Nos. 18-15144, 18-15166, 18-15255

United States Court of Appeals for the Ninth Circuit

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

Plaintiffs-Appellees,

– v. –

ALEX M. AZAR II, Secretary of the United States Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; R. ALEXANDER ACOSTA, in his official capacity as Secretary of the U.S. Department of Labor; U.S. DEPARTMENT OF LABOR; STEVEN TERNER MNUCHIN, in his official capacity as Secretary of the U.S. Department of the Treasury; U.S. DEPARTMENT OF THE TREASURY,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTHERN CALIFORNIA, OAKLAND IN CASE NO. 4:17-CV-05783-HSG, HAYWOOD S. GILLIAM, DISTRICT JUDGE

BRIEF OF PLANNED PARENTHOOD FEDERATION OF AMERICA, NATIONAL HEALTH LAW PROGRAM, AND NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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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.

/s/ Allan J. Arffa

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Counsel for Amici

Dated: May 29, 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. *See* ECF No. 26. 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.

INTRODUCTION

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 the no-cost contraceptive coverage that is essential to their health.

HHS suggests that women who lose no-cost contraceptive coverage under the expanded exemptions could simply resort to federal government safety net programs, such as Medicaid or Title X.[2] Not so. 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, and private insurance, *amici* write to provide the Court additional context concerning the existing federal safety net for reproductive health care and to explain why it is not a substitute for the Contraceptive Coverage Benefit.

To summarize, Medicaid- and Title X-funded reproductive health care programs are designed to provide health care for individuals with low incomes. Moreover, the budgets for such safety net 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 because of the expanded exemptions. Further, this proposed expansion undermines the purpose of these programs and threatens to take resources away from the individuals with low incomes these programs are meant to serve. The IFRs will thus cause many women to lose access to no-cost contraceptive coverage, putting them at greater risk of

[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); *see also* Brief of Intervenors-Defendants-Appellants The Little Sisters of the Poor Jeanne Jugan Residence et al. at 34–35, *California* v. *HHS*, Appeal No. 18-15255 (Apr. 9, 2018), ECF No. 19.

unintended pregnancies and other health problems.

For these and other reasons, *amici* submit this brief in support of Plaintiffs-Appellees State of California, State of Delaware, State of Maryland, State of New York, and Commonwealth of Virginia, and in support of affirmance.

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 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.[3] In furtherance of that goal, the ACA specified that most private insurance plans must cover certain preventive health care services without patient cost sharing.[4] Contraceptive care is an essential preventive health care service. It helps to avoid unintended pregnancies[5] and to promote healthy birth spacing, resulting in improved

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

[4] *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 . . . .").

[5] 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.

maternal, child, and family health.[6] Contraceptive care also has other preventive health benefits, including reduced menstrual bleeding and pain, and decreased risk of endometrial and ovarian cancer.[7] Accordingly, since 2011, HHS has included all FDA-approved contraceptive methods within the definition of the preventive care that the ACA requires to be covered at no cost to the patient under the Contraceptive Coverage Benefit.[8]

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 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.[9] Those who could purchase contraception were

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[6] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 615: Access to Contraception* 2 (Jan. 2015, reaffirmed 2017), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Contraception.

[7] *Id.*

[8] *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).

[9] 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/.

spending between 30 percent and 44 percent of their total annual out-of-pocket health care costs to that end,[10] and women were more likely to forego more effective long-acting reversible contraceptive ("LARC") methods (such as intrauterine devices) due to upfront costs.[11]

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.[12] Out-of-pocket spending on contraception has decreased, and more women are choosing to use LARC methods.[13] In addition, the percentage of pregnancies that are unintended in the United States is at a 30-year low.[14] Put differently, the Contraceptive Coverage

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[10] 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).

[11] *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).

[12] 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.

[13] Snyder, *supra* note 11, at 219.

[14] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 New Eng. J. Med. 843, 850 (2016).

Benefit has worked.

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. Many women who stand to lose coverage for contraceptive 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.[15]

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.[16] Medicaid eligibility is largely based on financial need.[17] Precisely because only a limited population is eligible for Medicaid

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[15] 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).

[16] 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 May 26, 2018).

