United States Court of Appeals

for the

First Circuit

Case No. 18-1514

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff-Appellant,

– against –

DEPARTMENT HEALTH AND HUMAN SERVICES, *et al.*,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS IN CASE NO. 1:17-CV-11930-NMG HONORABLE NATHANIEL M. GORTON

BRIEF OF *AMICI CURIAE* PLANNED PARENTHOOD FEDERATION OF AMERICA, NATIONAL HEALTH LAW PROGRAM, AND NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

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CORPORATE DISCLOSURE STATEMENT

The undersigned counsel certifies that the *amici curiae* Planned Parenthood Federation of America, National Health Law Program, and National Family Planning and Reproductive Health Association are not subsidiaries of any other corporation and no publicly held corporation owns 10 percent or more of any *amici curiae* organization's stock.

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Dated: September 24, 2018

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INTEREST OF AMICI CURIAE[1]

Planned Parenthood Federation of America ("PPFA") is the oldest and largest provider of reproductive health care in the United States, delivering medical services through more than 600 health centers operated by 56 affiliates. Its mission is to provide comprehensive reproductive health care services and education, to provide educational programs relating to reproductive and sexual health, and to advocate for public policies to ensure access to health services. PPFA affiliates provide care to approximately 2.5 million women and men each year. One out of every five women in the United States has received care from PPFA. In particular, PPFA is at the forefront of providing high-quality reproductive health care to individuals and communities facing serious barriers to obtaining such care—especially individuals with low income, individuals located in rural and other medically underserved areas, and communities of color.

The National Health Law Program ("NHeLP") is a 49-year-old public interest law firm that works to advance access to quality health care, including the full range of reproductive health care services, and to protect the legal rights of lower-income people and people with disabilities. NHeLP engages in education, policy

[1] Counsel for both parties have consented to the filing of this brief. No counsel for a party authored the brief in whole or in part; no party or party's counsel contributed money to fund preparing or submitting the brief; and no person other than the *amici curiae* or their counsel contributed money intended to fund preparing or submitting the brief.

analysis, administrative advocacy, and litigation at both state and federal levels.

The National Family Planning and Reproductive Health Association ("NFPRHA") is a national, nonprofit membership organization established in 1971 to ensure access to voluntary, comprehensive, and culturally sensitive family planning and sexual health care services, and to support reproductive freedom for all. NFPRHA represents more than 850 health care organizations and individuals in all 50 states, the District of Columbia, and the territories. NFPRHA's organizational members include state, county, and local health departments; private, nonprofit family planning organizations (including Planned Parenthood affiliates and others); family planning councils; hospital-based clinics; and Federally Qualified Health Centers. NFPRHA's members operate or fund a network of more than 3,500 health centers that provide high-quality family planning and related preventive health services to more than 3.7 million low-income, uninsured, or underinsured individuals each year.

SUMMARY OF ARGUMENT

On October 6, 2017, the U.S. Department of Health and Human Services ("HHS") announced new interim final rules (the "IFRs")—with an immediate effective date and without undergoing the notice-and-comment process—that dramatically expand possible exemptions to the requirement, pursuant to the Patient Protection and Affordable Care Act (the "ACA"), that insurers provide no-cost coverage for the full panoply of FDA-approved contraceptive methods (the "Contraceptive Coverage Benefit"). The IFRs threaten to deprive large numbers of

women of access to seamless, no-cost contraceptive coverage through their employer-sponsored health insurance that is essential to their health.

In the IFRs, HHS justified the expanded exemptions in part because, it claimed, women who lose no-cost contraceptive coverage could resort to safety net programs funded by federal and state governments as an alternative to employer-sponsored insurance, and specified Medicaid and Title X as two such federal programs.[2] The Commonwealth supplements federally-funded coverage through its own contribution to MassHealth, the Commonwealth's Medicaid program, and the Massachusetts Department of Health's Sexual and Reproductive Health Program ("SRHP"), which provides additional funding for Title X family-planning program providers.[3] Notwithstanding HHS's express invocation of state-funded safety net programs as a purported alternative to the Contraceptive Coverage Benefit,[4] HHS argued, and the District Court agreed, that the Commonwealth lacked standing to challenge the IFRs because the Commonwealth failed to demonstrate that Massachusetts women would lose contraceptive coverage and be forced to rely on

[2] *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,803 (Oct. 13, 2017) (to be codified at 45 C.F.R. pt. 147).

[3] *See* Appellant's Br. at 13–14; JA 42 ¶¶ 5–7.

[4] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. at 47,803.

state-funded programs.[5] The District Court similarly held that the Commonwealth did not satisfy the requirements of *parens patriae* standing because it failed to demonstrate any Massachusetts women would lose access to seamless no-cost contraceptive care under the IFRs.[6] For the reasons stated in Appellant's brief, both holdings should be reversed.

As providers of and advocates for reproductive health care to millions of women, including women whose cost of care is covered by Medicaid, Title X, MassHealth, SRHP, and private insurance, *amici* write to provide the Court additional context concerning the coverage these alternative programs provide for reproductive health care and to explain why, even with the additional coverage the Commonwealth's programs will provide to women in the Commonwealth if the IFRs take effect, these programs are not a substitute for the Contraceptive Coverage Benefit.

