expense) to both expand its no- and low-cost contraceptive and STD services, and absorb many of the immediate and long-term costs of unintended pregnancies on county residents, their families, and communities.

16. The final rules will likely increase demand for the County's no- and low-cost contraception and STD services as employers take advantage of the expanded exemption to eliminate coverage for contraceptive care. For example, as more employers eliminate contraceptive coverage under the final rules, more low-income people will likely seek family

planning services through Family PACT, and the costs to the County will increase. Similarly, the County will likely see increased use of its Ability to Pay Determination (APD) Program, which reduces the liabilities of certain indigent patients for services received from SCVMC, in accordance with their ability to pay. Patients who lack employer-provided insurance coverage for contraceptives and who are not eligible for other insurance may apply for the APD program, and more are likely to do so under the final rules, at direct cost to the County.

17. The County's health system already operates at a significant deficit because of the volume of uncompensated costs it incurs in serving uninsured and under-insured patients. For example, during Fiscal Year 2017-18, SCVMC received approximately $131.8 million in subsidies from the County's General Fund so it could continue to provide critical healthcare services to uninsured and under-insured patients. The final rules are likely to increase uncompensated costs and widen the health system's operating deficit, further straining the County's General Fund.

18. In addition to causing direct financial strain on state and local governments, non-profit health care providers, and scores of individuals, the final rules will likely also exacerbate public health concerns in the County. When people are less able to access contraceptive services, STD rates are likely to increase and the need for STD-related services rises. Thus, the rules are likely to increase the need for the County's free and low-cost services for STD prevention and treatment.

19. I also understand that the County's Public Health Department provides a range of STD-related services, including sexual health counseling, STD prevention supplies, STD screening, STD treatment, and HIV pre-exposure and post-exposure prophylaxis. The fees the clinic collects do not cover the costs of providing STD-related services, and these costs are likely to increase due to these rules.

20. These services are critical to protecting public health The County has experienced a rise in chlamydia, gonorrhea, and syphilis. Between 2010 and 2017, cases of chlamydia steadily increased over time from 271.3 cases per 100,000 people in 2010 to 392.7 cases in 2017, and

gonorrhea rates increased by nearly fourfold from 33.1 cases per 100,000 people in 2010 to 126.4 cases in 2017, with a 26% rapid increase from 2016 to 2017. Rates of early syphilis diagnoses nearly tripled from 6.2 cases per 100,000 people in 2010 to 21.1 cases in 2017. There was a sharp 57% increase in the number of early syphilis cases between 2015 and 2016. The number of early syphilis cases in 2017 was 16% higher than the number in 2016. HIV/AIDS is another serious public health concern in the County. In 2015, there were 2,734 people living with HIV/AIDS in the County, and in 2017, that number had risen to 3,361 people living with HIV/AIDS in the County. The rules are likely to exacerbate these serious public health problems and increase the burden on the County to address and prevent the spread of these diseases.

21. The effects of congenital syphilis illustrate the potentially devastating impact of the loss of insurance coverage for contraceptive services due to the final rules. Based upon my years of clinical practice as an obstetrician/gynecologist, I have observed that when a pregnant woman's syphilis infection is not caught during pregnancy, babies often contract congenital syphilis and suffer devastating clinical outcomes, including heart problems, blindness, deafness, bone deformities, and death. Prenatal care is an extremely effective defense against these devastating outcomes: 98 percent of cases of congenital syphilis can be prevented when a pregnant woman is treated. For this reason, state law requires health care providers to screen all pregnant patients for syphilis at their first prenatal encounter—ideally during the first trimester. Early detection leads to earlier treatment, which can reduce risks of morbidity to the pregnant patient and fetus, and thereby significantly reduce costs to the infant's family and public healthcare providers like the County. Healthcare for nonpregnant women of childbearing age—whether through Medicaid, CHIP, or otherwise—mitigates these risks, since the greater the incidence of early syphilis in these women and the greater risk of unintended pregnancies, the greater the risk for the public health and individual health harms associated with congenital syphilis.

22. Decreased access to contraception under these rules is also likely to increase unintended pregnancies, triggering immediate and long-term costs to the County and

communities nationwide. As the safety-net healthcare provider, the County funds many of the medical services associated with unintended pregnancies, which disproportionately affect young, low-income, minority women, without higher education who are likely to rely on the County-funded services if their employer eliminates contraceptive coverage.

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

Executed on June 24, 2019, in San José, California.

Phuong H. Nguyen, M.D.,
Interim Enterprise Chief Medical Officer
Santa Clara Valley Medical Center,
O'Connor Hospital and St. Louise Regional Hospital

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF ANA NOVAIS, DEPUTY DIRECTOR OF THE RHODE ISLAND DEPARTMENT OF HEALTH, IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Ana Novais, declare under penalty of perjury that the following is true and correct and of my own personal knowledge.

1. I have served as the Deputy Director of the Rhode Island Department of Health since June 1, 2019; prior to this recent promotion, I served as the agency's Executive Director since June 10, 2007. As Deputy Director and Executive Director, I have been primarily responsible for operationalizing our Director's three leading priorities for the agency: (1) addressing the socioeconomic and environmental determinants of health; (2) eliminating disparities of health and promoting health equity; and (3) ensuring access to quality health services for all Rhode Islanders, including the state's vulnerable populations. Preventing unintended pregnancies falls under each one of these priorities.

2. The State of Rhode Island provides publicly funded contraceptive coverage through its state Medicaid Program and the Title X Family Planning Program. There are about 222,000 women in need of contraceptive services in Rhode Island. Rhode Island's Title X Family Planning Program serves about 29,000 people each year. Rhode Island's Medicaid Program provides extended family planning benefits for two years post-partum.

3. Rhode Island does not have a state law that matches the federal guarantees provided by the Affordable Care Act (Public Health Service Act 2713(c)). For example, although Rhode

Island's statute covers prescription contraception for up to 365 days at a time, it does not prohibit cost sharing. Women in Rhode Island are at risk of losing Affordable Care Act required contraceptive coverage under the final regulations issued by the federal government. Forty-four (44%) of pregnancies in Rhode Island are unintended. 71,320 women need publicly funded contraceptive services in Rhode Island. The percentage of need met by Title X clinics and publicly supported providers in Rhode Island is currently only 35%.

As a result of these rules, Rhode Island women will either (a) utilize and seek coverage through the Title X Family Planning Program or (b) forgo coverage and experience unintended pregnancies. In both scenarios, the State will suffer increased costs and its residents will be harmed.

Executed on June 24, 2019 in Providence, Rhode Island.

Ana Novais
Deputy Director
Rhode Island Department of Health

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF JUDY MOHR PETERSON IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Judy Mohr Peterson, declare:

1. I serve as the Medicaid Director for the State of Hawaii. I have been in this role since July 2015. Prior to that, I served as the Medicaid Director for the Oregon Health Authority in the State of Oregon (2009-June 2015)

2. The State of Hawaii Medicaid program, Med-QUEST, provides coverage for family planning services, maternity and newborn care, pregnancy-related services, and contraceptives. Med-QUEST covers adults up to 133% of the federal poverty level, pregnant women up to 191% of the federal poverty level, and children up to 305% of the federal poverty level.

3. The State of Hawaii has a law that mandates employer group accident and health or sickness plans to provide contraceptive services or supplies. Unlike the federal law (Public Health Service Act 2713), Hawaii law permits an insurer to collect copayments on contraceptive supplies so long as they are not unusual. Hawaii law provides that coverage shall include reimbursement to a health care provider or dispensing entity for prescription contraceptive supplies intended to last up to a twelve-month period for an insured and that coverage of contraceptive services shall extend to any dependent of this subscriber who is covered under the policy. The State of Hawaii law does not cove women and covered dependents who have coverage through an employer that uses a self-insured plan. Hawaii has 30.5 percent of its workforce in a self-insured plan.

4. Med-QUEST covers and pays for nearly a third of all births in the state.

5. As a result of these rules, women will either (a) utilize and seek coverage through Med-QUEST resulting in increased enrollment, or (b) they will forgo coverage and experience unintended pregnancies. In both scenarios, the State will suffer increased costs.

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

Executed on June 21, 2019, in HONOLULU, HAWAII.

JUDY MOHR PETERSON
Administrator, Med-QUEST Division
Department of Human Services
State of Hawaii

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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.

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF ROBERT POMALES**

I, Robert Pomales, declare:

1. I am the Executive Director of University of Massachusetts Boston's ("UMass Boston") University Health Services ("UHS"").

2. I began working at UMass Boston in 2015 in my current role as an Executive Director. In my current position, I am responsible for managing the UMass Boston UHS and administration of all health and prevention services provided on campus to students of UMass Boston. I have personal knowledge of the services of and requirements governing the UMass Boston UHS.

3. UMass Boston UHS is committed to providing quality physical and mental health services to our students to promote and enhance the well-being of our campus community.

4. UMass Boston UHS services are designed to increase awareness of health related issues, assist students with making responsible decisions relative to health promotion and disease prevention, and provide quality health care to the UMass Boston students.

5. To support UM ass Boston's commitment to student health, among other things. UHS makes available to student clinic visits for contraceptive medication management.

6. Some UMass Boston students obtain health insurance under UMass Boston's student health insurance plan, some through their or someone else's employer-sponsored insurance. Others are insured through MassHealth, Massachusetts's Medicaid program, or other public insurance programs, and some students are uninsured.

7. UHS bills students' health insurance for the clinic visits related to contraceptive medication management.

8. In Fiscal Year 2017, UHS conducted 126 clinic visits for 92 unique patients for the purpose of contraceptive medication management. Eighteen of those patients had insurance other than through UMass Boston's student health insurance plan and accounted for 27 of the clinic visits, resulting in total charges of $2,025 by UHS to those outside insurance plans.

9. Approximately 14,000 UMass Boston students have health insurance coverage through their or someone else's employer-sponsored insurance. Some of these students receive

coverage from parents and/or employers that are located in states other than Massachusetts. In some instances, the insured resides in a second state and the employer is located in a third state.

10. An increase in the prevalence of employer-sponsored insurance that does not provide coverage for contraceptive coverage would result in an increase in the number of UHS clinic visits that would not be eligible for reimbursement by students' health insurance carrier.

11. An increase in the prevalence of services provided by UHS and not covered by students' health insurance would financially harm UMass Boston through absorbing the cost of providing such services without reimbursement and/or the administrative burden of seeking reimbursement directly from students.

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

Executed on December 17, 2018, in Boston, Massachusetts.

Robert Pomales
Executive Director
University Health Services
University of Massachusetts Boston

XAVIER BECERRA, State Bar No. 118517
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF JULIE RABINOVITZ IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Julie Rabinovitz, declare:

1. I am President and CEO at Essential Access Health, where I have worked since 2011.

2. Essential Access Health is the administrator of California's Title X federal family planning program, the nation's largest and most diverse Title X system. Essential Access Health supports the delivery of core family planning and related preventive health services for 1,000,000 low-income patients in 38 of California's 58 counties. Essential Access Health is committed to ensuring all individuals have access to affordable, high-quality family planning and sexual health services, including contraceptive services and supplies.

3. I am familiar with the two final rules on contraceptive access published in the *Federal Register* on November 15, 2018 (Final Rules).[1] The Final Rules discriminate against women by allowing virtually any employer to deprive women of basic contraceptive coverage, and would create barriers and inequities for women seeking essential and time-sensitive health care. The Final Rules will also result in more women seeking care from Title-X funded clinics across the state. This will divert critical resources away from the uninsured, low-income patients the program was designed to serve.

[1] "Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act," 83 Fed. Reg. 57536 (Nov. 15, 2018) and "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act," 83 Fed. Reg. 57592 (Nov. 15, 2018).