[17] 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/

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 incomes at or below 138 percent of the Federal Poverty Level ("FPL"),[18] which amounts to an annual income of $16,753 for an individual in 2018.[19] 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.[20] And many low-income parents did not meet the income eligibility limit for Medicaid coverage; in 2013, the median state Medicaid income eligibility cut-off for parents was only 61 percent of the FPL.[21] With the ACA's Medicaid expansion, Congress turned Medicaid "into a program to meet the health care needs of the entire

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attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

[18] 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 17, at 3.

[19] *Federal Poverty Level (FPL)*, HealthCare.gov, https://www.healthcare.gov/glossary/federal-poverty-level-FPL/ (last visited May 26, 2018).

[20] 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 17, at 3.

[21] Paradise, *supra* note 20, at 2.

nonelderly population with income below 133 percent of the poverty level."[22] Congress designed the expansion as "an element of a comprehensive national plan to provide universal health insurance coverage."[23]

In 2012, however, the Supreme Court barred HHS from terminating federal Medicaid funding to states that do not extend Medicaid coverage to the expansion population.[24] In effect, the decision made the expansion optional for states. As of April 2018, 18 states have not expanded Medicaid coverage pursuant to the ACA.[25] In those states, the median income limit for Medicaid-eligible parents is just 44 percent of the FPL, which amounts to an annual income of $7,242 for a two-person household in 2018—less than one fourth the income limit under the ACA's Medicaid expansion.[26] Thus, in these states, Medicaid does not cover: (1) nonelderly adults who have no children, are not pregnant, and do not have a disability; or (2)

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

[23] *Id.*

[24] *Id.* at 575–87.

[25] *Current Status of State Medicaid Expansion Decisions*, Henry J. Kaiser Family Found. (Apr. 27, 2018), https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision.

[26] *See Federal Poverty Level (FPL)*, *supra* note 19; Rachel Garfield & Anthony Damico, Henry J. Kaiser Family Found., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* 1 (2017), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

parents whose annual income is, on average, more than 44 percent of the FPL.[27] But even in Medicaid expansion states, where coverage is not contingent on membership in a covered group, Medicaid would not serve as a backstop for individuals whose annual income is more than 138 percent of the FPL.[28]

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,[29] and provides grants to public and private, non-profit agencies "to assist in the establishment and operation of voluntary family planning projects which . . . offer a broad range of acceptable and effective family planning methods and services," including contraception.[30] HHS awards Title

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[27] There is one exception. While Wisconsin has not adopted the Medicaid expansion, it does provide Medicaid coverage to individuals who would fall within the expansion population and whose income is under the FPL. *See* Letter from Brian Neale, Director, Dep't of Health & Human Servs, to Linda Seemeyer, Wis. Dep't of Health Servs. (Dec. 5, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf.

[28] Certain states have expanded coverage of family planning services under Medicaid, but this coverage is still based on income, with the highest eligible income in any state being 306 percent of the FPL. *See* Usha Ranji et al., Henry J. Kaiser Family Found., *Medicaid and Family Planning: Background and Implications of the ACA* 17 (2016), http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca.

[29] 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)).

[30] 42 U.S.C. § 300(a); *see also* 42 C.F.R. § 59.5.

X grants through a competitive process, and the Title X program funds a network of nearly 3,900 family planning centers, serving approximately 4 million clients every year.[31]

Title X grants are intended to serve "persons from low-income families."[32] While some women who are not eligible for Medicaid are able to obtain 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.[33] 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 ability to pay.[34] Those whose annual income is greater than 250 percent of the FPL are charged according to

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[31] Christina Fowler et al., RTI Int'l, *Family Planning Annual Report: 2016 National Summary* 7–8 (2017) [hereinafter, *2016 Annual Report*], https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[32] 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, HHS-OS-2018-0008, at 113 (draft posted May 22, 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" and is legally dubious because it is inconsistent with the purpose of Title X family planning funding. Further, HHS has 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.

[33] 42 C.F.R. § 59.5(a)(7).