To summarize, Medicaid- and Title X-funded reproductive health care programs and their state analogues are only designed to provide health care for individuals with low incomes. Moreover, the budgets for such programs are under threat of being drastically cut, and the programs simply would not have the capacity to provide coverage for an influx of women who lose no-cost contraceptive coverage

[5] JA 1403–18.

[6] *Id.* at 1418–22.

because of the expanded exemptions. Further, this proposed expansion of Medicaid and Title X contraceptive care patients undermines the purpose of these programs and threatens to take resources away from the individuals with low incomes these programs are meant to serve. In sum, if upheld, the IFRs will cause many women, including Massachusetts women, to lose access to seamless no-cost contraceptive coverage, putting them at greater risk of unintended pregnancies and other health problems.

For these and other reasons, *amici* submit this brief in support of Plaintiff-Appellant Commonwealth of Massachusetts, and in support of this Court's (a) reversal of the District Court's rulings on standing and (b) remand for consideration of the claims on the merits.

ARGUMENT

I. The ACA's Guarantee of No-Cost Contraceptive Coverage Is an Essential Part of an Integrated Strategy to Ensure That All Women Have Access to No-Cost Contraceptive Coverage

The ACA was designed, in part, to shift the focus of both health care and applicable insurance away from reactive medical care toward preventive care.[7] In furtherance of that goal, the ACA specified that most private insurance plans must cover certain preventive health care services, including women's preventive services,

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

without patient cost sharing.[8] Contraceptive care is an essential preventive health care service. It helps to avoid unintended pregnancies[9] and to promote healthy birth spacing, resulting in improved maternal, child, and family health.[10] Contraceptive care also has other preventive health benefits, including reduced menstrual bleeding and pain, and decreased risk of endometrial and ovarian cancer.[11] Accordingly, since 2011, HHS has defined women's preventive services to include all FDA-approved contraceptive methods.[12]

The Contraceptive Coverage Benefit is designed to increase access to contraceptive services by ensuring that women can access such services seamlessly through their existing health plans at no cost—an important factor that has an impact

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[8] *See, e.g.*, 42 U.S.C. § 300gg-13(a)(4) (specifying that insurance providers "shall not impose any cost sharing requirements . . . with respect to women, [for] such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration . . . .").

[9] An "unintended" pregnancy is defined as one that is "unwanted or mistimed at the time of conception." Comm. on Preventive Servs. for Women, Inst. of Med. of the Nat'l Acads., *Clinical Preventive Services for Women: Closing the Gaps* 102 (2011), http://nap.edu/13181.

[10] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 615: Access to Contraception* 2 (Jan. 2015, reaffirmed 2017), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co615.pdf?dmc=1&ts=20180918T1848086165.

[11] *Id.*

[12] *Id.* at 3; *see also Women's Preventive Services Guidelines*, Health Resources & Servs. Admin., https://www.hrsa.gov/womens-guidelines/index.html (last updated Oct., 2017).

on contraceptive method choice and use. Prior to the ACA, 1 in 7 women with private health insurance either postponed or went without needed health care services because they could not afford them.[13] Those who could purchase contraception were spending between 30 percent and 44 percent of their total annual out-of-pocket health care costs to that end,[14] and women were more likely to forego more effective long-acting reversible contraceptive ("LARC") methods (such as intrauterine devices) due to upfront costs.[15]

Recognizing that *no-cost* contraceptive coverage is an integral component of preventive health care, the Contraceptive Coverage Benefit filled the gap in existing preventive care coverage by eliminating the cost of contraceptive services for women with private insurance coverage. As a result of the requirement, more than 62 million women now have access to contraceptive services at no cost.[16] Out-of-pocket

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[13] Usha Ranji & Alina Salganicoff, Henry J. Kaiser Family Found., *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* 4, 30 (2011), https://www.kff.org/womens-health-policy/report/womens-health-care-chartbook-key-findings-from/.

[14] Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Aff. 1204, 1208 (2015).

[15] *See* Ashley H. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs Among Privately Insured Women*, 28 Women's Health Issues 219, 219 (2018).

[16] Nat'l Women's Law Ctr., *New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-of-Pocket Costs* 1 (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

spending on contraceptive care has decreased, and more women are choosing to use LARC methods.[17] In addition, the percentage of pregnancies in the United States that are unintended is at a 30-year low.[18] Put differently, the Contraceptive Coverage Benefit is working, and it benefits more than just the women who have access to contraceptive care.

II. Medicaid and Title X Are Not Adequate Substitutes for the Contraceptive Coverage Benefit

Safety net programs, particularly Medicaid and Title X, are not adequate or appropriate fail-safes for the loss of no-cost contraceptive coverage through private insurance coverage. HHS specifically rejected these options when it adopted the Contraceptive Coverage Benefit because "requiring [women] to take steps to learn about, and to sign up for, a new health benefit" through a government program instead of their primary insurance imposed unnecessary obstacles to accessing the benefit.[19] What is more, many women who stand to lose coverage for contraceptive

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[17] Snyder, *supra* note 15, at 219.