**Access to Contraception**

4. Before the Affordable Care Act (ACA), one in seven women with private health insurance and nearly one-third of women covered by Medicaid either postponed or went without needed services in the prior year because they could not afford it.[2] Prior to the law's enactment, women spent between 30% and 44% of their total out-of-pocket health costs on birth control.[3] Out-of-pocket costs prevented many women, not just low-income women, from accessing preventive services, including contraception.[4] The gap between men and women who struggled to access needed care was in fact widest among adults with moderate incomes.[5] By contrast, eliminating cost barriers has helped increase access to contraception for women with employer-sponsored coverage.[6] Because of the birth control benefit, women saved more than $1.4 billion in out-of-pocket costs on birth control pills in 2013 alone.[7]

5. The goal of preventive health care is to help people control, track, and better manage their life-long health, and the health of their families. Similarly, the goal of prevention of unintended pregnancy is to help women time and space their pregnancies, or prevent pregnancy

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[2] Kaiser Family Foundation. Women's Health Care Chartbook. 2011.

[3] *Id.*

[4] Su-Ying Liang et al., Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills between 1996 and 2006, 83 CONTRACEPTION 491, 531 (2010); see also Inst. of Med. of the Nat'l Acads., Clinical Preventive Services for Women: Closing the Gaps 19 (2011), https://www.nap.edu/read/13181/chapter/1. Another study of 11,000 employees with employer-sponsored coverage found that cost-sharing reduced use of pap smears, preventive counseling, and mammography. Geetesh Solanki et al., The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services, 34 HEALTH SERVS. RESEARCH 1331, 1342-43 (2000); 1342-43; see also David Machledt & Jane Perkins, Medicaid Premiums & Cost-Sharing 2-3 (2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-CostSharing#.WgCFehNSzeQ.

[5] Sheila D. Rustgi et al., The Commonwealth Fund, Women at Risk: Why Many Women Are Forgoing Needed Health Care 4 (2009), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf. Finding that sixty-five percent of women with incomes between $20,000 and $39,999 experienced problems accessing health care services because of cost.

[6] Adam Sonfield et al., Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update, 91 CONTRACEPTION 44, 45-47 (2014).

[7] Nora V. Becker and Daniel Polsky, Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing, Health Affairs, 34, no.7 (2015):1204-1211. Available at http://content.healthaffairs.org/content/34/7/1204.full.pdf+html.

altogether, in accordance with their own desires and to improve maternal, child, and family health outcomes.[8] Contraception enables women to prevent unintended pregnancy and control the timing of a desired pregnancy. In addition, access to birth control is particularly critical for women with underlying chronic, physical, and psychological conditions that can be exacerbated by pregnancy. These women may need to take particular care in planning their pregnancies to ensure that their health can support carrying a pregnancy to term.[9] Unintended pregnancies are associated with higher rates of long-term health complications for mother and infant. Women with unplanned pregnancies are more likely to delay prenatal care, leaving their health complications unaddressed and increasing risk of infant mortality, birth defects, low birth weight, and preterm birth.[10] Other long-term health harms of unintended pregnancy include the impact on health behaviors such as breastfeeding and negative physical and mental effects on children. Women with unintended pregnancies are also at higher risk for maternal morbidity and mortality, maternal depression, or experiencing physical violence during pregnancy.[11]

6. Unintended pregnancy rates are higher in the United States than in most other developed countries, with approximately 45% of pregnancies unintended nationwide.[12] Nearly half (48%) of all pregnancies (393,000) in California are unintended. The U.S. has the highest rate of maternal mortality in the developed world, and contraception is considered a major factor in reducing rates of maternal mortality and morbidity.[13] Contraceptive efficacy in preventing unintended pregnancy is well established and supported by numerous research studies.[14]

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[8] Women's Preventive Services Initiative, Recommendations for Preventive Services for Women 83 (2016), available for download at https://www.womenspreventivehealth.org/final-report/.

[9] *Id.* at 103-104.

[10] Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA 2006;295:1809–23.

[11] Tsui AO, McDonald-Mosley R, Burke AE. Family Planning and the Burden of Unintended Pregnancies. Epidemiologic Reviews. 2010;32(1):152- 174. doi:10.1093/epirev/mxq012.

[12] 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.

[13] Murray, J.L., Wang, H., Kassebaum, N., "Sharp Decline in Maternal and Child Deaths Globally, New Data Show." Institute for Health Metrics and Evaluation. University of Washington. 2016.

[14] Trussell J. Contraceptive failure in the United States. Contraception. 2011;83(5):397-404.

7. Insurance coverage of contraception is critical to ensuring women can use it. Unintended pregnancy rates are highest among those least able to afford contraception, particularly those who face additional barriers to accessing health care services including economic instability and/or discrimination based on race, ethnicity, gender identity, or sexual orientation.

8. The Final Rules place obstacles to receiving seamless contraceptive care that is free of cost-sharing, placing the rules in conflict with Congressional intent to reduce barriers to contraception for women across the United States. The result will be a lack of continuity of care and unequal protections for women employed by companies that refuse to cover contraceptives.

**Final Rules' Impact on Government-sponsored Programs**

9. The Final Rules assert that existing government-sponsored programs, such as Medicaid and Title X, can serve as alternatives for individuals who will lose access to contraceptive coverage without cost sharing. We expect that more women will come to Title X clinics for care under these Final Rules. Medicaid and Title X were created to serve low-income populations who would otherwise lack a pathway to care without out-of-pocket expenses. These vital publicly-funded public health programs were not designed to absorb the needs of higher income, privately insured individuals.

10. Enacted in 1970, Title X is the nation's only dedicated source of federal funding for family planning services. While Title X-funded health centers provide care to all patients, federal law requires them to give priority to "persons from low-income families." Low-income individuals receive services at low or no cost depending on their family income.

11. In California, 71% of Title X patients served last year had incomes at or below 100% of the Federal poverty level. Despite gains made in expanding health care coverage, almost half (49%) of all Title X patients served by the program last year remained uninsured.

12. Furthermore, on March 4, 2019, the Department of Health and Human Services issued a new final rule governing the Title X program ("Title X Rule"). The Title X Rule includes provisions with which Title X providers and sub-recipients cannot comply without

running afoul of legal and ethical obligations. The Title X Rule is currently enjoined, but if implemented, that Rule would force sub-recipients to leave the Title X program, decimating California's Title X network and limiting access to contraceptives. Thus, not only is Title X not designed to cover contraception for higher-income, privately insured individuals, but under the new Title X Rule, there would not be widespread contraceptive access under Title X to fill any coverage gaps. In that respect, the new Title X Rule would not help any coverage problems, it would in fact compound them.

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

Executed on June 17, 2019, in Berkeley, CA.

Julie Rabinovitz, MPH
President and CEO
Essential Access Health

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF KARYL T. RATTAY, M.D., M.S., IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept.: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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; and 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.

4. The current Title X family planning budget for Delaware for 2019 is $1,100,000, which covers a 1-year budget period. It has been communicated from the Office of Population Affairs that in fiscal year 2019, the program will be flat-funded. Women in need of

contraception and other services who lose coverage as a result of the final exemption rules and seek assistance at DPH will increase the responsibilities of the already overwhelmed Title X program. The current Delaware network of providers does not have the capacity or funding to provide services to those additional clients.

5. 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/sites/default/files/factsheet/de_8_0.pdf. 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.

6. 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.

7. If the final exemption 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 final exemption rules 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.

8. 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 final exemption 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.

9. 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.

10. 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.

Executed on June 18, 2019 in New Castle County, Delaware.

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

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF HELENE RIMBERG IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, HELENE RIMBERG, declare:

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

2. I am the section manager of the Adolescent, Genetics & Reproductive Health section within the Center for Prevention and Health Promotion, Public Health Division at the Oregon Health Authority. I have a doctorate degree in Psychology and more than 20 years' experience managing social service programs (non-governmental and governmental) with 13 of those years within the field of sexual and reproductive health.

3. I directly oversee the administration of the Reproductive Health Program's three funding sources:

- Oregon ContraceptiveCare ("CCare"), Oregon's family planning Medicaid waiver program. CCare covers services related to preventing pregnancy (i.e. contraceptive management) for individuals at or below 250% Federal Poverty Line ("FPL") who are U.S. citizens or have an eligible immigration status. As a Medicaid program, CCare is funded through a state/federal match.
- House Bill 3391 (2017), also known as the Reproductive Health Equity Act ("RHEA"), which provides state funding for certain women who because of immigration status are not eligible for other public assistance. RHEA covers a broad range of

reproductive health services, including abortion and 60-days of postpartum care for individuals who can become pregnant and who are ineligible for Medicaid due to immigration status.

- Federal Title X grant funds.

4. Among a number of components, Oregon's RHEA statute provides contraceptive coverage that matches the federal guarantee currently provided by the Affordable Care Act (Public Health Service Act 2713 (c)), specifically requiring coverage for the full range of contraceptive methods, counseling and services used by women, eliminating out-of-pocket costs, and limiting other health plan restrictions. RHEA also goes beyond federal guarantee by: affording this coverage regardless of gender thereby covering male sterilization without out-of-pocket costs, prohibiting health benefit plans from infringing upon an enrollee's choice of contraception by requiring prior authorization, step therapy or other utilization control techniques, and requiring health benefit plans to provide abortion with no out-of-pocket costs (with some exceptions).

5. Additional Oregon laws protecting reproductive health that go beyond the federal guarantee include (a) providing pharmacists the authority to prescribe and dispense hormonal contraceptives (ORS 689.683), and (b) requiring insurance plans to allow dispensing of a 12 month supply of contraceptives (ORS 743A.066) rather than a typical one- or three-month supply.

6. We estimate that in 2014 approximately 49 percent of pregnancies in Oregon were unintended. We are therefore concerned about the potential that the Contraception Exemption Rules could raise that percentage even higher. In 2017, we estimate that 67.7 percent of women at risk of unintended pregnancy in Oregon were using the most or at least a moderately effective method of contraception. Again, if a significant number of these women were to lose insurance coverage for contraception services, that percentage of women using effective contraception could be reduced significantly. The Contraception Exemption Rules would impose significant barriers for women to access substitute contraceptive coverage. Women would have to identify,

seek out and apply for other coverage. In my professional opinion and experience, some women will be unable to or fail to find contraceptive coverage in a timely way, if at all. In Oregon, we estimate there are 281,000 women who are eligible for publicly funded family planning and thus can be categorized as "Women in Need." The U.S. Census bureau estimates that in 2017 there were approximately 912,000 women in Oregon ages 15-49 women of child-bearing age.[1] If the rate of effective contraception use among these women were reduced only ten percentage points from 67.7 to 57.7 percent, this would mean an additional 91,000 Oregon women would be at greater risk of unintended pregnancy and therefore reliant on publicly funded family planning services.

7. Individuals who lose contraception coverage because of the Conscience Exemption Rules at issue in this case can, if they meet the eligible criteria (immigration status and income less than 250 percent of the federal poverty line), either seek coverage through CCare or RHEA. This will result in increased enrollment in these programs and additional costs to Oregon. Alternatively, individuals may forgo coverage and risk an unintended pregnancy, also leading to increased State health care costs.

8. For example, it is estimated that in 2017, Oregon's Reproductive Health Program alone averted over 6,000 unintended pregnancies through the provision of effective contraceptive methods and high-quality counseling services in Oregon's Title X clinics. The number of unintended pregnancies averted is calculated by comparing the effectiveness of the contraceptive methods clients used when they first came to a RH clinic and the methods they used at their most recent visit. For example: if 100 clients used male condoms, which have a typical failure rate of 18 percent, 18 clients would be expected to have an unintended pregnancy within a year. If all 100 clients switch to a Depo-Provera injection, which has a typical failure rate of 6 percent, only six clients would be expected to have an unintended pregnancy within a year. Thus, 12 unintended pregnancies have been averted. Using a conservative estimate of $16,000 for an

[1] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

(continued…)

average delivery and the first year of infant health care under Oregon's Medicaid program,[2] even if less than half of these 6,000 unintended pregnancies would have resulted in births, the savings to the state would be in excess of $40 million in taxpayer funds in Oregon alone in 2017 just considering the Title X program.

