Exhibit A

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

RICHARD W. DEOTTE, on behalf of himself and others similarly situated; YVETTE DEOTTE; JOHN KELLEY; ALISON KELLEY; BRAIDWOOD MANAGEMENT INC., on behalf of itself and others similarly situated,

Plaintiffs,

v.

ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services; STEVEN T. MNUCHIN, in his official capacity as Secretary of the Treasury; R. ALEXANDER ACOSTA, in his official capacity as Secretary of Labor; UNITED STATES OF AMERICA,

Defendants.

Case No. 4:18-cv-825-O

BRIEF FOR PLANNED PARENTHOOD FEDERATION OF AMERICA; THE NATIONAL HEALTH LAW PROGRAM; AND THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION AS AMICI CURIAE OPPOSING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

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INTEREST OF AMICI CURIAE[1]

Founded over 100 years ago, 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 53 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 2.4 million women and men each year. One out of every five women in the United States has received care from PPFA in her lifetime. 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 50-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 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 nearly 50 years ago 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);

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

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

Since 2012, the federal government has recognized that contraception is a key preventive health care service that, under the Patient Protection and Affordable Care Act (the "ACA"), insurers must cover for women with no cost-sharing (the "Contraceptive Coverage Benefit"). On November 15, 2018, however, the U.S. Department of Health and Human Services ("HHS") promulgated a pair of rules (the "Expanded Exemptions") that dramatically added new exemptions to the requirement that insurers provide no-cost coverage for the full panoply of FDA-approved contraceptive methods. Specifically, the exemptions would allow broad categories of employers to opt out of the Contraceptive Coverage Benefit, in whole or in part.[2] These Expanded Exemptions threaten to deprive large numbers of women of essential access to no-cost preventive health care guaranteed by the ACA, and have been enjoined by two separate courts pending the outcome of legal challenges.

Plaintiffs' motion for summary judgment seeks an end-run around the adjudication of those challenges: an injunction that would allow countless, unidentified employers to opt-out of the Contraceptive Coverage Benefit the same as they would under the Expanded Exemptions (the "Proposed Injunction").[3] Defendants do not oppose the motion for summary judgment on the merits[4]—in fact, the motion would accomplish Defendants' own goals of enforcing the

[2] *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018) [hereinafter *Final Religious Exemptions*] (to be codified at 45 C.F.R. pt. 147); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018) [hereinafter *Final Moral Exemptions*] (to be codified at 45 C.F.R. pt. 147).

[3] *See* Plaintiffs' Motion for Summary Judgment at 2, ECF No. 34.

[4] *See* Defendants' Response to Plaintiffs' Motion for Summary Judgment and Permanent Injunction at 3 (ECF No. 38).

Expanded Exemptions. In sum, if granted, the Proposed Injunction will cause many women to lose access to seamless no-cost contraceptive coverage, putting them at greater risk of unintended pregnancies and other health problems.

Some opponents of the Contraceptive Coverage Benefit, including Plaintiffs, argue that there are less restrictive means of achieving the ACA's goal of ensuring all women can access contraceptive care without cost sharing.[5] While acknowledging that legislation, if not appropriations, would be needed, Plaintiffs submit that the "government could require all non-objecting doctors, pharmacists, hospitals, and other health-care providers to dispense FDA-approved contraception free of charge to any woman whose insurance will not cover it, and allow those providers to seek reimbursement from the government for the contraception that they provide to uninsured or underinsured patients."[6] Others—including, at one time, defendant HHS[7]—have claimed that state and federal safety net programs, such as Title X and Medicaid, could fill the gap in in no-cost contraceptive coverage caused by exempting objecting employers (like Plaintiffs) from the requirement. They cannot.