[18] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 New Eng. J. Med. 843, 850 (2016). Contraceptive coverage with no out-of-pocket costs is particularly effective in reducing the number of unwanted pregnancies. *See* Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1291 (2012). States like Massachusetts have an interest in reducing the number of unintended pregnancies because the Commonwealth incurs additional costs for pre-and post-natal care through programs like MassHealth and SRHP. *See* Appellant's Br. at 34–35.

[19] Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,888 (Jul. 2, 2013).

services are simply not eligible for Medicaid. And Title X is not designed to meet the needs of women who stand to lose access to no-cost contraceptive coverage through their private insurance plans.[20]

A. Medicaid

Established in 1965 as Title XIX of the Social Security Act, Medicaid is a joint federal-state program designed to provide health insurance coverage for a limited population of low-income individuals.[21] Medicaid eligibility is largely based on financial need.[22] Precisely because only a limited population is eligible for Medicaid benefits, Medicaid cannot serve as a substitute for the Contraceptive Coverage Benefit.

In an attempt to address the health needs of low-income individuals nationwide, the ACA expanded Medicaid eligibility to include all individuals with

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[20] Further, Congress specifically intended for *private insurers* to guarantee women access to preventative services in order to end the "punitive practices of insurance companies that charge women more and give [them] less in a benefit" and to "end the punitive practices of the private insurance companies in their gender discrimination." 155 Cong. Rec. 28,842 (2009) (statement of Sen. Mikulski).

[21] 42 U.S.C. § 1396-1 (noting that the purpose of Medicaid is to enable states to furnish medical assistance on behalf of certain individuals "whose income and resources are insufficient to meet the costs of necessary medical services"); *Program History*, Medicaid.gov, https://www.medicaid.gov/about-us/program-history/index.html (last visited Sept. 18, 2018).

[22] Robin Rudowitz & Rachel Garfield, Henry J. Kaiser Family Found., *10 Things to Know About Medicaid: Setting the Facts Straight* 1, 3 (2018), http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

incomes at or below 138 percent of the Federal Poverty Level ("FPL"),[23] which amounts to an annual income of $16,753 for an individual in 2018.[24] Before the ACA's Medicaid expansion took effect, only certain population groups—parents, pregnant women, individuals with a disability, and seniors—were eligible for Medicaid.[25] And many low-income parents did not meet the income eligibility criteria for Medicaid coverage; in 2013, the median state Medicaid income eligibility cut-off for parents was only 61 percent of the FPL.[26] With the ACA's Medicaid expansion, Congress turned Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level."[27]

Massachusetts participated in the Medicaid expansion[28] through its MassHealth program, which also provides secondary coverage for certain services not

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[23] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 120, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)); *see also* Rudowitz & Garfield, *supra* note 22, at 3.

[24] *Federal Poverty Level (FPL)*, HealthCare.gov, https://www.healthcare.gov/glossary/federal-poverty-level-FPL/ (last visited Sept. 18, 2018).

[25] Julia Paradise, Henry J. Kaiser Family Found., *Medicaid Moving Forward* 2 (2015), http://files.kff.org/attachment/issue-brief-medicaid-moving-forward; Rudowitz & Garfield, *supra* note 22, at 3.

[26] Paradise, *supra* note 25, at 2.

[27] *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 583 (2012).

[28] In 2012, the Supreme Court barred HHS from terminating federal Medicaid funding to states that do not extend Medicaid coverage to the expansion population, effectively making the expansion optional for states. *Id.* at 575–87.

covered by a resident's commercial coverage, including contraceptive care.[29] MassHealth covers some residents with incomes up to 300 percent of the FPL and is funded, in part, by the Commonwealth.[30] Massachusetts residents generally must have income lower than $16,040 per year for a single-person household, or $32,718 per year for a household of four, to qualify for coverage under the expansion.[31] Thus, many women who lose contraceptive coverage due to the IFRs would not be able to turn to MassHealth to replace their lost coverage. Further, even those women who would be eligible for MassHealth would be forced to jump through new administrative and logistical hoops to access alternative no-cost contraceptive care, potentially delaying or even preventing their access to care.

B. Title X

As with Medicaid, Title X cannot fill the gap to serve women who currently have contraceptive coverage through private insurance. Title X of the Public Health Service Act was adopted in 1970,[32] and provides grants to public and private, non-profit agencies "to assist in the establishment and operation of voluntary

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[29] Appellant's Br. at 13–14.

[30] *Id.*

[31] *Massachusetts MassHealth (Medicaid)*, Benefits.gov, https://www.benefits.gov/benefits/benefit-details/1282 (last visited Sept. 22, 2018).

[32] Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (1970) (codified as amended at 42 U.S.C. § 300a (2012)).

family planning projects which . . . offer a broad range of acceptable and effective family planning methods and services," including contraception.[33] HHS awards Title X grants through a competitive process, and the Title X project funds a network of nearly 3,900 family planning centers across the country, serving approximately 4 million clients every year.[34] The Commonwealth supplements Title X funding through SRHP to expand coverage of family planning services for low-income residents.[35]

Title X grants are intended to serve "persons from low-income families."[36] While some women who are not eligible for Medicaid are able to obtain

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[33] 42 U.S.C. § 300(a); *see also* 42 C.F.R. § 59.5.