9. In my professional opinion, there would be increased costs to Oregon as a result of unintended pregnancies for clients losing employer-funded contraceptive coverage. As discussed above, if any number of the 912,000 women in Oregon ages 15 to 49 lost their contraception coverage and either were ineligible for or unaware of alternative state programs, Oregon's costs would be approximately $16,000 for each birth from an unintended pregnancy. Thus, the impact to Oregon's Medicaid program could be very large.

Executed on 6/21, 2019, in Portland, Oregon.

HELENE RIMBERG
Oregon Health Authority

[2] Data on costs for labor, delivery, and first year of infant health care under the state's Medicaid program, the Oregon Health Plan, are provided from the Oregon Health Authority, Office of Health Analytics.

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IN THE UNITED STATES DISTRICT COURT

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Plaintiffs,

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Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF REVEREND SUSAN RUSSELL IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

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 1930s.

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 former member of the Clergy Advocacy Board of Planned Parenthood. I served as a member of the Board from 2013-2018. As a prior member, I remain in regular contact with the Board. As a member I was honored to stand with people of faith whose support for reproductive health care is firmly rooted in their faith.

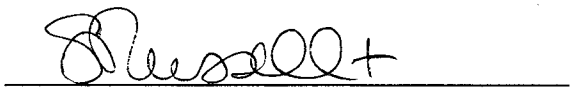
4. The Clergy Advocacy Board builds on the long history of faith leaders taking an active role in reproductive health care and has been working for more than two decades with Planned Parenthood at the national and state levels to further the goal of full reproductive rights and freedom for all women 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 modem 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.

6. 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 June 25, 2019 in Pasadena, CA.



The Reverend Susan Russell

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF AMANDA SKINNER IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Amanda Skinner, declare:

1. I am President and CEO of Planned Parenthood of Southern New England (PPSNE). I have been in this role since May of 2017. Prior to joining PPSNE I worked as an executive in a large, national health care services organization, Optum, and spent 6 years as an executive at a large academic medical center that shares the same geographical region as PPSNE, Yale New Haven Health. I am a certified nurse-midwife and provided direct health care services to women in Connecticut for 10 years.

2. I base this declaration on my professional knowledge, my review of records here at PPSNE and my experience in the health care field. If called and sworn as a witness, I could and would testify competently to the information contained in this declaration.

3. PPSNE is a two-state affiliate also including Rhode Island. We are the sole Planned Parenthood entity that is responsible for services throughout Connecticut. In addition to providing a range of quality health services, Planned Parenthood meets our mission in Connecticut and Rhode Island by offering a range of educational programs to communities we serve, informing individuals about their right to health care; and we also engage in advocacy to ensure that laws are in place to protect those rights.

4. In Connecticut, PPSNE operates 16 reproductive health centers located throughout the state, including two (in Hartford and Stamford) which are designated as patient centered medical homes by the National Center for Quality Assurance (NCQA). We served nearly 78,000 patients in 2018 (in both states), the vast majority of whom are in Connecticut.

5. As I stated in my December 2018 declaration in this litigation, I believe that the two final rules on exemptions to contraception coverage issued on November 15, 2018, by the U.S. Department of Health and Human Services in conjunction with the U.S. Department of Labor and U.S. Department of Treasury (Final Rules), will have a devastating impact on women in Connecticut who need contraceptive services. The Final Rules will also have a severe impact on the State of Connecticut because they will require the State to increase funding for public health programs to ensure women have access to contraceptive services when employers refuse to offer insurance coverage formerly required by law.

**Planned Parenthood of Southern New England's Role in Supporting Patients and Providing Public Health in Connecticut**

6. PPSNE provides services to 24% of women who need publicly funded contraceptive services in Connecticut. In 2018, Planned Parenthood of Southern New England provided services to 61,900 patients in Connecticut at health centers in Bridgeport, Danbury, Danielson, Enfield, Hartford, Manchester, Meriden, New Britain, New Haven, New London, Norwich, Old Saybrook, Stamford, Torrington, Waterbury, West Hartford, and Willimantic.

7. PPSNE provides services to patients who are uninsured, participate in the Medicaid program, or are commercially insured.

8. Patients who lack insurance coverage for contraceptive services pay only a portion of the cost for those services based on income-based, sliding-fee scale. PPSNE covers the remainder of the cost of care with our own funding as well as grants from the federal Title X program, and a family planning grant from our State Department of Public Health.

9. In Fiscal Year 2019 (April 1, 2018 through March 31, 2019) PPSNE received $3,547,799 in family planning funding from Title X and the Connecticut State Department of Public Health. The funding amounts of these two grants are fixed and will not be adjusted if there is an increase in demand for coverage of contraception services. The State of Connecticut is experiencing budget constraints; and PPSNE's Title X funding is threatened by the imposition of a "gag rule" limiting the counseling Title X grantees can provide. These factors make it unlikely that PPSNE will receive any grant increases to cover any increase in patient volume.

10. PPSNE provides health services including wellness examinations, contraceptive counseling, clinical breast examinations, cancer screenings, birth control, HPV vaccinations, screening and treatment of sexually transmitted infections, PREP treatment for those at risk of HIV infection, pregnancy testing and options counseling, transgender health care, emergency contraception, and abortion services.

11. Of the 61,900 patients PPSNE treated in Connecticut last year, 87% were female. The payer mix for this group was:

a. 47% Medicaid patients.

b. 8% Title X patients (uninsured & at or below 100% federal poverty level)

c. 5% patients with funding from State DPH grant

d. 5% patients who received services including abortion, not covered by the Title X program, or who fall into a miscellaneous eligibility category.

e. 32% commercially insured patients.

**Risk Posed by the Final Rules to Planned Parenthood of Southern New England's Insured Patients**

12. As noted above, nearly 32% of PPSNE's female patients have commercial insurance coverage. PPSNE patients, who are covered by employer-funded, commercial insurance plans,

are at risk for losing contraceptive coverage under the Final Rules because their employers may drop coverage based upon a claim of a religious or moral objection. This will result in a loss of coverage for PPSNE patients with commercial insurance plans. Since 1999, Connecticut has required that any commercial insurance plan that covers prescription drugs must cover contraception, with limited exceptions for entities and employers that are specifically deemed to be "religiously affiliated." In 2018, Connecticut codified the contraceptive benefit of the Affordable Care Act, and broadened it to allow access to a 12-month supply of contraceptives. Self-funded insurance plans are not required to comply with state law, as they are exempt from state insurance law under ERISA, the federal Employee Retirement Security Act.

13. The Final Rules also permit individual policy holders to make decisions that will affect coverage for all family members on a plan. Under the Final Rules, a policy holder can decline insurance coverage for contraception. This provision puts even more of PPSNE's covered patients are at risk, because in many cases our patients are not the holder of or subscriber to the insurance plan, but covered under the plan of a parent, spouse or partner. This means that women could lose coverage for contraceptive care due to the objections or beliefs of the policy holder. Those facing domestic violence are also at risk due to the moral or religious objections of their policy's holder and, if that person is the abuser he or she may seek to cancel contraceptive coverage. PPSNE providers often see, in the course of offering care, women who are unable to access care or fearful of doing so, because of the abusive and controlling actions of their partner or spouse.

**Increase in Women Seeking Family Planning and Contraceptive Care at Planned Parenthood**

14. With the Final Rules, women in insurance plans which the employer self-funds will be at risk of losing contraceptive coverage. In Connecticut, about half of privately insured population is covered by a self-insured plan. *See* State of Connecticut Office of the Healthcare Advocate,

https://www.ct.gov/oha/cwp/view.asp?a=4363&q=520250 (last viewed June 21, 2019). This means that a significant number of Connecticut women are at risk for losing contraceptive coverage. Moreover, when employers decide to discontinue coverage, as permitted under these Rules, they are not required to provide any accommodation to ensure their employees' contraception services continue to be covered.

15. Based on my own professional experience, and the fact that PPSNE is a highly trusted provider of reproductive health care, and because of our presence across the State, I believe that many women impacted will very naturally turn to PPSNE for family planning and contraceptive care when they lose employer coverage. Currently, our only options for funding contraception care are the Title X program, the Medicaid program, which only provides care to those under significant income constraints and the State Medicaid "limited benefit" family planning program. Due to recent rules affecting Title X, PPSNE may be forced to withdraw from that Program. *See generally, California v. Azar,* Docket No. 19-15974, ECF # 25, (9th Cir. June 20, 2019) (granting stay of preliminary injunction orders and permitting Title X "gag rule" to go into immediate effect).

**The Final Rules Impact on the Title X Program**

16. Title X is the national family planning program, which, in Connecticut, has been administered for over 30 years by PPSNE as the direct grantee of the U.S. Department of Health and Human Services, Office of Population Affairs. PPSNE received a total of $2.2 million in Title X dollars for Fiscal Year 2019-2020. A Rule that will impose a gag rule and a physical separation requirement for grantees has been promulgated by HHS and, at this time, allowed to go into effect during the pendency of litigation. *See generally, California v. Azar,* Docket No. 19-15974, ECF # 25, (9th Cir. June 20, 2019).

17. The PPSNE services funding through the Title X program prevents thousands of unintended pregnancies in Connecticut each year.

18. Women with incomes up to 250% of the federal poverty level are eligible for Title X services. Women who qualify for Title X services may be uninsured or covered by commercial insurance. For women with insurance, Title X covers services that their insurance plan may not. All Title X patients, with the exception of the lowest income levels, must contribute to the cost of their care on a sliding fee scale, based on their income.

19. With the Final Rules, I believe that there will be a greater number of Connecticut women who will turn to Title X for services when they lose employer coverage. Under the new Title X Rule that is now permitted to take effect, Title X family planning providers are prevented from providing full and unbiased counseling to pregnant patients, and from referring any such patient for abortion if that is her decision. If the Title X gag rule is enforced and there is no court relief entered against it, PPSNE will no longer be able to serve as the Title X grantee, and will no longer receive these funds. As a result, patients seeking Title X-covered services will need to go somewhere other than PPSNE. Patients seeking the trusted care offered by PPSNE will come to our Connecticut centers and we will do our best to provide free or low cost contraceptives and care to them because that is our core mission. However, neither PPSNE nor other public health providers in Connecticut will be in a position to readily accommodate an influx of patients seeking family planning or birth control services that could result from a loss of commercial employer coverage.

20. Regardless, the Final Rules will impose additional burden on insured women who lose their coverage, turn to a Planned Parenthood or community health center for services, and will, in most cases, be asked to pay for a portion of their care. For the most effective contraceptive

methods, such as long-acting reversible (LARCs), this cost may be unaffordable for many women.

**Impact of the Increase in Women Turning to the Medicaid Limited Benefit Family Planning Program**

21. Connecticut has a limited benefit family planning program that covers access to family planning services (only) for eligible women (and men) under 250% of FPL. This program is funded on a 90-10% basis (federal versus state contribution), and last year PPSNE (the primary provider of services under this program) provided services to 2500 women and men covered by the program, resulting in $572,000 in revenue. There is no cost-sharing for these services to participants. Increased enrollment in this program would of course increase the amount the State contributes to care for women who, by all accounts, should have commercial coverage for contraceptive services.

22. Due to the Final Rules, I believe that insured patients who qualify for it will seek services under the Medicaid limited benefit family planning program, and that this will result in increased need for State dollars to support this program.

