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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants,

4:17-cv-05783-HSG

DECLARATION OF HELENE RIMBERG

and,

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

Defendant-Intervenors.

STATE OF OREGON,

Intervenor-Plaintiff,

v.

ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Intervenor-Defendants.

I, HELENE RIMBERG, declare:

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

2. I am the section manager of the Adolescent, Genetics & Reproductive Health section within the Center for Prevention and Health Promotion, Public Health Division at the Oregon Health Authority. I have a doctorate degree in Psychology and more than 20 years' experience managing social service programs (non-governmental and governmental) with 13 of those years within the field of sexual and reproductive health.

3. I directly oversee the administration of the Reproductive Health Program's three funding sources:

- Oregon ContraceptiveCare ("CCare"), Oregon's family planning Medicaid waiver program. CCare covers services related to preventing pregnancy (i.e. contraceptive management) for individuals at or below 250% Federal Poverty Line ("FPL") who are U.S. citizens or have an eligible immigration status. As a Medicaid program, CCare is funded through a state/federal match.
- House Bill 3391 (2017), also known as the Reproductive Health Equity Act ("RHEA"), which provides state funding for certain women who because of immigration status are not eligible for other public assistance. RHEA covers a broad range of reproductive health services, including abortion and 60-days of postpartum care for individuals who can become pregnant and who are ineligible for Medicaid due to immigration status.
- Federal Title X grant funds.

4. Among a number of components, Oregon's RHEA statute provides contraceptive coverage that matches the federal guarantee currently provided by the Affordable Care Act (Public Health Service Act 2713 (c)), specifically requiring coverage for the full range of contraceptive methods, counseling and services used by women, eliminating out-of-pocket costs, and limiting other health plan restrictions. RHEA also goes beyond federal guarantee by: affording this coverage regardless of gender thereby covering male sterilization without out-of-pocket costs, prohibiting health benefit plans from infringing upon an enrollee's choice of contraception by requiring prior authorization, step therapy or other utilization control techniques, and requiring health benefit plans to provide abortion with no out-of-pocket costs (with some exceptions).

5. Additional Oregon laws protecting reproductive health that go beyond the federal guarantee include (a) providing pharmacists the authority to prescribe and dispense hormonal contraceptives (ORS 689.683), and (b) requiring insurance plans to allow dispensing of a 12 month supply of contraceptives (ORS 743A.066) rather than a typical one- or three-month supply.

6. We estimate that in 2014 approximately 49 percent of pregnancies in Oregon were unintended. We are therefore concerned about the potential that the Contraception Exemption Rules could raise that percentage even higher. In 2017, we estimate that 67.7 percent of women at risk of unintended pregnancy in Oregon were using the most or at least a moderately effective method of contraception. Again, if a significant number of these women were to lose insurance coverage for contraception services, that percentage of women using effective contraception could be reduced significantly. The Contraception Exemption Rules would impose significant barriers for women to access substitute contraceptive coverage. Women would have to identify, seek out and apply for other coverage. In my professional opinion and experience, some women will be unable to or fail to find contraceptive coverage in a timely way, if at all. In Oregon, we estimate there are 281,000 women who are eligible for publicly funded family planning and thus can be categorized as "Women in Need." The U.S. Census bureau estimates that in 2017 there were approximately 912,000 women in Oregon ages 15-49 women of child-bearing age.[1] If the rate of effective contraception use among these women were reduced only ten percentage points from 67.7 to 57.7 percent, this would mean an additional 91,000 Oregon women would be at greater risk of unintended pregnancy.

7. Individuals who lose contraception coverage because of the Conscience Exemption Rules at issue in this case can, if they meet the eligible criteria (immigration status and income less than 250 percent of the federal poverty line), either seek coverage through CCare or RHEA. This will result in increased enrollment in these programs and additional costs to Oregon. Alternatively, individuals may forgo coverage and risk an unintended pregnancy, also leading to increased State health care costs.

8. For example, it is estimated that in 2017, Oregon's Reproductive Health Program alone averted over 6,000 unintended pregnancies through the provision of effective contraceptive methods and high-quality counseling services in Oregon's Title X clinics. The number of unintended pregnancies averted is calculated by comparing the effectiveness of the contraceptive

[1] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

methods clients used when they first came to a RH clinic and the methods they used at their most recent visit. For example: if 100 clients used male condoms, which have a typical failure rate of 18 percent, 18 clients would be expected to have an unintended pregnancy within a year. If all 100 clients switch to a Depo-Provera injection, which has a typical failure rate of 6 percent, only six clients would be expected to have an unintended pregnancy within a year. Thus, 12 unintended pregnancies have been averted. Using a conservative estimate of $16,000 for an average delivery and the first year of infant health care under Oregon's Medicaid program,[2] even if less than half of these 6,000 unintended pregnancies would have resulted in births, the savings to the state would be in excess of $40 million in taxpayer funds in Oregon alone in 2017 just considering the Title X program.

9. In my professional opinion, the costs to Oregon in unintended pregnancies for clients losing employer-funded contraceptive coverage could be even greater. As discussed above, if any number of the 912,000 women in Oregon ages 15 to 49 lost their contraception coverage and either were ineligible for or unaware of alternative state programs, Oregon's costs from the approximately $16,000 for each birth from an unintended pregnancy to Oregon's Medicaid program could be very large.

Executed on 1/7, 2019, in Portland, Oregon.

NAME

[2] Data on costs for labor, delivery, and first year of infant health care under the state's Medicaid program, the Oregon Health Plan, are provided from the Oregon Health Authority, Office of Health Analytics.