[34] *Id.* § 59.5(a)(8).

a "schedule of fees designed to recover the reasonable cost of providing services."[35] In addition, Title X is not designed as backup coverage for individuals who have private insurance. Indeed, Title X is designed to 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 work together to pay for care and direct Title X-funded agencies to seek payment from such third-party payers.[36]

In short, like Medicaid, Title X is not designed as a substitute 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, neither Title X nor Medicaid is a viable alternative to provide 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

[35] *Id.*

[36] If a woman has private insurance, the Title X clinic generally must bill third parties deemed obligated to pay for the services. 42 C.F.R. § 59.5(a)(7).

women.

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.[37] In fiscal year 2017, 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.[38] 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.[39] Taking inflation into account, the level of funding for Title X today is less than 30 percent of what it was in 1980.[40]

At the same time, two-thirds of state Medicaid programs face challenges in securing an adequate number of providers,[41] particularly when it comes to specialty

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[37] *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).

[38] *Title X Budget & Appropriations*, Nat'l Fam. Plan. & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited May 26, 2018).

[39] *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).

[40] *Id.*

[41] 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

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.[42] Many federally qualified health centers ("FQHCs") have struggled to fill persistent staff vacancies and shortages.[43]

Cuts to 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.[44] In 2016 that number dropped to just over 4 million.[45] This decline coincides with with more than $30 million in cuts to Title X's annual appropriation over the same period.[46] And 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 44) who

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& 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.

[42] *See Access to Care*, *supra* note 41, at 21.

[43] 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.

[44] 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.

[45] *2016 Annual Report*, *supra* note 31, at 8.

[46] *See id.* at 1; *2010 Annual Report, supra* note 44, at 1.

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.[47] This number represents an overall increase of 5 percent since 2010.[48]

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).[49] 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.[50] 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.[51] Rural populations

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

[48] *Id.*

[49] *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.*

[50] *Id.*

[51] *Id.* at 9.

are also in great need of contraceptive services. Among the 14 states ranked the highest on 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.[52]

Under these conditions, the resources of the family planning safety net are best allocated to the populations of women it was designed to serve, rather than the women 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 (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 Benefit) under private insurance plans would further stretch Medicaid's and Title X's resources

[52] *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.

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.

A. Medicaid Could Face Cuts to Funding and States Are Changing Their Eligibility Requirements

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.[53] The federal government 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).[54] Either model would result in insufficient federal funding

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

[54] 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/

for the growing number of women of reproductive age who would otherwise rely on Medicaid for birth control access.

In addition to overall federal funding cuts, some states are also seeking to restrict Medicaid eligibility, thereby reducing access to Medicaid coverage. With the support of the White House and HHS, several states have resorted to the waiver process to condition Medicaid eligibility on compliance with specific work requirements.[55] HHS has signaled its willingness to approve such a policy for every state,[56] and has already approved work requirements in Kentucky, Indiana, Arkansas, and New Hampshire.[57]

Many women will be negatively affected by any imposition of a work requirement tied to Medicaid eligibility. One study found that 30 percent of non-working adults on Medicaid reported that they did not work because they were taking

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

[55] *See* Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Servs, Speech at the National Association of Medicaid Directors 2017 Fall Conference (Nov. 7, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html; Letter from Brian Neale, Director, Dep't of Health & Human Servs, to State Medicaid Directors (Jan. 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

[56] *See* Neale, *supra* note 55.

[57] Henry J. Kaiser Family Found., *Approved Section 1115 Medicaid Waivers* (as of May 24, 2018), http://files.kff.org/attachment/Which-States-Have-Approved-and-Pending-Section-1115-Medicaid-Waivers-Approved.

care of home or family[58]—a situation in which many women find themselves. In fact, 62 percent of non-working Medicaid enrollees in 2016 were women.[59] While the approved work requirements do contain various exemptions, there is a risk that individuals will lose coverage due to their inability to verify that they are either eligible for an exemption or that they are in fact working.[60] In light of the threats to Medicaid funding and the onerous eligibility requirements that many states are imposing or may impose through the waiver process, 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.