**Impact of Increase of Women and their Families Turning to the Medicaid (HUSKY) Program**

23. The federal Medicaid program has, since its inception, covered family planning as a mandated service without cost sharing. In Connecticut, individuals are eligible for Medicaid (HUSKY) if their income is up to 250% of the federal poverty level. In 2018, PPSNE provided family planning services to 25,787 HUSKY enrollees.

24. As a result of the Final Rules, I believe that some women, if eligible, will forego employer coverage and enroll in Medicaid for full or wrap-around coverage. As a result the cost of coverage will shift from the employer to the State and federal government, with the State of

Connecticut covering 10% of the cost of family planning services, and 50% of other health care costs incurred under Medicaid.

**A Loss of Contraceptive Coverage Will Have Serious Negative Consequences for the Women of Connecticut**

25. It is well understood that the advent of effective prescription contraception is among the greatest factors contributing to the advancement of the status of women during the 20th century. In Connecticut alone, the recent improved access to contraceptives (since the Affordable Care Act was adopted) has resulted in a dramatic decrease in the numbers of unintended pregnancies, teen births and abortions for women of all ages. It is my understanding that Connecticut Department of Public Health data indicate that births to teens age 15 to 19 in Connecticut decreased 46% between 2010 and 2015. For African American and Latinx youth during this same period the decrease was even more pronounced - 52%. In addition, according to Connecticut DPH data, the number of abortions in Connecticut decreased 23% between 2012 and 2018. *See generally,* Teen birth data: CT Dept. of Public Health, *Annual Registration Report,* report for years 2010 to 2015; Abortion data: CT Dept. of Public Health, *Statistical Summary of Legal Induced Abortions*, reports for years 2012 to 2017).

26. Women who lose contraceptive coverage, and who do not qualify for one of the programs cited above, are at much greater risk for unintended pregnancy, sexually transmitted infection (and its longer range impact including infertility) and overall at risk for poorer health outcomes. At Planned Parenthood and throughout the developed world we frankly take for granted that family planning and the access to effective, proven methods of birth control, is a right women enjoy, not a privilege. A loss of access to contraception will have very real and measurable effects.

27. For example, a 2016 report of the Guttmacher Institute which I have reviewed indicates that for the years examined in Connecticut 51% of all pregnancies were unintended. This was higher than the national average of 45%. *See* https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states (last viewed June 21, 2019). The Guttmacher Institute also concluded that women in Connecticut who are using contraception account for only 5% of unintended pregnancies; while women who are not using contraception, or not using it consistently account for 95% of unintended pregnancies. Without publicly funded family planning centers, Guttmacher estimates, there would be an additional 16,700 unintended pregnancies a year in Connecticut. *See,* The Guttmacher Institute, *Unintended Pregnancy in the United States*, September 2016.

28. The role contraceptive access can play in women's lives is significant, and coverage should be a fundamental part of any basic insurance plan. We also understand the key role that control of one's fertility may play in access to further educational and employment opportunities.

**The Final Rules Will Result in an Unpredictable Patchwork of Coverage and Services**

29. As I have stated previously, it is the mission of PPSNE to provide reproductive health services to the best of our ability, regardless of any patient's ability to pay. However, in order to continue to do so, PPSNE, like any other health provider, needs to be able to count on a predictable funding stream or payer source. If employers who refuse to cover contraceptive care drive their female employees or dependents to publicly-funded service providers, the burden imposed by these Rules will be on the States and, ultimately, the tax payers. Moreover, not all women who require services will be eligible for publicly funded programs.

30. The Final Rules allow employers, individuals and insurers to separate contraceptive coverage from other health coverage and, in doing so, create a confusing patchwork of coverage (or lack thereof) for most services, but not for the basic care most women expect and need. It

goes without saying that stigma and concerns about confidentiality will impact the willingness for any individual woman to express her concerns about her birth control coverage to her employer, her Human Resources department, or, potentially, even to her own family members.

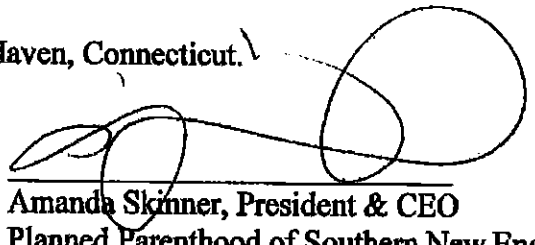
**The Final Rules Overall Impact on the State of Connecticut**

31. The Final Rules will undoubtedly create a financial burden for the State of Connecticut, which will be required to supplant services covered for those otherwise commercially insured, with publicly funded care. If the State does not cover women, they will be at increased risk for unintended pregnancy and birth which, themselves, will present increased cost both to families themselves, to the health care system generally, and ultimately to the State.

32. Connecticut has taken a lead nationally in covering the full range of reproductive health care for all individuals. However, it is experiencing a challenging budget crisis. Diverting desperately needed state funds in order to backfill family planning care for those whose employer's drop coverage is a poor use of our state dollars.

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

**Executed on June 21, 2019 in New Haven, Connecticut.**



**Amanda Skinner, President & CEO**
**Planned Parenthood of Southern New England**

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

| | |
|---|---|
| **THE STATE OF CALIFORNIA; THE DISTRICT OF COLUMBIA, ET AL.,**<br>Plaintiffs,<br>**v.**<br>**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; ET AL.,**<br>Defendants,<br>and,<br>**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**<br>Defendant-Intervenors. | 4:17-cv-05783-HSG<br>**DECLARATION OF STEPHEN C. TAYLOR** |

Pursuant to 28 U.S.C. § 1746, I, Stephen C. Taylor, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained herein, and testify based on my personal knowledge and information.

2. I am the Commissioner of the District of Columbia (District) Department of Insurance, Securities and Banking (DISB). I have served in this position since November 3, 2015,

and I was Acting Commissioner from June through November 2015. In this role, I serve as the chief regulator of the District of Columbia's financial-services industries, including insurance companies and their representatives and captive insurance companies. As part of my responsibilities, I am a Member of the Executive Board of the District of Columbia Health Benefit Exchange (HBX), and a Member of the Board of Directors of the Washington DC Economic Partnership.

3. I have over 15 years of experience in financial services regulation and finance and fiscal affairs. I have served in various leadership roles including General Counsel and Acting Deputy Commissioner with DISB, and General Counsel with the former Department of Banking and Financial Institutions. In those roles, I directed legislative and regulatory drafting programs and assisted in implementing the Patient Protection and Affordable Care Act (ACA). Previously, I served as Assistant Attorney General with the Office of the Attorney General for the District of Columbia, where I provided legal counsel to the District Department of Health Care Finance.

4. I serve as the Vice Chair of the Northeast Zone of the National Association of Insurance Commissioners (NAIC). Also, I am a member of the NAIC's Executive Committee. I serve as a Vice Chair of the Life Insurance and Annuities Committee and a Member of the International Insurance Relations Committee. I am Chair of the Consumer Liaison Committee and the Consumer Participation Board of Trustees, and serve as Vice Chair of the Receivership and Insolvency Task Force and the Risk Retention Group Task Force.

5. I hold a Juris Doctor and Master of Laws from Georgetown University Law Center, and a Bachelor of Arts from Fordham University.

6. DISB regulates financial services businesses in the District. Our mission is two-fold: (1) protect consumers and (2) develop and improve market conditions to attract and retain financial services firms to the District. Specifically, DISB protects the interests of District consumers by ensuring that insurers and individuals presenting insurance products in the District are qualified, appropriately licensed, and meet and act in accordance with all requirements of the insurance laws of the District of Columbia. The Insurance Bureau monitors the financial condition and marketing activities of insurers and producers, and reviews insurance policies and

rates to ensure compliance with applicable laws.

7. DISB 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 Commissioner, my responsibilities include implementing and enforcing the Patient Protection and Affordable Care Act (ACA) and related District laws in the District's health insurance market.

9. As Commissioner, I am responsible for ensuring compliance with 42 U.S.C. § 300gg-13(a)(4), incorporated into District law at D.C. Code Ann. § 31-3834.02, which requires self-funded employer plans and group and individual health insurance policies to cover women's preventative health care services, including contraceptive coverage, with no cost-sharing.

10. Conservative estimates from the federal government that indicate that over 100,000 District women obtained access to cost-free preventative health care services under the ACA.

11. As Commissioner, I am responsible for enforcing District laws, including the Vital Records Modernization Act of 2018, D.C. Law 22-164 (Act 22-438), which amended the Women's Health and Cancer Rights Federal Law Conformity Act of 2000 to require individual and group health plans to cover all FDA-approved contraceptive drugs, devices, products and services for women without cost-sharing no later than January 1, 2019. *See* D.C. Code § 31-3834.03. District law thus ensures that health insurance plans offered in the District provide contraceptive coverage that matches the federal mandate provided by the Affordable Care Act (Public Health Service Act 2713 (c)) specifically requiring coverage for the full range of contraceptive methods, counseling and services used by women; eliminating out-of-pocket costs; and limiting other health plan restrictions.

12. Some of the District's laws go further than the federal mandate. For example, District law permits pharmacists to prescribe and dispense prescription methods of contraception for up to a 12-month supply at one time for women who do not face serious risks from contraception. D.C. Code § 31-3834.01. The purpose of the provision is to eliminate barriers to continuous contraceptive use, thereby helping reduce the possibility of an unintended pregnancy. The

provision requires individual and group health plans to cover a full-year supply of prescription contraceptives. *Id.*

13. District law thus ensures that District residents and workers will continue to have access to the full range of contraceptive drugs, devices, products, or services without cost-sharing, regardless of any changes in federal law. However, District law only applies to District-regulated health plans, through which over 54% of covered workers are insured. Self-funded health plans are governed by the Federal Employee Retirement Income Act of 1974 (ERISA) and are regulated by the U.S. Department of Labor, Employee Benefits Security Administration. Notably, when the District of Columbia passed the Vital Records Modernization Act of 2018, the Interim Final Rules were enjoined from taking effect, so women with a self-funded health plan were similarly guaranteed access to cost-free contraceptive coverage. District law does not protect the approximately 114,690 workers in the District who are covered by one of the approximately 5,730 self-insured employers' health plans. In addition to female employees of self-insured District employers being at risk of losing access to contraceptives under the Final Rules, the female dependents of these employees also stand to lose access to contraceptives.

14. District law includes a narrow religious employer exemption that applies only to nonprofit churches, their integrated auxiliaries, conventions of associations of churches, and the exclusively religious activities of any religious order. *See* D.C. Code § 31-3834.04(a).

15. District law parallels federal law in that it permits employers to request an accommodation to the contraceptive coverage requirements of District law by self-certifying that the employer is a non-profit religious organization or a closely-held for-profit entity that objects to covering some or all of the contraceptive drugs, devices, products, or services on account of sincerely held religious beliefs. *See* D.C. Code § 31-3834.04(b) & (c).

16. Based on my knowledge and experience as the District's insurance regulator, I anticipate that the Final Rules on religious and moral exemptions to the coverage of contraceptives are unreasonably broad and will result in women in the District losing coverage for contraceptives in their health plans.

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

Executed on May 20th, 2019, in Washington, District of Columbia.