[34] Christina Fowler et al., RTI Int'l, *Title X Family Planning Annual Report: 2017 National Summary* 7–8 (2018), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[35] Appellant's Br. at 14–15; JA 42 ¶¶ 4–7; *see also MDPH-Funded Family Planning Programs*, Mass.gov, https://www.mass.gov/info-details/mdph-funded-family-planning-programs#resources- (last visited Sept. 22, 2018). Even with the expanded coverage in Massachusetts, only 25 percent of women who would lose contraceptive coverage under the IFRs would be eligible to receive contraception under a Commonwealth-funded program. Appellant's Br. at 33.

[36] 42 U.S.C. § 300a-4(c)(1). A recently proposed revision to the Title X regulations, if adopted, would purport to expand the definition of "low income" for purposes of Title X eligibility to include all women (regardless of income) who lose contraceptive coverage due to their employers' taking advantage of the challenged exemptions. *See* Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502, 25,514 (June 1, 2018) [hereinafter, *Proposed Regulation*] (to be codified at 42 C.F.R. pt. 59). This proposed rule does not reflect the current definition of "low income," bears no relation to the plain meaning of that term, and also is legally flawed because it is inconsistent with the purpose of Title X family planning funding. Further, HHS has

contraception through a Title X program, only women whose annual income is at or below the FPL are entitled to receive Title X services at no cost.[37] Women whose annual income is 101 percent to 250 percent of the FPL receive care at a reduced cost based on a schedule of discounts that corresponds to their income.[38]

Under Title X, those whose annual income is greater than 250 percent of the FPL are charged according to a "schedule of fees designed to recover the reasonable cost of providing services."[39] SRHP extends this population of individuals covered in some form to those making up to 300 percent of the FPL.[40] In addition, Title X is not designed as backup coverage for individuals who have private insurance. If a woman has private insurance, the Title X clinic generally must bill third parties deemed obligated to pay for the services.[41] Indeed, Title X is designed to partially subsidize a program of care, not pay all of the cost of any service or activity. Thus, the Title X statute and regulations contemplate that Title X and third-party payers will

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not proposed any additional *funding* to accommodate this proposed expansion of Title X-eligible women. Given the many unknowns as to what a final rule would look like and when it would take effect, the proposed rule should have no bearing on this appeal.

[37] 42 C.F.R. § 59.5(a)(7).

[38] *Id.* § 59.5(a)(8).

[39] *Id.*

[40] JA 42 ¶ 6.

[41] 42 C.F.R. § 59.5(a)(7).

work together to pay for care and direct Title X-funded agencies to seek payment from such third-party payers.

In short, although some women who lose coverage because of the IFRs could obtain low- or no-cost care from a Title X- or SRHP-funded provider, many would still incur some out-of-pocket costs. And, like Medicaid, Title X and SRHP are not designed as substitute sources of care for individuals above a limited level of income. Thus, for many of the women who would lose access as a result of the expanded exemptions to the Contraceptive Coverage Benefit, none of these programs are viable alternatives to provide seamless access to no-cost contraceptives to fulfill the ACA's guarantee.

C. Increasing the Reliance on the Underfunded Federal Safety Net Will Disproportionately Affect the Women Who Need It Most

The federal reproductive health safety net cannot replace the Contraceptive Coverage Benefit for the additional reason that it is already stretched thin. An influx of new patients who previously obtained no-cost contraceptive care through their insurers would interfere with providers' ability to serve the neediest women. In states like Massachusetts that recognize the importance of access to contraceptive care to the health and wellbeing of their residents, this will lead to increasing strain on those states to absorb the costs of such care for patients who lose coverage under their employer-sponsored insurance plans because of the IFRs.

A recent study found that the cost of providing family planning services

for all low-income women of reproductive age who need such services would range from $628 to $763 million annually.[42] In fiscal year 2018, Title X received just $286.5 million—a fraction of that estimated cost, and a level of funding that has not increased since 2011 and is not expected to increase in fiscal year 2019.[43] In fact, the trend is in the opposite direction. Between 2010 and 2016, Congress cut funding for Title X by 10 percent, even as the need for publicly funded contraceptive services and supplies increased by 5 percent over that same period.[44] Taking inflation into account, the level of funding for Title X today is less than 30 percent of what it was in 1980.[45]

At the same time, two-thirds of state Medicaid programs face challenges in securing an adequate number of providers,[46] particularly when it comes to specialty

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[42] *See* Euna M. August et al., *Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act*, 106 Am. J. Pub. Health 334, 336 (2016).

[43] *Title X Budget & Appropriations*, Nat'l Fam. Plan. & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Sept. 19, 2018).

[44] *See* Joerg Dreweke, *"Fungibility": The Argument at the Center of a 40-Year Campaign to Undermine Reproductive Health and Rights*, 19 Guttmacher Pol'y Rev. 53, 58 (2016).