This brief explains three issues that are essential to understanding the potential impact of Plaintiffs' motion and the Proposed Injunction. *First*, it describes the background of the Contraceptive Coverage Benefit and why it was determined to be an essential preventive health care service under the ACA. *Second*, this brief explains why existing safety net programs are insufficient to fill the gap in no-cost contraceptive coverage caused by the Expanded Exemptions and, by extension, the Proposed Injunction. To summarize, Congress designed Title X and Medicaid only to provide health care for certain individuals with low incomes. The programs thus simply do not have the capacity to provide coverage for an influx of women who lose no-cost contraceptive coverage because of the Expanded Exemptions. *Finally*, it briefly touches

[5] *Id.* at 1.

[6] Plaintiffs' Brief in Support of Motion for Preliminary Injunction at 22, ECF No. 21-1.

[7] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,803 (proposed Oct. 13, 2017).

upon additional burdens women who lose no-cost contraceptive coverage would face in order to obtain contraceptives without cost sharing.

For these and other reasons, *amici* submit this brief in opposition to Plaintiffs' Motion for Summary Judgment.

ARGUMENT

I. NO-COST CONTRACEPTIVE COVERAGE IS AN INTEGRAL COMPONENT OF PREVENTIVE HEALTH CARE

The ACA was designed, in part, to shift the focus of both health care and applicable insurance away from reactive medical care toward preventive health care.[8] In furtherance of that goal, the ACA specified that most private insurance plans must cover certain preventive health care services, including women's preventive health services, without patient cost sharing.[9] Contraceptive care is one such essential preventive health care service. It helps to avoid unintended pregnancies[10] and to promote healthy birth spacing, resulting in improved maternal, child, and family health.[11] Contraceptive care also has other preventive health benefits, including reduced menstrual bleeding and pain and decreased risk of endometrial and ovarian

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

[9] *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 . . . .").

[10] 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.

[11] 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.

cancer.[12] Accordingly, since 2011, HHS has defined women's preventive health services to include all FDA-approved contraceptive methods.[13]

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.[14] Those who could purchase contraception were spending between 30 and 44 percent of their annual out-of-pocket health care costs to that end,[15] and women were more likely to forego more effective long-acting reversible contraceptive ("LARC") methods (such as intrauterine devices) due to upfront costs.[16]

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, more than 62 million women now have access to contraceptive services at no cost**.[17] Out-of-pocket spending on contraceptive care has decreased, and more women are choosing LARC methods.[18] In addition, the percentage of unintended pregnancies in

[12] *Id.*

[13] *Id.* at 3; *see also Women's Preventive Services Guidelines*, Health Resources & Servs. Admin., https://www.hrsa.gov/womens-guidelines/index.html (last updated Sept. 2018).

[14] 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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8164.pdf.

[15] 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).

[16] *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).

[17] 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.

[18] Snyder, *supra* note 16, at 219.

the United States is at a 30-year low.[19] Put differently, the Contraceptive Coverage Benefit is working.

II. TITLE X AND MEDICAID ARE NOT ADEQUATE SUBSTITUTES FOR THE CONTRACEPTIVE COVERAGE BENEFIT

Safety net programs, particularly Title X and Medicaid, are not adequate or appropriate fail-safes for the loss of no-cost contraceptive coverage through private insurance. HHS specifically rejected these options when it first 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 using their primary insurance, imposed unnecessary obstacles to accessing the benefit.[20] 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.[21] And, many women who stand to lose coverage for contraceptive services are simply not eligible for Medicaid.

Even if all women who lose contraceptive coverage as a result of Expanded Exemptions *could* receive no-cost contraception through Medicaid or Title X (and, as explained below, they cannot), those programs themselves face ongoing threats of drastic cuts to covered services, funding, and eligibility, hindering their continued ability to provide the same level of care to those they already serve. Adding an influx of patients previously covered by private insurance plans would further stretch the resources of Medicaid and Title X and would take resources away

[19] 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).

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

[21] Further, Congress specifically intended for *private insurers* to guarantee women access to preventive 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).