Stephen C. Taylor
Commissioner
District of Columbia Department of
Insurance, Securities and Banking

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF LAUREN J. TOBIAS IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Lauren Tobias, declare:

1. I am currently the Director of the Division of Family Health in the New York State Department of Health (Department) and have been in this role since 2016. As Director of the Division of Family Health, I support and supervise the New York State Title X program, Comprehensive Adolescent Pregnancy prevention program and other areas of work related to sexual and reproductive health. I analyze policy and work to improve programs that aim to reduce mistimed pregnancies to improve health and wellbeing of all New Yorkers and support the ability for all New Yorkers to choose when and if to get pregnant. Prior to this position, I worked in leadership roles in other areas of the Department including the Office of Primary Care and Health Systems Management and the Office of Health Insurance Programs. I have also worked in the non-profit sector on areas related to women's health. These roles give me a strong foundation to understand public health programs, health care delivery systems and public insurance options. I have a Master's degree in Public Administration and Policy from Rockefeller College of the State University at Albany. I submit this declaration in support of the above-captioned lawsuit challenging the Defendants' Exemption Rules.

2. The State of New York ensures contraceptive coverage and access through public insurance options, contraceptive equity laws, and a publicly supported state and federal family planning program.

3. The State of New York's Family Planning Program ("FPP"), which includes NY's Title X program, serves 305,357 unduplicated clients annually which is an increase of over 1% from the year before. Of the clients served, 89.4% are females and 10.6% are males. Teens comprise 16.7% of the clients served and women age 20-29 comprise 48%. Clients whose income is below 100% of the federal poverty line compromise 65.9% of the clients in 2017. Clients at or under 200% of the federal poverty level rose from 80.8% to 84.9% in 2017. Over 76,799 clients use private insurance to access their family planning services. In addition to offering and providing methods of birth control, family planning providers offer primary and preventive health services including, cervical cancer screening, clinical breast exams, sexually transmitted disease testing and treatment.

4. If the Exemption Rules are enforced in New York, women who lose access to contraceptives through their employer-sponsored plans will either (a) seek coverage through New York's programs including New York's FPP, resulting in increased enrollment and therefore increased costs to the State; or (b) forgo coverage and experience an unintended pregnancy, which will increase the lifetime medical costs of both mother and child.

5. It is my understanding that the federal government suggests that women affected by the Exemption Rules should seek out services at Title X clinics. In New York State, Title X clinics are the same clinics that provide Family Planning Program services. Accordingly, the broad exemptions created by the Exemption Rules will result in more women receiving FPP services. As a result, this program will risk being overwhelmed by the increase in patients who previously received contraceptive coverage through their employer-sponsored insurance.

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

Executed on June 25, 2019, in New York, New York.

Lauren J. Tobias

Lauren J. Tobias
Director of Family Health
New York State Department of Health

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF DANETTE WONG TOMIYASU IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, DANETTE WONG TOMIYASU, declare:

1. I am the Deputy Director of the Health Resources Administration of the Hawai'i State Department of Health ("HDOH"). I oversee the Maternal and Child Health Branch which includes family planning services.

2. Title X funding is critical to the provision of family planning services in Hawai'i. Since approximately July 1, 2017, Title X funding has been provided directly to two Hawai'i grantees: the HDOH, the state's only public direct grantee, and Planned Parenthood of the Great Northwest and the Hawaiian Islands (PPH). Between July 1, 2016 and June 30, 2017, HDOH's Title X grant sub-recipients (including PPH) served 16,002 unduplicated clients across the state. In the client visit records maintained by HDOH, 95% served were women. Hawai'i's Title X program provides comprehensive family planning and related preventive health services, including contraceptive services and client-centered education, non-directive counseling, and referrals. These services are provided on six islands (Kauai, Oahu, Molokai, Maui, Lanai, and Hawai'i) through 12 contracts at 31 services sites. These sites include, but are not limited to, eight Federally Qualified Health Centers in medically underserved rural areas, three academic settings on Kauai, Maui and Hawai'i Island, and one hospital-based setting on Molokai. In almost all of

the rural and medically underserved areas throughout the state, Hawai'i's Title X-funded clinics are the only source for low-cost family planning services.

3. The State of Hawai'i has a law that mandates employer group accident and health or sickness plans to provide contraceptive services or supplies. Unlike the federal law (Public Health Service Act 2713), Hawai'i law permits an insurer to collect copayments on contraceptive supplies so long as they are not unusual. Hawai'i law provides that coverage shall include reimbursement to a health care provider or dispensing entity for prescription contraceptive supplies intended to last up to a twelve-month period for an insured and that coverage of contraceptive services shall extend to any dependent of the subscriber who is covered under the policy. The State of Hawai'i's law does not cover women and covered dependents who have coverage through an employer that uses a self-insured plan. As a result of these rules, women will either: (a) utilize and seek coverage through HDOH's family planning program resulting in increased enrollment or (b) they will forgo coverage and experience an unintended pregnancy. In both scenarios, the State will suffer increased costs.

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

Executed on June 20, 2019, in HONOLULU, HAWAI'I.

Danette Wong Tomiyasu
Deputy Director of Health Resources Administration
Hawai'i State Department of Health

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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.

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF JENNA TOSH**

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.. 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 fourteen 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 720,000 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 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 November 15, 2018 (Final Rules) 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 Final Rules 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 720,000 patients annually, almost 30% of the California women of reproductive age who are in need of publicly

funded family planning services. Eighty-one percent (81%) 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.

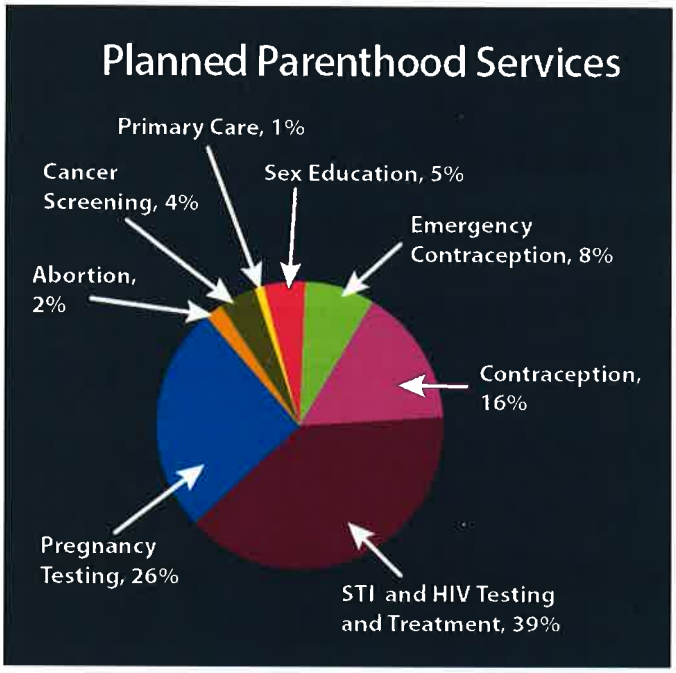
11. CPPEF is a membership organization consisting of the seven California Planned Parenthood affiliates. Each affiliate is a separately incorporated non-profit organization with its own Board of Directors, budget, management and staff. Each affiliate is responsible for delivering health care services in a distinct geographic region. These affiliates provide sexual education and reproductive health care across California through 115 separate health centers. In 2018, these affiliates served almost 720,000 patients; 89.3% were at or below 200% of the federal poverty line. The California Planned Parenthood affiliates provided contraception to nearly 585,000 patients, conducted 450,000 pregnancy tests, and provided 1.8 million tests and treatments of sexually transmitted infections. They also provided sexual health education programs to over 182,000 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; PEP and PReP for HIV prevention; pregnancy testing and services; breast and cervical cancer screenings; and safe and legal abortion. In addition, five affiliates 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 2018, Planned Parenthood saw over 720,000 patients in 1.3 million appointments. In 2018, we served California with:

a. Contraception to nearly 585,000 patients

b. Nearly 240,000 emergency contraception tests

c. 450,000 pregnancy tests

d. Over 72,300 cervical cancer screenings

e. Almost 65,000 breast cancer exams

f. Over 1.8 million tests and treatments for sexually transmitted infections

g. Sexual health education programs reaching 182,000 youth.

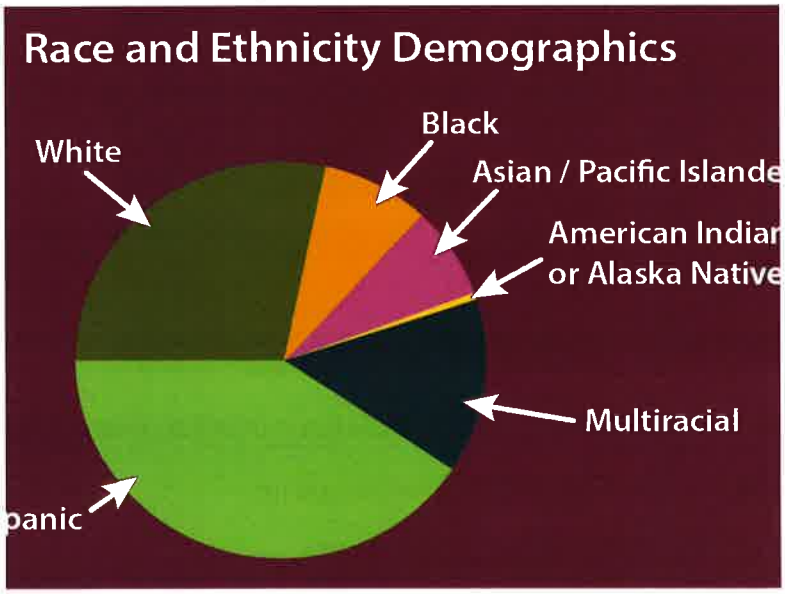
16. To give a sense of the volume that Planned Parenthood handles, the Los Angeles affiliate alone sees more than 1000 patients a day and fields more than 3000 calls at its call center.

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-nine percent (89.3%) are below 200% of the federal poverty level ($24,280 for one person). Of those, 78.4% are below 138% of the federal poverty level ($16,753 for one person);

c. The demographics of our patients roughly mirror the demographics of California: 23.8% are white (non-Hispanic), 36.7% are Hispanic, 8.9% Black; 8.6% Asian/Pacific Islander, 6.6% multi-racial and 17% 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.

f. Planned Parenthood operates its health centers in many medically underserved areas.

g. For example, Planned Parenthood Pacific Southwest operates 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.

h. 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.

18. 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.

19. 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 2018, our sexual health education programs reached more than 182,000 youth.

## IV. FAMILY PACT AND MEDICAID

20. Approximately 81% of Planned Parenthood's patients receive their health care through Medi-Cal. 42% are enrolled in the Family PACT program, described in greater detail below. 5.8% receive their care through Medi-Cal fee-for-service. And 33.1% are enrolled in Medi-Cal managed care. California reimburses Planned Parenthood for the care it provides patients through these programs. Generally, Medicaid services (which include Medi-Cal Fee-For Service, Medi-Cal Managed Care, and Family PACT) receive a 50% Federal Medical Assistance Percentage (FMAP). The exceptions are abortion, which receive no federal dollars, and "family planning services," which receive an enhanced FMAP of 90%. "Family planning services" are not specifically defined by the federal government, but in California the enhanced percentage applies to family planning office visits, contraceptive care (including sterilization), and STI testing.

21. 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 1.16 million patients each year.[1]

22. 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:

- the rates of unintended pregnancy and unplanned births to decline 82%[2]

[1] http://www.familypact.org/Research/reports/Annual_Report_FY_15-16.pdf; Bixby Center for Global Reproductive Health, University of California San Francisco, *Family PACT Program Report Fiscal Year 2013-2014*, at 5 (Bixby Annual Report).

[2] Guttmacher Institute, *State Facts on Publicly Funded Family Planning Services: California* (continued…)

- the teen birth rate to decline by 71%[3]
- the number of abortions to fall by 50%.

23. 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]

24. 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.

25. 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]

26. There are additional public sector costs stemming from unintended pregnancy. Low income pregnant women can qualify for several public health and social programs which provide free or low-cost services before and after delivery for themselves and their children. One

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(…continued)
(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.

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]

27. 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 1.16 million income eligible men and women of childbearing age through a network of 2,472 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.