[45] *Id.*

[46] U.S. Gov't Accountability Office, *States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance* 19 (2012), http://www.gao.gov/assets/650/649788.pdf; Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Access to Care: Provider Availability in Medicaid Managed Care*, at 8 (2014) [hereinafter *Access to Care*], http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

services like obstetrics and gynecology ("OB/GYN") services. A government report found that only 42 percent of in-network OB/GYN providers were able to offer appointments to new patients in 2014.[47] Many federally qualified health centers ("FQHCs") have struggled to fill persistent staff vacancies and shortages.[48]

Cuts to funding for federally funded reproductive care have an impact on the number of women who can access reproductive health services. In 2010, the number of clients served at Title-X funded health centers was approximately 5.2 million.[49] In 2016 that number dropped to just over 4 million.[50] This decline coincides with more than $30 million in cuts to Title X's annual appropriation over the same period.[51] This decline did not occur because fewer women are in need of these services. To the contrary, the number of women in need of publicly funded care has *increased*: In 2014, of the 38.3 million women of reproductive age (ages 13 to

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[47] *See Access to Care*, *supra* note 46, at 21.

[48] Nat'l Ass'n of Cmty. Health Ctrs., *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers* 2–4 (2016), http://www.nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf.

[49] Christina Fowler et al., RTI Int'l, *Family Planning Annual Report: 2010 National Summary* 8 (2011) [hereinafter *2010 Annual Report*], https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf.

[50] Christina Fowler et al., RTI Int'l, *Family Planning Annual Report: 2016 National Summary* 8 (2017), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[51] *See id.* at 1; *2010 Annual Report, supra* note 49, at 1.

44) who were estimated to be in need of contraceptive services, 20.2 million were in need of publicly funded contraceptive services because they were either teenagers or adult women whose family income was 250 percent below the FPL.[52] This number represents an overall increase of 5 percent since 2010.[53]

The increased need for publicly funded contraceptive services is particularly acute among women who come from under-served populations. The largest increases in the need for family planning services between 2010 and 2014 were among poor and low-income women (11 percent and 7 percent, respectively), and Hispanic women (8 percent).[54] Between 2000 and 2014, the proportion of women who were considered "poor" increased as a share of all women in need of publicly funded services by 6 percent.[55] Similarly, the proportion of Hispanic women who need publicly supported care increased by 9 percent, and the proportion of black women who need publicly supported care increased by 6 percent.[56] Rural populations

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[52] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2014 Update* 8 (2016) [hereinafter *2014 Contraceptive Needs*], https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

[53] *Id.*

[54] *Id.* This report defines "low-income women" as "those whose family income is between 100 percent and 250 percent of the [FPL]." *Id.* at 5. "Poor women" is defined as "those whose family income is under 100% of the federal poverty level." *Id.*

[55] *Id.*

[56] *Id.* at 9.

are also in great need of contraceptive services. Among the 14 states ranked the highest as to the percentage of women of reproductive age in need of publicly funded contraceptive services and supplies, 9 have rural populations exceeding 33 percent of the state population.[57]

Under these conditions, the resources of the family planning safety net are necessary and not even sufficient for the populations of women it was designed to serve, and not available to all women, regardless of means, whose employers opt out of the Contraceptive Coverage Benefit.

III. Medicaid and Title X Additionally Cannot Meet an Increased Demand Because They Are at Risk of Losing Funding and Being Detrimentally Restructured

Even if all women who lose contraceptive coverage as a result of the dramatic expansion of exemptions the IFRs make to the Contraceptive Coverage Benefit *could* receive no-cost contraception through Medicaid or Title X (and as explained above, they cannot), those programs themselves face threats of even more drastic cuts to covered services, funding, and eligibility, calling into question their continued ability to provide the same level of care to those they already serve. Adding an influx of patients previously covered (as a result of the Contraceptive Coverage

[57] *See* Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 586: Health Disparities in Rural Women* 2 (Feb. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20180519T0125239210dmc=1&ts=20180514T1322391916.

Benefit) under private insurance plans would further stretch Medicaid's and Title X's resources and would take resources away from those individuals the safety net programs are intended to serve: low-income individuals and families who are in the greatest need of publicly funded health care services. Once again, the burden will fall on states like Massachusetts to fill part of this void.

A. Medicaid Could Face Cuts to Funding

Contraceptive coverage and continued access to Medicaid-covered services overall is by no means secure, even for those who currently qualify for Medicaid. In its 2019 budget, the White House demonstrated a commitment to scaling back Medicaid funding when it proposed a $25 billion cut to the budget for Medicaid.[58] Congress has also considered dramatic proposals to restructure Medicaid that would result in $1.4 trillion in cuts to the program over the course of a decade by granting states the flexibility to choose either of two cost-reducing reforms: states could elect to (i) receive a fixed amount per Medicaid enrollee, which would be the same for every enrollee in a certain eligibility group, irrespective of the person's actual health care costs (the "per-capita cap" model); or (ii) receive a fixed amount that would not vary by the number of Medicaid enrollees (the "block grant" model).[59]

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[58] *See* Comm. for a Responsible Fed. Budget, *Analysis of the President's FY 2019 Budget* 6 (Feb. 12, 2018), http://www.crfb.org/sites/default/files/PB_FY_2019_Final.pdf.