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. Title X's Purpose Is to Serve Low-Income Persons

Title X was adopted in 1970[22] to provide family planning services to low-income persons. It provides grants to public and private nonprofit 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.[23] HHS awards Title X grants through a competitive process, and Title X funds a network of nearly 3,900 family planning centers across the country, serving approximately 4 million clients every year.[24]

Title X grants fund "projects" that are intended to serve "persons from low-income families."[25] Generally, only individuals whose annual income is at or below the Federal Poverty Level ("FPL") are entitled to receive Title X services at no cost.[26] Other patients receive services based on a sliding fee scale. Individuals 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.[27] Finally, 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."[28]

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

[23] 42 U.S.C. § 300(a); *see also* 42 C.F.R. § 59.5(a)(1).

[24] 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.

[25] 42 U.S.C. § 300a-4(c)(1).

[26] 42 C.F.R. § 59.5(a)(7).

[27] *Id.* § 59.5(a)(8).

[28] *Id.*

Title X was designed to provide family planning health care to individuals with financial need, not to serve as substitute coverage for individuals who have private insurance through an employer. If a patient has private insurance, the Title X clinic generally must bill third parties deemed obligated to pay for the services.[29] Indeed, Title X is designed partially 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.

Implicitly acknowledging that Title X was not intended to provide relief to individuals who lose contraceptive coverage through their private insurers due to the Expanded Exemptions, HHS recently proposed that the Title X guidelines be changed (albeit without proposing a related increase in funding) so that individuals who lose coverage due to the Expanded Exemptions would qualify for free Title X services as a "low income family."[30] However, that proposal has now been abandoned. Thus, unless these individuals qualify for free contraceptive care under Medicaid or Title X, or their state analogues, these women must make the decision to pay out-of-pocket for contraceptive care or forego care entirely.

Indeed, under HHS's approach, Title X project directors may, *at their discretion*, provide care to individuals employed by religious or moral objectors who lack access to contraceptive coverage.[31] That is a far cry from a solution to the coverage gap created by the Expanded Exemptions. *First*, whether a woman who loses contraceptive coverage because of the Expanded Exemptions will receive any relief at all from the Title X Final Rule is subject entirely to the discretion of the Title X project director. *Second*, even under the Final Rule, HHS did not provide any additional funding to compensate Title X projects for supplementing the costs of contraceptive services that would otherwise be covered by employer-sponsored insurance plans, making it less likely that such discretion could be feasibly exercised.

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[29] *Id.* § 59.5(a)(7).

[30] *See Title X Final Rule*, 84 Fed. Reg. at 7734.

[31] *See Title X Final Rule*, 84 Fed. Reg. at 7734.

In short, although some women who lose coverage because of the Expanded Exemptions could obtain low- or no-cost care from a Title X provider, many of them would still incur some out-of-pocket costs. And, Title X is not designed as a substitute source of care for individuals above a limited level of income.

B. Medicaid's Purpose Is to Serve a Limited Subset of Low-Income Persons

Nor can Medicaid fill the gap to serve women who currently have contraceptive coverage through private insurance. Established in 1965, Medicaid is a joint federal-state program designed to provide health insurance coverage for a limited population of low-income individuals.[32] Medicaid eligibility is largely based on financial need.[33] 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 incomes at or below 133 percent of the FPL,[34] which amounts to an annual income of $16,612 for an individual in 2019.[35] Before the ACA's Medicaid expansion took effect, only certain population groups—parents, pregnant

[32] 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 Mar. 22, 2019).

[33] 42 U.S.C. § 1396a(a)(10)(A), (C); *see also* Robin Rudowitz et al., 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.

[34] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 120, 271 (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)). Some publications report that the ACA expanded Medicaid eligibility to include all individuals at or below 138 percent of the FPL because the legislation includes an income disregard of the top five percent of a household's income. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I)); *see also* Rudowitz et al., *supra* note 33, at 3.

