EXHIBIT S

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, and STATE OF NEW JERSEY Plaintiffs, v. DONALD J. TRUMP, *et al.* Defendants.	**Civil Action No: 2:17-cv-04540-WB**

DECLARATION OF SARAH ADELMAN

I, Sarah Adelman, declare and state as follows:

1. I serve as Deputy Commissioner of the New Jersey Department of Human Services. In this capacity I oversee the Division of Medical Assistance and Health Services ("DMAHS").

2. DMAHS administers New Jersey's $17 billion state- and federally- funded Medicaid and Children's Health Insurance Programs (collectively referred to as "NJ FamilyCare") that provide health coverage for certain low to moderate income residents. Through its programs, DMAHS serves more than 1.7 million people in New Jersey.

3. NJ FamilyCare provides comprehensive medical coverage and family planning services to its beneficiaries.

4. New Jersey also has Title X family planning clinics within the state that are not affiliated with DMAHS.

5. Medicaid is a program jointly funded by the states and the federal government that makes health care available to low-income individuals and families. States have responsibility for administering Medicaid, but are subject to federal oversight.

6. Medicaid is funded according to a formula under which the federal government contributes a specific amount for every dollar spent by New Jersey. If additional New Jerseyans enroll in the Medical Assistance program, the federal and state government will both spend more on the program, thereby shifting costs from the private to the public sector.

7. As of October 2018, there were 1,747,375 NJ FamilyCare beneficiaries in New Jersey. For State fiscal year 2018, a total of approximately $16,267,000,000 in state and federal funding was spent on NJ FamilyCare. Of that amount, roughly $9,843,000,000 was provided by the federal government, and $6,424,000,000 was provided by New Jersey.

8. For fiscal year 2018, DMAHS's estimated cost to provide contraceptive and family planning coverage through NJ FamilyCare was approximately $15 million, with the federal government covering 90% of that cost.

9. Eligibility for NJ FamilyCare is based primarily on income level. The Affordable Care Act expanded Medicaid eligibility so that individuals and families with incomes up to 138% of the federal poverty level would generally be eligible for the program. However, in National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), the Supreme Court ruled that states could not be required to expand Medicaid under the Affordable Care Act, and therefore the expansion was rendered optional.

10. New Jersey elected to expand Medicaid in January 2014, so that single adults, childless couples, parents, and caretakers with incomes up to 138% of the federal poverty limit

are eligible for the program. Over 500,000 of these individuals have enrolled in NJ FamilyCare since its expansion.

11. For women who are pregnant, NJ FamilyCare has expanded income-based eligibility so that pregnant women are eligible if they have incomes at or below 205% of the federal poverty level. At present, 205% of the federal poverty level is $4,302 per month for a family of four.

12. DMAHS is planning the 2019 rollout of a family planning benefit program called Plan First for individuals with income ranging from 133% to 205% of the federal poverty level.

13. DMAHS projects that there will be 10,000 to 12,000 Plan First participants in the first year of the program, and between 31,000 to 55,000 participants by the fifth program year.

14. DMAHS designed the Plan First program to allow pregnant women to transition seamlessly into the Plan First program after the 60-day postpartum period and to allow Plan First beneficiaries who become pregnant to easily transition to a DMAHS program ensuring early prenatal treatment. The eligibility standards for Plan First will mirror the current NJ FamilyCare requirements for pregnant women.

15. NJ FamilyCare provides beneficiaries with a variety of contraception options, and there is no co-pay for family planning preventive services.

16. Among those options is long-acting reversible contraception ("LARC"), which includes intrauterine devices and birth control implants. While NJ FamilyCare has always covered LARC devices in an outpatient setting or as part of a bundled inpatient payment, it began to allow providers to bill separately for devices and insertion in the immediate postpartum period (defined as within 10 minutes after delivery of the placenta) in July 2018. In addition, the Plan First program will provide for access to LARCs for additional individuals in 2019.

17. New Jersey recognizes the importance of allowing members who wish to utilize LARC devices to have free and open access to them to reduce the rate of unplanned pregnancies. Although LARCs can have high upfront costs, they are not associated with compliance issues that can cause failures with other comparable methods of birth control, and as such are more effective than most other methods of contraception and would likely result in better outcomes and better long-term savings to the State when compared to other contraceptive methods.

18. LARCs facilitate optimal "birth spacing," defined as a minimum 18 month interval between pregnancies. Without birth spacing, babies are more likely to be premature, of low birthweight, small for their gestational age, and, consequently, more likely to face long-term health problems and higher mortality rates. In 2017, the prematurity rate in New Jersey was one in eleven babies.[1]

19. DMAHS anticipates that some women, particularly low-income women, who lose contraceptive coverage through their employer's plans may seek contraceptive coverage from other sources, such as NJ FamilyCare, Plan First, and Title X. This will result in additional costs to New Jersey, which will be forced to absorb additional costs presently borne by private insurers.

20. Other women who lose their contraceptive benefits may forego contraceptive use entirely, which would result in increased numbers of unintended pregnancies and a dramatic increase in costs to State-funded programs designed to ensure the health of women and infants.

21. The loss of employer-sponsored health insurance coverage for contraception can be expected to disproportionately impact New Jersey's women of color. In 2015, 28% of New

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[1] March of Dimes, *A Profile of Prematurity in New Jersey, available at* https://www.marchofdimes.org/peristats/tools/prematurityprofile.aspx?reg=34.

Jersey pregnancies were unplanned, including 53.1% among non-Hispanic black women and 31.8% among Hispanic women.[2]

22. I am generally familiar with the Affordable Care Act's Contraceptive Care Mandate, which requires non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage to provide coverage for FDA-approved methods of contraception without imposing cost-sharing requirements.

23. I understand that the Administration has issued rules that expanded the exemptions from the Contraceptive Care Mandate. Under these rules, covered entities may opt out of complying with the mandate on the basis of a sincerely held moral or religious conviction.

24. The expanded exemptions are expected to result in greater financial expenditures by both the State of New Jersey and women in New Jersey on contraceptive coverage and on healthcare generally for women and infants.

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

Sarah Adelman

Dated: 12/7/18

[2] The Centers for Disease Control and Prevention and New Jersey Department of Health, *Pregnancy Risk Assessment Monitoring Report on Pregnancy Intention 2012-2015, available at* https://www.nj.gov/health/fhs/maternalchild/documents/NJ%20Pregnancy%20Intention%20Topic%20Report%202012-2015.pdf.