[59] Gretchen Jacobson et al., Henry J. Kaiser Family Found., *What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?* 4–5 (2017), https://www.kff.org/

Either model would result in insufficient federal funding for the growing number of women of reproductive age who would otherwise rely on Medicaid for birth control access.

In light of the threats to Medicaid funding, there is no guarantee that those currently enrolled in Medicaid will be able to continue receiving contraceptive coverage, let alone that women who lose access to contraceptive services through their private plans will have access to those services through Medicaid.

B. Title X Faces Threats of Complete Defunding and Is Being Undermined

Title X serves a critical role by providing no- and low-cost family planning services for certain women who need such services—in particular for low-income women who are uninsured and ineligible for Medicaid coverage—yet this program is similarly at risk.

Beyond its current underfunding,[60] Title X faces opposition from some legislators who wish to defund the program altogether. For fiscal year 2019, the House Appropriations Committee omitted *all* Title X funding from its discretionary appropriations.[61] Indeed, the House Appropriations Committee has proposed to

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medicare/issue-brief/what-could-a-medicaid-per-capita-cap-mean-for-low-income-people-on-medicare/.

[60] *See supra* p. 13.

[61] *See* Press Release, U.S. House of Representatives Comm. on Appropriations, *Appropriations Committee Releases the Fiscal Year 2019 Labor, Health and Human Services,*

eliminate all Title X funding for 7 out of the past 9 fiscal years.[62] A proposal to completely defund Title X passed the House in 2011.[63]

Other attacks on Title X are not to its overall funding, but could prove just as devastating, if not more so. Title X has been targeted for detrimental reform that threatens its very purpose: "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," primarily for "persons from low-income families."[64] Recently proposed regulations would severely limit the ability of Title X clinics to provide safe and effective family planning services to their patients and are intended to render certain providers, many of which are the only family planning resources in a community, ineligible for Title X grants, putting further strains on the Commonwealth's SRHP program to provide funding to ensure access to

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Education Funding Bill (June 14, 2018), https://appropriations.house.gov/news/documentsingle.aspx?DocumentID=395353; Press Release, U.S. House of Representatives Comm. on Appropriations, *Appropriations Committee Approves the Fiscal Year 2019 Labor, Health and Human Services, Education Funding Bill* (July 11, 2018), https://appropriations.house.gov/news/documentsingle.aspx?DocumentID=395373; *see also* Katelyn Burns, *Anti-Choice Lawmakers Use Federal Budget Bills to Launch All-out Assault on Reproductive Rights (Updated)*, Rewire News (June 15, 2018, https://rewire.news/article/2018/06/15/anti-choice-lawmakers-use-federal-budget-bills-launch-assault-reproductive-rights/.

[62] *See* Press Release Dated June 14, 2018, *supra* note 61; *Title X Budget & Appropriations*, *supra* note 43.

[63] *See* Dreweke, *supra* note 44, at 54.

[64] 42 U.S.C. §§ 300(a), 300a-4(c).

contraceptive care for Commonwealth residents.

On May 18, 2018, the Trump administration announced that it planned to revive and retool a Reagan-era rule that would mandate "physical separation" between Title X-funded family planning providers and providers of abortion care (even though no federal dollars pay for abortion), as well as restrict these Title X-funded providers from referring patients to providers of abortion care.[65] The proposal emphasizes fertility awareness as a form of family planning and would redirect Title X funding to sites that promote less reliable methods of family planning.[66] The proposal, which was quickly denounced by medical groups such as

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[65] *See Proposed Regulation, supra* note 36, at 25,505–07, 25,525; Julie Hirschfeld Davis & Maggie Haberman, *Trump Administration to Tie Health Facilities' Funding to Abortion Restrictions*, N.Y. Times (May 17, 2018), https://www.nytimes.com/2018/05/17/us/politics/trump-funding-abortion-restrictions.html; Sarah McCammon & Scott Neuman, *Clinics That Refer Women for Abortions Would Not Get Federal Funds Under New Rule*, NPR (May 18, 2018), https://www.npr.org/sections/thetwo-way/2018/05/18/612222570/white-house-to-ban-federal-funds-for-clinics-that-discuss-abortion-with-patients.

[66] *Proposed Regulation*, *supra* note 36, at 25,515–16. The most recent funding opportunity announcement ("FOA") for Title X grants promoted the inclusion of sites that "have developed expertise in [only] one family planning approach or method," while omitting any citation to the standard of comprehensive contraceptive care that is at the core of Title X (indeed, omitting any reference to "contraceptive" or "contraception" at all). *See* Dep't of Health & Human Servs., *Announcement of Anticipated Availability of Funds for Family Planning Services Grants* (Feb. 23, 2018) [hereinafter *FOA FY 2018*], https://www.hhs.gov/opa/sites/default/files/FY18%20Title%20X%20Services%20FOA_Final_Signed.pdf. This shift away from emphasizing comprehensive coverage and medically approved contraceptive methods in Title X programs threatens to reduce women's access to a complete repertoire of options for their contraceptive needs.

the American Medical Association, poses a severe threat to the effectiveness of the overall Title X program, and, by extension, the health and safety of women who receive services in Title X-funded health centers.[67]