[35] This number represents 133 percent of the FPL for 2019. *See* Annual Update of the HHS Poverty Guidelines, 84 Fed. Reg. 1167, 1168 (Feb. 1, 2019).

women, individuals with a disability, and seniors—were eligible for Medicaid, provided that they met other eligibility criteria.[36] And many low-income parents living below the poverty level 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.[37] 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."[38] Congress designed the expansion as "an element of a comprehensive national plan to provide universal health insurance coverage."[39]

In 2012, however, the Supreme Court barred HHS from terminating federal Medicaid funding to states that do not extend Medicaid coverage to this larger population,[40] effectively making the decision whether to expand Medicaid, in the first instance, an option for the states. As of April 2019, 14 states have not expanded Medicaid coverage pursuant to the ACA.[41] The median income limit for Medicaid-eligible parents in those states was just 40.5 percent of the FPL in 2018, which would correspond to an annual income of $8,639 for a three-person household in 2019—less than one-third the income limit under the ACA's Medicaid expansion.[42] Thus, in these states, Medicaid does not cover: (1) nonelderly adults who have no children, are

[36] Julia Paradise, Henry J. Kaiser Family Found., *Medicaid Moving Forward* 2 (2015), http://files.kff.org/attachment/issue-brief-medicaid-moving-forward; Rudowitz et al., *supra* note 33, at 3.

[37] Paradise, *supra* note 36, at 2.

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

[39] *Id.*

[40] *Id.* at 575–87.

[41] *Status of State Medicaid Expansion Decisions: Interactive Map*, Henry J. Kaiser Fam. Found. (April 11, 2019), https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision.

[42] *See* Annual Update of the HHS Poverty Guidelines, 84 Fed. Reg. at 1168; *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, Henry J. Kaiser Fam. Found. (as of Jan. 1, 2018), https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

not pregnant, and do not have a disability; or (2) parents whose annual income is, on average, more than 44 percent of the FPL.[43] 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 most individuals whose annual income is more than 138 percent of the FPL.[44]

Like Title X, therefore, Medicaid is not designed to serve as a viable alternative to the ACA's guarantee of seamless access to no-cost contraceptive care to individuals who lose it because of the Expanded Exemptions.

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

Putting aside the purpose of the federal safety net programs, the federal reproductive health safety net cannot replace the Contraceptive Coverage Benefit because 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 patients.

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.[45] As noted above, in fiscal year ("FY") 2019, Title X received just $286.5 million—a fraction of that estimated cost, and a level of funding that has not increased since

[43] 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 Seema Verma, Adm'r, Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to Casey Himebauch, Deputy Medicaid Dir., Wis. Dep't of Health Servs., 3 (Oct. 31, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf.

[44] Twenty-five states have expanded coverage of family planning services under Medicaid, but coverage is still based on income in 22 of these states, with the highest eligible income in any state being 306 percent of the FPL. *See Medicaid Family Planning Eligibility Expansions*, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions (last visited Mar. 22, 2019). Only Florida offers coverage to those losing full coverage for any reason, and two other states only cover patients in the postpartum period. *Id.*

[45] *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).

2011.[46] In fact, 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 over that same period.[47] Accounting for inflation, the level of funding for Title X in 2016 was about 30 percent of what it was in 1980.[48]

At the same time, two-thirds of state Medicaid programs face challenges in securing an adequate number of providers,[49] particularly when it comes to specialty services like obstetrics and gynecology ("OB/GYN"). A government report found that only 42 percent of in-network OB/GYN providers were able to offer appointments to new Medicaid patients in 2014.[50] Many federally qualified health centers ("FQHCs") have struggled to fill persistent staff vacancies and shortages.[51]

Cuts to funding for federally funded reproductive care have a direct impact on the number of individuals who can access reproductive health services. In 2010, the number of clients served at Title X-funded health centers was approximately 5.2 million.[52] In 2016, that

[46] *Title X Budget & Appropriations*, Nat'l Fam. Plan. & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Mar. 22, 2019). HHS's budget for FY 2020 proposes $286 million for Title X programing. *Dep't of Health & Human Servs.*, *supra* note **Error! Bookmark not defined.**, at 30.