28. 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 1.8 million STI tests in California in 2018.

## V. New Final Rules

29. I have reviewed and am familiar with the new contraceptive coverage Final Rules, 2018-24512 and 2018-24514. Under them, any employer that claims a religious or moral objection to providing contraceptive coverage would be exempt. In addition, the Final Rules

[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.

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.

30. 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.

31. 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 Final Rules, 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 (44.1%) 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.

32. 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.

33. I also believe that California will see an increase in unintended pregnancies as a result of the Final Rules. 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,

[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).

the State will have increased costs shouldering the costs of delivery. For those women with 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.

34. 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 June 17, 2019 in Santa Barbara, California.

Jenna Tosh
President & CEO
Planned Parenthood California Central Coast

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Attorney General of California
KATHLEEN BOERGERS, State Bar No. 213530
Supervising Deputy Attorney General
NELI PALMA, State Bar No. 203374
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*Attorneys for Plaintiff State of California*

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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.**

4:17-cv-05783-HSG

**DECLARATION OF JOANN VOLK IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**DEPARTMENT OF THE TREASURY; DOES 1-100,**
Defendants,
and,
**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**
Defendant-Intervenors.

I, JoAnn Volk, declare:

1. I am currently a Research Professor at the Georgetown University Center on Health Insurance Reforms.

2. I currently receive my healthcare coverage through my employer, Georgetown University.

3. Attached hereto as Exhibit 1 is a redacted copy of information I received from my health insurance regarding contraception for the current plan year.

4. Attached hereto as Exhibit 2 is a redacted copy of my CVS contraceptive coverage card for the current plan year.

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

Executed on Jun 26, 2019, in Washington, DC.

JoAnn Volk
Research Professor
Georgetown University Center

# EXHIBIT 1

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
www.carefirst.com

January 28, 2019

[redacted]

Dear Member:

Thank you for choosing CareFirst BlueCross BlueShield as your health insurance carrier. Your business is important to us and we want to be sure that you understand any changes made to your health plan.

Under the Affordable Care Act, employers with religious objections to providing contraceptive services as part of their group health plan coverage may qualify as an eligible organization and exclude contraceptive services from their group health plan benefits. While the employer may exclude the benefits, employees will still receive contraceptive benefits under an accommodation. The accommodation provides that the cost of contraceptive services for members of the employer's health care plan will be reimbursed by CareFirst, **when provided by an in-network provider**, for as long as the member is covered under the employer's health care plan.

Your employer has certified that your group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, CareFirst will provide in-network contraceptive services that you use, without cost sharing, for so long as you are enrolled in your group health plan. Your employer will not administer or fund these payments.

If you have any questions about this notice, please contact Customer Service at the number listed on your ID card.

Sincerely,

Eric Showalter
Vice President
Large Group Service Operations

MBR4803 (9/14)

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst MedPlus is the business name of First Care, Inc. CareFirst of Maryland Inc., Group Hospitalization and Medical Services, Inc., First Care Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

# Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

**If you need these services, please call 855-258-6518.**

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

**To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.**

## Civil Rights Coordinator, Corporate Office of Civil Rights

| | |
|---|---|
| Mailing Address | P.O. Box 8894<br>Baltimore, Maryland 21224 |
| Email Address | **civilrightscoordinator@carefirst.com** |
| Telephone Number | 410-528-7820 |
| Fax Number | 410-505-2011 |

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc.,The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus and CareFirst Diversified Benefits are the business names of First Care, Inc. In Virginia, CareFirst MedPlus and CareFirst Diversified Benefits are the business names of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). ® Registered trademark of the Blue Cross and Blue Shield Association. ℠ Registered trademark of CareFirst of Maryland, Inc.

## Foreign Language Assistance

*Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call* 855-258-6518 *and wait through the dialogue until prompted to push* 0. *When an agent answers, state the language you need and you will be connected to an interpreter.*

*አማርኛ (Amharic)* ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነጮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

*Èdè Yorùbá (Yoruba)* Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

*Tiếng Việt (Vietnamese)* Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

*Tagalog (Tagalog)* Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

*Español (Spanish)* Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

*Русский (Russian)* Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

*हिन्दी (Hindi)* ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

*Bǎsɔ́ɔ̀-wùdù (Bassa)* Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùdù mú ɓé m̀ ké se wídí dò péè. Kpooɔ̀ nyɔ ɓě mɛ ɖá fǔùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓé wa kéɛ m̀ gbo cɛ̃ ɓé m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwè. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ ɔ ké nì wuɖuɔ̀ mú zà.

*বাংলা (Bengali)* লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

*اردو (Urdu)* توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

*فارسی (Farsi)* توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

*اللغة العربية (Arabic)* تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

*中文繁体 (Traditional Chinese)* 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

*Igbo (Igbo)* Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

*Deutsch (German)* Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

*Français (French)* Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

*한국어(Korean)* 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee iłh hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil nik'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíłígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee iłh hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs biłh adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

# SUMMARY PLAN DESCRIPTION

# FOR THE AVAILABILITY OF SEPARATE PAYMENTS FOR CONTRACEPTIVE SERVICES

**As required under Section 2713 of the Public Health Service Act, added by the Patient Protection and Affordable Care Act, as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code**

**The distribution of this Summary Plan Description does not create an employee welfare benefit plan or an employer relationship between CareFirst and the participants**

# Administrative Information about Your Benefits

This section of your guide contains information on the administration and funding of your medical and pharmacy contraceptive benefits for female employees or female dependents. Some of the information is required under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

## Plan Sponsor

Your contraceptive benefits are paid for by CareFirst, Inc. and certain of its affiliated, subsidiary, and related companies. Company headquarters are located at 10455 Mill Run Circle, Owings Mills, Maryland 21117. A complete list of affiliated, subsidiary, and related companies that sponsor these plans may be obtained upon written request of the Plan Administrator or may be examined at the offices of the Plan Administrator.

The Employer Identification Number (EIN) for CareFirst, Inc. is 52-2069215.

## Contraceptive Benefits

**You must obtain Contraceptive Services from a plan provider or CareFirst BlueChoice Contracting Pharmacy.** Your contraceptive benefits include the following:

1. Contraceptive patient education and counseling for all female Members with reproductive capacity;

2. All FDA-approved contraceptive drugs and devices for all female Members, and sterilization procedures and other contraceptive methods for female Members that must be administered to the female Member in the course of a covered outpatient or inpatient treatment;

3. The insertion or removal, and any medically necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA;

4. Any self-administered contraceptive drug or device that is approved by the FDA for use as a contraceptive; or

5. Female elective sterilization procedures and any related services.

The following Exclusions and Limitation also apply to your contraceptive benefits:

1. Self-administered FDA-approved contraceptive drugs or devices that are not included on CareFirst BlueChoice's Preferred Preventive Drug List require prior authorization from CareFirst BlueChoice and will not be made available unless medically necessary. A copy of the CareFirst BlueChoice Preferred Preventive Drug List is available to you by calling Member Services at the telephone number below or at the telephone number on the back of your identification card.

2. The Contraceptive Services made available hereunder exclude abortion services and exclude mifepristone, methotrexate, misoprostol, or any other drug or compound not identified or described herein that is used to induce an abortion.

## Employees Covered

Generally, the contraceptive benefit coverage described in this guide cover the female employees or female dependents of groups that have identified themselves as eligible organizations and have requested an Accommodation for Contraceptive Services.

## Program Administration

The Contraceptive Coverage is subject to the overall administration of the Plan Administrator, according to Section 2713 of the Public Health Service Act, added by the Patient Protection and Affordable Care Act, as

amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. The Plan Administrator has the authority to interpret plan provisions at its discretion, including eligibility for benefits, and the authority of the Plan Administrator is final and binding. The Plan Administrator is:

**CareFirst, Inc.**
10455 Mill Run Circle
Owings Mills, MD 21117
Telephone: Please refer to the number on the
back of your ID card

## Agent for Service of Legal Process

If you want to take legal action for any reason related to a contraceptive benefit claim, you may contact the Company's General Counsel for the service of legal process for Company benefit plans:

General Counsel
CareFirst BlueCross BlueShield Legal Department
1501 S. Clinton Street, Mailstop CT10-06
Baltimore, MD 21224

You may also serve legal process on the Plan Administrator.

## Updating Your Benefit Records: Basic Information about You

You are responsible for ensuring the information in your benefit records is correct. Updates to your personal information (i.e., name, address, marital status), should be made with your employer. Changes submitted as part of your health benefits plan will also change the benefit records associated with contraceptive benefit coverage.

## Basic Information about Your Dependents

To update your records for life status changes, follow your Employer's procedures for updating your benefit records.

# COBRA

If you elect COBRA benefits under your medical policy, all of your COBRA rights in that policy apply to your contraceptive benefit. If you do not elect COBRA under your medical policy, you do not have the COBRA benefits described hereunder.

# HIPAA Privacy Rights

CareFirst BlueChoice complies with the privacy requirements for Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). For a copy of the CareFirst BlueChoice Notice of Privacy Practices, you may contact CareFirst BlueChoice Member Services at 443-738-2920 or 1-888-567-9155

# ERISA Rights Notice

As a participant with contraceptive benefits coverage, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

## *Receive Information about Your Benefits*

You are entitled to:

- Examine, without charge, all documents governing the benefits. You are entitled to examine these documents at the Plan Administrator's office and at other specified locations, such as worksites;

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the benefits. The Plan Administrator may make a reasonable charge for the copies.

## *Prudent Actions by Fiduciaries*

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate this plan are called "fiduciaries," and they have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## *Enforce Your Rights*

If your claim for a benefit is denied or ignored, you are entitled to:

- Know why this was done;

- Obtain copies of documents relating to the decision without charge; and

- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps that you can take to enforce your rights. For example, you may file suit in federal court if:

- You have a claim for benefits, which is denied or ignored, in whole or in part. You may also file suit in state court; or

- You disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and legal fees. This could occur if the court finds your claim frivolous.

## *Assistance with Your Questions*

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is listed in your telephone directory. You may also contact:

Division of Technical Assistance and Inquiries Employee

Benefits Security Administration U.S. Department of Labor
200 Constitution Avenue, NW Washington,
DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at 1-866-275-7922. You may also visit the EBSA's website on the Internet at http://www.dol.gov/ebsa.

# Claiming Benefits

Claims must be submitted within 12 months following the date services were rendered.

Once your claim has been documented and the necessary forms are complete, your claim generally must be processed within a certain time frame. You will be notified in writing before the expiration date of the initial claim period if an additional claim period is required to complete claim processing.

If your claim is denied, you will be notified in writing. This written notice will tell you why the claim was denied and the specific plan provisions on which the denial was based. It will also tell you if there is any additional information which could change the decision to deny the claim. Finally, the notice will tell you how you can file an appeal to have the decision reviewed.

# Appealing a Denied Claim

## *Health Care Claims*

**Pre-Service Health Care Claims**

For questions about this process, contact CareFirst Pharmacy Member Services at (800) 241-3371.

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**Post-Service Health Care Claims**

**QUESTIONS OR COMPLAINTS**

If you have any questions about these benefits, contact CareFirst BlueChoice at the Member Services telephone number provided on your identification card. You can also contact CareFirst BlueChoice in writing at:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

Any complaints or disputes relating to Contraceptive Services will be handled pursuant to the Benefit Determinations and Appeal and Grievance Procedures or the Claims Procedures in the Evidence of Coverage.

# EXHIBIT 2

## Welcome to Contraceptives Card services provided by CVS Caremark.

Contraceptives are now covered at no cost under the Affordable Care Act. CVS Caremark is providing you contraception coverage.