The proposed rule is also intended to prevent PPFA affiliates and other Title X providers who provide abortion services from continuing to participate in the program. PPFA's health centers serve *41 percent* of the over 4 million patients receiving Title X care.[68] Past exclusions of PPFA from public programs illustrate the dire effects these measures would have on women's health. For example, after PPFA affiliates were excluded from a Texas family planning program in 2013, there was a

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[67] *See* David O. Barbe, M.D., Am. Medical Ass'n, *AMA Response to Administration's Attack on Family Planning Services* (May 23, 2018), https://www.ama-assn.org/ama-response-administrations-attack-family-planning-services; Am. Acad. of Family Physicians et al., *Joint Principles for Protecting the Patient-Physician Relationship* (May 23, 2018), https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/Joint-Principles-for-Protecting-the-Patient-Physician-Relationship; Am. Coll. of Obstetricians & Gynecologists et al., *America's Women's Health Providers Oppose Efforts to Exclude Qualified Providers from Federally-Funded Programs* (May 23, 2018), https://www.acog.org/About-ACOG/News-Room/Statements/2018/Health-Providers-Oppose-Efforts-to-Exclude-Qualified-Providers-from-Federally-Funded-Programs; Am. Nurses Ass'n, *ANA Condemns Title X Funding Cuts Proposed by the Trump Administration* (May 22, 2018), https://www.nursingworld.org/news/news-releases/2018/ANA-condemns-title-x-funding-cuts--proposed-by-the-trump-administration/.

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

sizable drop in claims for certain contraceptives.[69] A number of states that are Title X recipients have announced they would decline Title X funds if the proposed rule is finalized.[70] Massachusetts Governor Charlie Baker has also publicly opposed the proposed rule, stating that it "proposed rule should be rescinded in its entirety," and noting that it "would enact unnecessary barriers to a woman's right to choose, to be offered a comprehensive set of family health planning options, and to be provided with the information necessary to make an informed and non-coerced decision that best meets the needs of her individual or family circumstance."[71]

At the same time, HHS has indicated that it will favor funding for

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[69] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. Med. 853, 856–58 (2016).

[70] Press Release, Wash. Governor Jay Inslee, *Inslee Statement on Protecting Washington Women from Trump Gag Rule* (July 30, 2018), https://www.governor.wa.gov/news-media/inslee-statement-protecting-washington-women-trump-gag-rule; Press Release, N.Y. Governor Andrew M. Cuomo, *Governor Cuomo Issues Letter to HHS Secretary Threatening Legal Action if Title X Rule Changes Are Adopted* (July 30, 2018), https://www.governor.ny.gov/news/governor-cuomo-issues-letter-hhs-secretary-threatening-legal-action-if-title-x-rule-changes-are; Press Release, Haw. Governor David Ige, *Governor Ige Opposes Trump Administration's Attempt to Limit Women's Health Care Services* (July 30, 2018), https://governor.hawaii.gov/newsroom/latest-news/office-of-the-governor-news-release-governor-ige-opposes-trump-administrations-attempt-to-limit-womens-health-care-services/; Press Release, Or. Governor Kate Brown, *Governor Brown on Federal Title X Rollbacks on Access to Reproductive Health* (July 30, 2018), https://mailchi.mp/oregon/news-release-governor-brown-on-federal-title-x-rollbacks-on-access-toreproductive-health?e=351baaef1c.

[71] Shira Schoenberg, *Gov. Charlie Baker Opposed President Donald Trump's Title X Abortion Rule*, Mass Live (July 23, 2018), https://www.masslive.com/politics/index.ssf/2018/07/gov_charlie_baker_opposes_pres.html.

providers such as FQHCs and other comprehensive primary care providers that offer family planning services in the broader context of primary care.[72] While FQHCs are an important component of the safety net, they cannot replace dedicated reproductive health centers. A majority of women prefer seeing reproductive health specialists,[73] and many FQHCs cannot offer the full range of contraceptive services available at dedicated Title X providers.[74] Additionally, FQHCs are required to offer a broad range of services—from vaccinations, to dental, vision, and mental health services—to any new patients seeking contraceptive care, drastically increasing the FQHCs' workload beyond their current capacity.[75] Moreover, because the shift in funding would come at the expense of dedicated reproductive health care providers who currently make up 72 percent of the Title X network, women only seeking reproductive health care could lose their choice of provider.[76]

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[72] *See Proposed Regulation, supra* note 36, at 25,516; *FOA FY 2018*, *supra* note 64; Kinsey Hasstedt, *Four Big Threats to the Title X Family Planning Program: Examining the Administration's New Funding Opportunity Announcement*, Guttmacher Inst. (Mar. 5, 2018), https://www.guttmacher.org/article/2018/03/four-big-threats-title-x-family-planning-program-examining-administrations-new.

[73] Julie Schmittdiel et al., *Women's Provider Preferences for Basic Gynecology Care in a Large Health Maintenance Organization*, 8 J. Women's Health Gender-Based Med. 825, 828 (1999).

[74] Kinsey Hasstedt, *Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. 67, 69 (2017).