[47] *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).

[48] *Id.*

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

[50] *See Access to Care*, *supra* note 49, at 21.

[51] 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.

[52] 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.

number dropped to just over 4 million.[53] This decline coincides with more than $30 million in cuts to Title X's annual appropriation over the same period,[54] and it 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 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.[55] That is an overall increase of 5 percent between 2010 and 2014.[56]

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).[57] 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.[58] Similarly, the proportion of black women who need publicly supported care increased by 6 percent, and for Hispanic women it increased by 9 percent.[59] Rural populations are also in great need of contraceptive services.[60]

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

[54] *See id.* at 1; *2010 Annual Report*, *supra* note 52, at 1.

[55] 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.

[56] *Id.*

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

[58] *Id.* at 8.

[59] *Id.* at 9.

[60] 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, nine have rural populations

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 those resources will thus be entirely inadequate for such additional women, regardless of means, whose employers opt out of the Contraceptive Coverage Benefit.

D. Title X Cannot Bear Additional Demands Because It Is Being Dismantled by the Current Administration

As explained above, Title X serves a critical role by providing no- and low-cost family planning services for low-income individuals, yet this program is at risk. Recent regulations adopted by HHS are intended to render certain providers, many of which are the only family planning resources in a community, ineligible for Title X grants. They will decimate the Title X network, will severely limit the ability of the remaining Title X clinics to provide safe and effective family planning services to their patients, and will lead to fewer Title X-funded entities providing a full range of contraceptive methods.

Specifically, on March 4, 2019, HHS issued the Title X Final Rule[61] (discussed in part above) that would, should it take effect,[62] significantly alter the landscape of Title X-funded family planning providers in several respects. *First*, the Title X Final Rule bars medical providers from referring patients to providers of abortion care, even in response to patients' questions, and instead requires them to direct patients toward carrying a pregnancy to term.[63]

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exceeding 33 percent of the state population. *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.

[61] *See Title X Final Rule*, 84 Fed. Reg. at 7715, 7744–48.

[62] Several legal challenges to the Final Rule are pending, and its implementation has been preliminarily enjoined. *See, e.g.*, Opinion and Order, *Am. Med. Ass'n* v. *Azar*, No. 19 Civ. 318 (D. Or. Apr. 29, , 2019) (granting nationwide preliminary injunction enjoining the enforcement of the Final Rules), ECF No. 135; Order Granting Plaintiffs' Motions for Preliminary Injunction, *Washington* v. *Azar*, No. 19 Civ. 3040 (E.D. Wash. Apr. 25, 2019) (same), ECF No. 54.

[63] *See Title X Final Rule*, 84 Fed. Reg. at 7715, 7744–48; 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*

Second, the Title X Final Rule requires "physical separation" between family planning providers that receive Title X funding and any entity that supports or provides certain activities prohibited by the Final Rule, such as abortion care.[64] These requirements will force many Title X providers to drop out of the program; those that stay will be forced to expend limited resources to try to satisfy the "physical separation" requirement, if it is even possible.

Third, the Title X Final Rule seeks to redirect Title X funding to sites that promote less reliable, non-evidence based methods of family planning, such as abstinence counseling and "fertility awareness," in part by eliminating a requirement that methods of family planning be "medically approved."[65] This shift away from comprehensive, medically-approved contraceptive methods threatens to reduce access to reliable and effective contraceptive care, let alone no-cost contraceptive care, through Title X-funded clinics.

Indeed, the Title X Final Rule is transparently intended to prevent Planned Parenthood Federation of America ("PPFA") affiliates and other providers of comprehensive reproductive health services from continuing to participate in the program, though the impact of the rule extends much further. PPFA's health centers serve approximately *40 percent* of the almost 4 million patients who receive Title X care annually.[66] Past exclusions of PPFA from public programs illustrate the dire effects these measures would have on women's health: after PPFA affiliates were excluded from a Texas family planning program in 2013, there was a sizable drop in claims for certain contraceptives.[67]

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.