## No cost to you.

This Contraceptives Card is not provided by your group health plan. CVS Caremark will provide separate payments for the contraceptive services that you use at no cost to you for as long as you remain enrolled with your current health plan.

## Visit Caremark.com.

Your Contraceptives Card is separate from your prescription benefit card so it must be registered and used separately. Go to www.caremark.com to register the ID number from your Contraceptives Card and find a list of participating pharmacies where you can use your card. If you have any questions, please call Customer Care toll-free at 1-888-924-8738.

## Add your Contraceptives Card to your wallet.

This contraceptives coverage is separate from your health plan and will require you to show your Contraceptives Card when ordering or picking up your prescription contraceptive.

## Choose what's right for you.

Talk with your doctor to review the enclosed list of no-cost contraceptives and decide which option is best for you.

### Contraceptives Card

| | |
|---|---|
| RxBIN | 004336 |
| RxPCN | ADV |
| RxGRP | RX3924 |
| Issuer (80840) | |

ID [redacted]
Name

03486118968

**Present this card to fill your prescription for contraceptives at any participating pharmacy.**

GLOBAL-2PPDF-3_30_Contraceptive_Letter-1017

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
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CVS caremark®

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF JENNIFER WELCH IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Jennifer Welch, declare:

1. I declare under penalty of perjury that the following is true and correct and of my own personal knowledge. This declaration is based on my professional knowledge, my knowledge of the operations of Planned Parenthood of Illinois (PPIL), and my review of two Final Rules published by the Departments of Health and Human Services, Treasury, and Labor on November 15, 2018, entitled "Religious Exemptions and Accommodations for Coverage of Certain Preventative Services Under the Affordable Care Act" and "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act." If called and sworn as a witness, I could and would testify competently to the information contained in this declaration.

2. I am the President and CEO of PPIL. I have been President and CEO since May 2017. I have a thirty-year career in public service in government and nonprofit leadership. In my professional opinion, the Final Rules will cause a strain on public funding for contraceptive care in the State of Illinois, including on the Illinois Medicaid and Title X programs.

3. PPIL's mission is to provide and promote compassion, comprehensive reproductive health care, education, and rights. PPIL's work is dedicated to creating access for all to quality reproductive health care without judgment and with respect. PPIL operates 17 health

centers throughout Illinois. It served more than 68,000 patients in 2017. In many Central Illinois communities, PPIL is the only provider of long-acting reversible contraceptives. For many of our patients, Planned Parenthood is the only health care provider they see all year – and we take that responsibility seriously. Our goal is to treat every person who comes through our doors with compassion, dignity, and respect while giving them the care they need – no matter their background, identity, or income.

**Access to Contraceptive Coverage in Illinois**

4. Illinois law requires all individual or group health insurance policies amended, delivered, issued, or renewed in Illinois to provide contraceptive coverage that matches the federal guarantee provided by the Affordable Care Act (Public Health Service Act 2713(c)). Illinois Insurance Code, 215 ILCS 5/356z.4. The law specifically requires coverage for all contraceptive drugs, devices, and other products approved by the United States Food and Drug Administrative, including all over-the-counter drugs, devices, and products. *Id.* This coverage must be provided without cost-sharing and must provide for the dispensing of 12 months' worth of contraceptives at one time. *Id.* The law also requires coverage of voluntary sterilization procedures and contraceptive services, patient education and counseling, and follow-up services. *Id.* However, the law does not cover women or covered dependents who have coverage through an employer that uses a self-insured plan. Therefore, Illinois women in self-insured employer-sponsored health insurance plans are at risk of losing contraceptive coverage if their employer uses the new accommodations or exemptions in the Final Rule.

5. The State of Illinois also ensures access to contraceptive coverage to Illinois women through its Medical Assistance (Medicaid) program. Illinois Public Aid Code, 305 ILCS 5/5-5. Illinois women with incomes of up to 138% of the federal poverty level are eligible for the

Illinois Medicaid program. 305 ILCS 5/5-2. Illinois Medicaid provides coverage for "reproductive health care that is otherwise legal in Illinois." 305 ILCS 5/5-5.

6. The State of Illinois also provides contraceptive coverage through the Illinois Department of Public Health's (IDPH) Family Planning Program. IDPH is a grantee in the federal Title X National Family Planning Program, administered by the U.S. Department of Health and Human Services. Title X is a federal grant program developed to provide funding for a broad range of high-quality family planning services for underserved individuals. IDPH's Title X funding currently provides direct support to a network of 28 family planning Delegate Agencies. These agencies run 63 clinic sites throughout Illinois that consist of local health departments, health centers, school-based health centers, and hospitals.

**Contraceptive Care Provided by PPIL is Largely Funded by Public Programs**

7. PPIL is a participant in the Title X National Family Planning Program, administered by the U.S. Department of Health and Human Services. As a direct grantee of that program, PPIL provides no-cost family planning and related preventive health care to individuals with incomes up to 250% of the federal poverty level. For individuals with incomes above 250% of the federal poverty level, PPIL provides services for a sliding scale fee. PPIL receives federal funding to reimburse the costs for individuals who receive family planning services pursuant to Title X. PPIL served more than 40% of all Illinois patients that access family planning support from a Title X health center. The vast majority of young people that access sexually transmitted infections treatment and additional services at PPIL rely on public health coverage programs to afford care. Without the ability to access Medicaid or Title X subsidies, young people will face additional barriers to obtaining the preventive care they need to stay healthy.

8. PPIL also receives reimbursement from the State of Illinois for services provided to individuals enrolled in the Illinois Medicaid program. PPIL participates in Illinois Medicaid and is contracted with the Illinois Department of Healthcare and Family Services (IHFS) and Illinois Medicaid Managed Care Organizations (MCOs). Last fiscal year, almost 23,000 of PPIL patients were Illinois Medicaid recipients, accounting for 34% of all the patients we served. Like any other provider, Planned Parenthood submits insurance claims for services rendered to Medicaid patients and is reimbursed at the Illinois Medicaid fee schedule for contracted services with IHFS and MCOs. For example, if a woman comes in to get a pap smear or birth control, our PPIL health center will apply for reimbursement to Medicaid for those services. Patients come to Planned Parenthood for a variety of reasons, including that we accept Medicaid. Many providers don't accept Medicaid because the reimbursement rates are very low.

9. PPIL also serves patients with commercial insurance, employer-sponsored insurance, and individuals without any coverage. More than 22,000 PPIL patients seen last year had third party (commercial) insurance, accounting for 33% of all patients served, a very similar percentage as those we serve with public insurance.

**Women May Seek Publicly Funded Contraceptive Care from PPIL and Other Providers if They Cannot Get Coverage Through Their Employer-Sponsored Plan**

10. In my professional experience, women who do not have health insurance coverage for contraceptives will likely still seek such care from providers like PPIL and other Title X providers. Part of PPIL's mission is to ensure that all women have access to crucial healthcare, including contraceptives and family planning services, regardless of their health insurance coverage or ability to pay. PPIL currently serves approximately 22,000 Illinois individuals who are uninsured or do not have coverage for contraceptive care. This group represented the final third of our patients served. PPIL will provide contraceptive care to women who lose coverage

previously provided by their employer-sponsored insurance as a result of the Final Rules. I expect that the number of Illinois women seeking contraceptive care from PPIL without coverage for contraceptive care will increase if the Final Rules go into effect. At least some of these women seeking contraceptive care will be financially unable to afford doing so, and such services will be publicly funded by the State of Illinois, the federal government, or go uncompensated.

11. Additionally, PPIL currently serves, and will continue to serve, women who receive dependent coverage through a spouse or parent who is a policyholder. For those women, a decision by the policyholder's employer to exclude contraceptive coverage may leave them without alternatives to coverage. Women whose insurance comes from their spouse or parent's employer's may be limited in their ability to obtain alternative insurance (public or private) that includes coverage for contraceptive care. These women are likely to continue to seek contraceptive care from PPIL, only now it may be reimbursed by Title X or other publicly funded programs, rather than the policyholder's insurance.

12. It is likely that some women who are denied contraceptive coverage by their employer, or the employer of their spouse or parent, will forego such insurance and enroll in the Illinois Medicaid program if their incomes are less than 138% of the federal poverty level. This shifts the cost of contraceptive care for these women from their employer to the State of Illinois. In other instances, women with incomes below 250% of the federal poverty level will seek services compensated by Title X. At least some of these women will seek services from PPIL or from one of the clinics in the IDPH Family Planning Program. Approximately 101,619 women received family planning services from a Title X provider in Illinois in 2017. U.S. Department of Health and Human Services, "Title X Family Planning Annual Report: 2017 National Summary," Appendix B, Exhibit B-1. Of those, 38% had publicly funded insurance, 28% had private insurance, and 33% were uninsured. *Id.* at Appendix B, Exhibit B-3a. If these numbers expand

because of a loss of employer-sponsored coverage under the Final Rules, this will constrain the resources of Title X funding throughout the State of Illinois and put additional financial burdens on reduced no-cost contraceptive services and programs in Illinois, as well as emotional and financial strain on the women who are now seeking contraceptive care without the benefit of employer-sponsored insurance coverage.

**Women Who Do Not Seek Contraceptive Care or Services from Planned Parenthood or Other Title X Providers May Experience Unintended Pregnancies**

13. Family planning and the use of contraceptives is the most effective way to avoid unintended pregnancies. If it is more difficult for women to access contraceptives, unintended pregnancies will naturally increase. In my professional experience, it is likely that women who lose contraceptive coverage as a result of the Final Rules may not receive contraceptive care and experience unintended pregnancies. Those unintended pregnancies are likely to increase costs for Illinois Medicaid and other publicly funded programs. According to one study, 78.3% of unplanned pregnancies were publicly funded in Illinois, at least in part with state funds. Guttmacher Institute, "Public Costs from Unintended Pregnancies and bbthe Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010," Feb. 2015.

Executed on 6/28, 2019, in CHICAGO, ILLINOIS.

JENNIFER WELCH
President & CEO
Planned Parenthood of Illinois

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

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Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF JONATHAN WERBERG IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

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**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Jonathan Werberg, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am currently the Director of the Department of Research and Analytics at the Office of the Attorney General for the State of New York ("OAG"), having previously served as the Senior Data Scientist. I have been at the OAG since May 2015. I assist, support and supervise 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' Final Exemption Rules.

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 Exemption Rules 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 as likely to use the exemptions provided by the Exemption Rules 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.

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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).

6. Hobby Lobby Stores, Inc. is a for-profit national arts and crafts store chain with 32,000[4] employees across the United States. In New York State, Hobby Lobby has eighteen store locations[5] and employs approximately 720 people.[6]

7. Nyack College, an affiliate of the Christian and Missionary Alliance, is a liberal arts college in New York, with approximately 2,500[7] students enrolled in its programs; the college employs approximately 1,100 people.[8]

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 6,000 students.[9]

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 Exemption Rules.

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

Executed on June 24, 2019, in New York, New York.

Jonathan Werberg
Director of Research and Analytics
New York State Office of the Attorney General

[4] "Hobby Lobby Stores on the Forbes America's Largest Private Companies List." Forbes. October 24, 2018. Accessed June 20, 2019. https://www.forbes.com/companies/hobby-lobby-stores/#1dc96046cee6.

[5] Parrish, Tory N. "Hobby Lobby opens 2 LI locations as part of nationwide expansion" Newsday, updated May 29,2018, accessed December 6, 2018.

[6] "Hobby Lobby Stores on Forbes Lists" https://www.forbes.com/companies/hobby-lobby-stores/?list=largest-private-companies#56cf4fa16cee Accessed December 6, 2018.

[7] "How Does Nyack College Rank Among America's Best Colleges?" U.S. News & World Report. Accessed June 20, 2019. https://www.usnews.com/best-colleges/nyack-college-2790.