[75] *Id.* at 71.

[76] Mia R. Zolna & Jennifer J. Frost, Guttmacher Inst., *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols* 8 (2016),

The threatened elimination of all funding of Title X, combined with the shift of Title X's focus away from comprehensive contraceptive services and reproductive health specialists, call into significant question Title X's ability to absorb any of the need created by the IFRs.

IV. Massachusetts Has Standing Based on Its Own Economic Injury and as *Parens Patriae*

The Commonwealth demonstrated that it has standing based on the additional costs it will incur based on the 25 percent of Massachusetts women who will turn to state-funded programs after losing contraceptive coverage because their employers opt out of the Contraceptive Coverage Benefit.[77] While that matter alone justifies reversal, *amici*, as providers of and advocates for reproductive health care, write to strongly urge this Court to find that the Commonwealth has *parens patriae* standing based on the IFRs' threat to the health and wellbeing of Massachusetts women who will not be eligible for any federal or state safety net program to replace their lost contraceptive coverage.

In *Alfred L Snapp & Sons* v. *Puerto Rico*, 458 U.S. 592, 602, 607 (1982), the Supreme Court explained that quasi-sovereign interests that may be vindicated through *parens patriae* actions "consist of a set of interests that the State has in the

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https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[77] Appellant's Br. at 21–44.

well-being of its populace," including an "interest in the health and well-being—both physical and economic—of its residents in general."[78] The Commonwealth has demonstrated a commitment to supporting access to contraceptive care, and its challenge to the IFRs is in furtherance of that same quasi-sovereign interest.[79]

It is true that some women who lose contraceptive coverage will have access to low- or no-cost coverage through the federal and state programs outlined above. But even in a state like Massachusetts that supplements federal health care programs with the state coffers, these programs do not and cannot fulfill the ACA's promise of no-cost contraceptive coverage for all privately-insured women.[80] As a

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[78] Although *Alfred* stated in footnote dicta that "[a] state does not have standing as *parens patriae* to bring an action against the Federal Government," *id.* at 610 n.16, the Court subsequently held that the Commonwealth did have *parens patriae* standing to maintain an action against the Environmental Protection Agency. *Massachusetts* v. *E.P.A.*, 549 U.S. 497, 519–21 (2007). Thus, *Alfred* does not preclude a finding of *parens patriae* standing in this case.

[79] *See* Appellant's Br. at 11–14.

[80] *See* Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. at 39,888. Those women would also have to engage in the logistical challenges of enrolling in, or obtaining benefits from, one of these government-funded programs. Women may have to seek out new providers that accept Medicaid or provide services through Title X, and some may have difficulty locating Medicaid providers or Title X-funded providers within a reasonable distance. *See* Henry J. Kaiser Family Found., *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians* 7 (2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8178.pdf; *Publicly Funded Contraceptive Services at U.S. Clinics: Clinics Providing Publicly Funded Contraceptive Services by County, 2015*, Guttmacher Inst., https://gutt.shinyapps.io/fpmaps/ (last visited May 27, 2018). Any of these choices

result, women may choose less effective contraceptive methods, or forego contraceptives entirely, which increases the likelihood of unintended pregnancy and the health risks that go along with it. All of this would contribute to the overall decline of women's health. The Commonwealth thus has a quasi-sovereign interest in maintaining this action that confers *parens patriae* standing upon it.

CONCLUSION

The IFRs would deprive women of the seamless no-cost contraceptive coverage that the ACA and the Commonwealth both recognize is an essential element of an integrated strategy to ensure access to contraceptive coverage for Commonwealth residents. To be sure, the Commonwealth will continue to provide funding for programs that supplement lost coverage for Massachusetts women who are affected by the IFRs. But federal and Commonwealth funded safety net programs are simply not substitutes for employer-sponsored insurance plans, and Massachusetts women are at risk of losing coverage and being forced to pay out-of-pocket for contraceptive care or forego care entirely.

Most women do not satisfy the requirements for no-cost coverage under these Medicaid and Title X-funded programs or their state analogues. In any event,

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would present challenges and the loss of the continuity of care they previously had with their preferred health care providers.

such programs lack the resources to accommodate all of the women who stand to lose coverage under the IFRs. The threat of underfunding combined with an influx of new patients would further interfere with the safety net programs' ability to serve the women of limited means for which these programs were designed, let alone accommodate new patients.

For these reasons, *amici* join Plaintiffs-Appellants in urging the Court to reverse the District Court's decision and remand for a decision on the merits.

Dated: September 24, 2018

Respectfully submitted,

By: /s/ Allan J. Arffa

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CERTIFICATE OF COMPLIANCE

I hereby certify that:

This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and Circuit Rule 32(g)(1) because this brief contains 6,819 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Further, this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in 14-point Garamond font.

/s/ Allan J. Arffa
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Dated: September 24, 2018

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the United States Court of Appeals for the First Circuit by using the CM/ECF system on September 24, 2018.

I certify that all participants in the case are registered CM/ECF users and thus will be served by the CM/ECF system, which constitutes service pursuant to Fed. R. App. 25(c)(2) and First Circuit Rule 25.0.

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