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[58] Rachel Garfield et al., Henry J. Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* 4 (2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[59] *Id.*

[60] *Id.*

Beyond its current underfunding,[61] Title X faces opposition from some legislators who wish to defund the program altogether. For fiscal year 2018, the House Appropriations Committee omitted *all* Title X funding from its discretionary appropriations.[62] Indeed, the House Appropriations Committee has proposed to eliminate all Title X funding for 6 out of the past 8 fiscal years.[63] A proposal to completely defund Title X passed the House in 2011.[64]

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."[65] Recently proposed regulations would severely limit the ability of Title X clinics to provide safe and effective family planning services to their patients

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[61] *See supra* p. 13.

[62] *See* Teddy Wilson, *House Committee Throws Out Family Planning Funding in Spending Bill*, Rewire News (July 20, 2017), https://rewire.news/article/2017/07/20/house-committee-throws-family-planning-funding-spending-bill/.

[63] *See id.*; Christine Grimaldi, *House Republicans Wield Appropriations Process Against Title X Funding*, Rewire News (July 6, 2016), https://rewire.news/article/2016/07/06/house-republicans-wield-appropriations-process-title-x-funding/.

[64] *See* Dreweke, *supra* note 39, at 54.

[65] 42 U.S.C. §§ 300(a), 300a-4(c).

and are intended to render certain providers, many of which are the only family planning resources in a community, ineligible for Title X grants. 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.[66] The proposal would further omit the requirement that family planning methods offered by Title X clinics be "medically approved" and would eliminate the practice of requiring Title X projects to cover all 18 FDA-approved contraceptive methods, while instead emphasizing fertility awareness as a form of family planning and encouraging the redirection of Title X funding to sites that promote less reliable methods of family planning.[67] The proposal, which was

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[66] *See Proposed Regulation, supra* note 32, at 22–25, 43; 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.

[67] *Proposed Regulation*, *supra* note 32, at 53–63. 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)

quickly denounced by medical groups such as 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.[68]

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.[69] 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 sizable drop in claims for certain contraceptives.[70]

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

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[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.

[68] *See* David O. Barbe, M.D., Am. Medical Assoc., 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.

[69] 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).

[70] 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).

providers such as FQHCs and other comprehensive primary care providers that offer family planning services in the broader context of primary care.[71] 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,[72] and many FQHCs cannot offer the full range of contraceptive services available at dedicated Title X providers.[73] 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.[74] 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.[75]

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[71] *See Proposed Regulation, supra* note 32, at 59; *FOA FY 2018*, *supra* note 67; 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.

[72] 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).

[73] 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).

[74] *Id.* at 71.

[75] 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 complete funding cuts to 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. Women Who Lose Private Coverage of Contraceptive Supplies Face Additional Burdens

Even if existing federal safety net providers could serve an expanded population of patients, and *even if* the new population were eligible for Medicaid or no-cost services under Title X, and *even if* those programs are not further restricted, significant burdens would still remain that would interfere with access to seamless contraceptive coverage without cost sharing. Women no longer covered by private insurance due to the expanded exemptions to the Contraceptive Coverage Benefit seeking to benefit from the federal safety net would 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.[76] Any of these

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

[76] *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*

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

As a result of these hurdles and challenges, some 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.

CONCLUSION

The IFRs, if allowed to go into effect, would deprive women of the no-cost contraceptive coverage that is an essential element of the integrated strategy to ensure access to contraceptive coverage. Federal government safety net programs are not enough to fill the void left by the expanded exemptions, and women will lose coverage and either have to switch to a state-funded program, be forced to pay out-of-pocket for contraceptive care, or have to forego care entirely. Most women do not satisfy the requirements for no-cost coverage under these Medicaid and Title X-funded programs and, in any event, such programs lack the resources to accommodate all of the women who stand to lose coverage under the interim rules. At the outset, these programs are already under threat from lack of funding and programmatic reform contrary to their mandates. An influx of new patients would

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Services by County, 2015, Guttmacher Inst., https://gutt.shinyapps.io/fpmaps/ (last visited May 27, 2018).

further interfere with the safety net programs' ability to serve the women of limited means for which these programs were designed.

For these reasons, *amici* join Plaintiffs-Appellees in urging the Court to affirm in full the District Court's decision.

Dated: May 29, 2018

Respectfully submitted,

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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 32-1 because this brief contains 6,052 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.

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Dated: May 29, 2018

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on May 29, 2018.

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Dated: May 29, 2018