[8] Nyack College IRS Form 990 for Fiscal Year ending June 30, 2017.

[9] "How Does Biola University Rank Among America's Best Colleges?" U.S. News & World Report. Accessed June 20, 2019. https://www.usnews.com/best-colleges/biola-university-1122.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MASSEY S. J. WHORLEY IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Massey S. J. Whorley, declare:

1. I am over the age of 18 and competent to make this declaration.

2. I have been the Director of Innovation and Strategic Initiatives at the Virginia Department of Social Services since July 2018. Previously, I served as the Senior Policy Advisor to Governors Ralph S. Northam and Terence R. McAuliffe in the Office of the Governor of Virginia. Prior to September 2016, 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, 2018, 136,074 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 2018 (July 1, 2017 through June 30, 2018) was $7,239,586, 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 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 November 7, 2018 (FRs). Under the FRs, 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 FRs 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 that 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.

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

Executed on June 14, 2019, in Richmond, Virginia.

MASSEY S. J. WHORLEY
Director of Innovation and Strategic Initiatives
Virginia Department of Social Services

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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.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS 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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

4:17-cv-05783-HSG

**DECLARATION OF WALKER A. WILSON**

I, WALKER A. WILSON, declare:

1. I am the Assistant Secretary of Policy at the North Carolina Department of Health and Human Services. I was previous the Director of the Health Policy Office at Blue Cross Blue Shield North Carolina, where I led the team analyzing federal regulations under the Affordable Care Act.

2. The State of North Carolina provides contraceptive coverage through a statewide Family Planning program funded by multiple sources (Title X, Title V, State money, and TANF). The goal of the program is to decrease the incidence of unintended pregnancies, reduce cases of STD/HIV, improve birth outcomes, and improve the overall reproductive health among North Carolinians. Every effort is made to ensure that families with incomes at or below 100% of the federal poverty level are given priority in receiving family planning services, including adolescents.

3. North Carolina has a minor consent law allowing for a minor to consent to see a medical professional for the diagnosis, treatment, and prevention of: pregnancies, STDs, mental health, or substance use.

4. North Carolina Medicaid provides family planning coverage to men and women who have incomes at or below 195% of the federal poverty level through a program called "Be Smart." Both public and private medical providers accept "Be Smart" family planning patients.

5. All women in North Carolina are at risk of losing Affordable Care Act required contraceptive coverage under the final regulations issued by the federal government. North Carolina's 2017 population is 10,052,564; women make up 5,157,196 of the total population (according to the American Community Survey 5-year estimate). The percentage of unintended pregnancies in North Carolina in 2017 was 50.5% (according to the NC State Center for Health Statistics). As a result of these rules, women will either (a) utilize and seek coverage through State program, (North Carolina Statewide Family Planning Program), (b) they will forgo coverage and experience an unintended pregnancy. In both scenarios, the State will suffer increased costs and its residents harmed.

Executed on December 18, 2018, in Raleigh, North Carolina.

Walker A. Wilson

WALKER A. WILSON
Assistant Secretary for Policy
North Carolina Department of Health and Human Services

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF DR. JUDY ZERZAN-THUL IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Dr. Judy Zerzan-Thul, declare:

1. I am over the age of 18 and have personal knowledge of all the facts stated herein.

2. I am the Chief Medical Officer for the Washington State Health Care Authority (HCA) and have been employed in this position since August 20, 2018. I am responsible for assessing and improving the quality of care for State-purchased health care programs, including Apple Health (which is commonly referred to as Medicaid) and the Employee and Retirees Benefits program.

3. Prior to joining HCA, I was employed as the Chief Medical Officer for the State of Colorado Department of Health Care Policy and Financing for nine years. In that capacity, I was responsible for providing clinical guidance for Colorado Medicaid and the Children's Health Insurance Program, including pharmacy and medical benefits, measuring and improving quality, and data analysis.

4. I obtained my M.D. degree from Oregon Health & Science University. I also hold a Master's degree in Public Health from the University of North Carolina. I am Board Certified in Internal Medicine and I have over twenty years of experience as a medical doctor. I have an active current license to practice medicine in the state of Colorado and in Washington.

5. The Health Care Authority administers federally and state funded medical assistance programs under the name Washington Apple Health, which is commonly referred to as Medicaid. Apple Health provides integrated health care services that promote health, wellbeing, and quality

of life for almost 1.8 million Washington residents. As part of that mission, and as required by the Federal Government in order to participate in Medicaid, Apple Health provides coverage for reproductive health services including family planning and pregnancy related services for eligible Washington residents through a variety of programs. Family planning services include all FDA approved contraceptive methods and the clinical services necessary for clients to safely and effectively use their chosen contraceptive method.

6. Eligibility for Apple Health programs is based on several factors, including age, household size, tax filing status, pregnancy status, and income level. For example, childless adults are generally eligible up to 133% of the Federal Poverty Level (FPL), whereas pregnant women are eligible up to 193% of the FPL. Children under 19 are eligible up to 312% of the FPL. Through Apple Health, the Health Care Authority also administers a Family Planning Only Demonstration Waiver Program (FPO) that is an agreement with the Federal Government to provide coverage of family planning specific services for women and men otherwise ineligible for Medicaid, up to 260% of the FPL. Because FPL is established by income level and family/household size, generally a woman with a spouse and two children would qualify at a higher income level then a woman with no spouse or children.

7. In 2017, the Health Care Authority and its contracted Managed Care Organizations spent -$27,387,882.24 in combined federal and state dollars for coverage of family planning services for Apple Health clients enrolled in programs receiving federal funding.

8. The Health Care Authority serves as a secondary payor for services not otherwise fully covered by employer or higher education sponsored health plans for those clients that have both primary health coverage and Apple Health coverage. In 2016, the Health Care Authority provided secondary Apple Health coverage for 120,328 clients who had primary health coverage from other sources such as employer-sponsored coverage and student coverage. Of the total Apple Health clients that have primary health coverage from sources other than Apple Health, 69,652 are women, 38,336 of which are ages 15-44.

9. If employers or colleges and universities in Washington choose to no longer cover contraception for their employees and students pursuant to the federal government's newly-created and expanded exemptions to the Affordable Care Act's contraceptive mandate, the cost of family planning services will shift to the State for employees who have or will seek and be qualified for Apple Health coverage as secondary insurance through the Health Care Authority.

10. Women who lose access to contraceptive coverage through employer and college or university sponsored insurance plans may be unable to afford their current form of contraception and have an unintended pregnancy. The potential for women to reduce or stop working due to pregnancy could change the families' income, potentially causing these families to become eligible for one of the Apple Health programs. The change in family size due to a new birth could also cause these families to become eligible for one of the Apple Health programs. This could result in an increase in state expenditures related to pregnancy and future family planning services.

11. In 2017, the Health Care Authority and its contracted Managed Care Organizations spent on average $10,215 per delivery for women with Medicaid-paid maternity care. Additionally, there are pregnancy services costs for pregnancy losses prior to 20 weeks gestation. Apple Health paid for maternity care for 41,457 women who delivered in 2017. Approximately 30% of Medicaid-funded births in 2013 were from unintended pregnancies.

12. The Affordable Care Act's implementation correlates with a decrease in the FPO program enrollment. The number of enrollees receiving FPO services dropped by 71% from the 2012-13 fiscal year to the 2014-15 fiscal year. By the 2016-17 fiscal year there was a further drop of 48% in enrollees. Enrollment would be expected to increase if the expanded contraceptive exemptions are allowed to take effect.

13. The State of Washington Public Employees Benefits Board (PEBB) Program purchases and coordinates health benefits for more than 300,000 eligible public employees and retirees. PEBB members may elect to add their spouse or state-registered domestic partner to their health plan if they lose contraception coverage through their own employer's health plans. When

state employees do so, it will cost the State additional money to provide health coverage for those spouses and state-registered domestic partners.

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

Executed on June 24, 2019, in Olympia, Washington.

DR. JUDY ZERZAN-THUL

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**THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF HAWAII; THE STATE OF ILLINOIS; THE STATE OF MARYLAND; THE STATE OF MINNESOTA, BY AND THROUGH ITS DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; THE STATE OF WASHINGTON,**

Plaintiffs,

**THE STATE OF OREGON,**

Plaintiff-Intervenor,

**THE STATE OF COLORADO; THE STATE OF MICHIGAN; THE STATE OF NEVADA,**

Proposed-Plaintiffs-Intervenors,

**v.**

**ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL**

4:17-cv-05783-HSG

**DECLARATION OF MARIE L. ZIMMERMAN IN SUPPORT OF STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT**

Date: September 5, 2019
Time: 2:00 p.m.
Dept: 2, 4th Floor
Judge: The Honorable Haywood S. Gilliam, Jr.

Action Filed: October 6, 2017

**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,

and,

**THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,**

Defendant-Intervenors.

I, Marie L. Zimmerman declare:

1. I am the Assistant Commissioner for the Health Care Administration at the Minnesota Department of Human Services. The Health Care Administration is responsible for administering the Minnesota Family Planning Program and Minnesota's Medicaid program, both described below.

2. The Minnesota Department of Human Services administers the Medical Assistance program ("MA"), which is Minnesota's Medicaid program for people with low income. In fiscal year 2017, MA provided coverage to a monthly average of 1.1 million Minnesotans. MA covers comprehensive family planning services. The cost of family planning services is paid for with State and Federal funds with the federal government generally covering 90 percent and the State of Minnesota covering 10 percent, respectively.

3. The Minnesota Department of Human Services also administers the Minnesota Family Planning Program ("MFPP"). This program provides access to family planning services for low-income Minnesotans who are not enrolled in MA subject to certain eligibility requirements. The family planning services covered by MFPP include, for example, family planning office visits, education, various birth control methods, and transportation to and from a provider of family planning services. In 2017, the program served a total of more than 20,000 people, with a monthly average enrollment of approximately 11,000. Total spending for the program was about $8.6 million. The cost of MFPP services is paid for with State and Federal funds with the federal

government generally covering 90 percent and the State of Minnesota covering 10 percent, respectively.

4. I understand that the U.S. Health and Human Services Department, in conjunction with the U.S. Department of Labor and U.S. Department of Treasury recently issued two final rules that would allow certain employers to cease providing contraceptive coverage to their employees based on a religious or moral objection. Minnesota 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.

5. Minnesota women who lose contraceptive coverage as a result of these rules may seek coverage through MA or MFPP. If additional individuals enroll in MA or MFPP due to these final rules, it will increase the administrative and financial burden on the Department of Human Services.

6. Women who lose coverage may also choose to forgo seeking contraception and related services if they do not have the means to pay for it, thereby risking unintended pregnancy and other poor health outcomes related to reproductive care. Because Minnesota and its Department of Human Services pay for child delivery for women on MA, the state and the Department of Human Services may bear a financial risk when women lose contraceptive coverage. Minnesota and its Department of Human Services are also obligated to pay for newborn care, which can be expensive if there are complications, for children born to certain low income women or families.

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

Executed on June 25, 2019, in St. Paul, Minnesota.

MARIE L. ZIMMERMAN
Assistant Commissioner
Minnesota Department of Human Services

|#4513131-v1

# CERTIFICATE OF SERVICE

Case Name: **State of California v. Health and Human Services, et al.** No. **4:17-cv-05783-HSG**

I hereby certify that on July 1, 2019, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

**STATES' OPPOSITION TO DEFENDANTS' AND INTERVENORS' MOTIONS TO DISMISS AND MOTIONS FOR SUMMARY JUDGMENT; STATES' REPLY IN SUPPORT OF STATES' MOTION FOR SUMMARY JUDGMENT**

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on July 1, 2019, at Sacramento, California.

| Michele Warburton | */s/ Michele Warburton* |
|---|---|
| Declarant | Signature |

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