[64] *See Title X Final Rule*, 84 Fed. Reg. at 7715, 7763–68.

[65] *Id.* at 7740–44.

[66] 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) (citing that PPFA's health centers serve approximately 41 percent of this population).

[67] 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).

At the same time, HHS has indicated that it will favor funding for providers such as FQHCs and other providers that offer family planning services in the broader context of comprehensive primary care.[68] 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,[69] and many FQHCs do not offer the full range of contraceptive services available at dedicated Title X providers.[70] 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.[71] 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 seeking only reproductive health care could lose their choice of provider.[72]

Together, these revisions threaten to undermine the very purpose of Title X: "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."[73] They also impose substantial barriers to Title X's ability to absorb the needs created by the Expanded Exemptions.

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[68] *See Title X Final Rule*, 84 Fed. Reg. at 7749–50; Dep't of Health & Human Servs., *Announcement of Availability of Funds for Title X Family Planning Services Grants* 15, 24 (Jan. 11, 2019), https://www.hhs.gov/opa/sites/default/files/FY2019-FOA-FP-services-amended.pdf; 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.

[69] 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, 830 (1999).

[70] 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).

[71] *Id.* at 71.

[72] 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), https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[73] 42 U.S.C. §§ 300(a), 300a-4(c)(1).

E. State Medicaid Programs May Not Be Able to Meet Increased Demand Due to Threats to Their Medicaid Funding

As to Medicaid, 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,[74] and followed up on that commitment with a dramatic proposal in its 2020 budget to restructure Medicaid.[75] The 2020 budget calls for nearly $1.5 trillion in cuts to the program over the course of a decade,[76] accomplished in part by eliminating the Medicaid expansion and converting Medicaid from an entitlement program into a program under which states receive either (i) a fixed amount per Medicaid enrollee, irrespective of the individual's actual health care costs (the "per-capita cap" model) or (ii) a fixed amount that would not vary by the number of Medicaid enrollees (the "block grant" model).[77] Either model would dramatically reduce federal funding available to states to cover individuals 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 even those currently enrolled will be able to maintain Medicaid, let alone that women who lose access to contraceptive services through their private plans will have access to those services through Medicaid.

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[74] *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.

[75] *See* Comm. for a Responsible Fed. Budget, *Analysis of the President's FY 2020 Budget* 6 (Mar. 11, 2019), http://www.crfb.org/sites/default/files/Analysis%20of%20the%20President%27s%20FY%202020%20Budget%20March_11_2019.pdf.

[76] Office of Mgmt. & Budget, Exec. Office of the President, *A Budget for a Better America: Budget of the U.S. Government, Fiscal Year 2020*, at 109, 111 (2019).

[77] *See* Comm. for a Responsible Fed. Budget, *supra* note 75.

III. WOMEN WHO LOSE PRIVATE COVERAGE OF CONTRACEPTIVES FACE ADDITIONAL BURDENS

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, meaning providers participating in the programs *could* serve an expanded population of patients, 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 who are seeking services through Medicaid or Title X 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 those providers within a reasonable distance.[78] These choices will present challenges to affected women, including the potential 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 contraceptive care 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 Proposed Injunction, if granted, would harm many women by depriving them of the no-cost contraceptive coverage that is an essential element of the ACA's integrated strategy to ensure access to contraceptive coverage. Federal government safety net programs are simply not substitutes for employer-sponsored insurance plans, and such programs lack the resources to accommodate all of the women who stand to lose coverage under the Proposed Injunction. Further, the threat of underfunding combined with an influx of new patients would interfere with

[78] *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 Mar. 21, 2019).

the safety net programs' ability to serve the patients of limited means for whom these programs were designed, let alone accommodate new patients.

For these reasons, *amici* urge this Court to deny Plaintiffs' Motion for Summary Judgment and for a Permanent Injunction.

Respectfully submitted,

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