No. 19-431 and 19-454

In the Supreme Court of the United States

THE LITTLE SISTERS OF THE POOR SAINTS PETER AND PAUL HOME, PETITIONER

v.

COMMONWEALTH OF PENNSYLVANIA AND THE STATE OF NEW JERSEY.

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL., PETITIONERS

v.

COMMONWEALTH OF PENNSYLVANIA AND THE STATE OF NEW JERSEY.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR PLANNED PARENTHOOD FEDERATION OF AMERICA, NATIONAL HEALTH LAW PROGRAM, NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, AND RAISING WOMEN'S VOICES FOR THE HEALTH CARE WE NEED AS AMICI CURIAE SUPPORTING RESPONDENTS

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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

[1] Pursuant to Rule 37.6, amici affirm that no counsel for a party authored this brief, in whole or in part, and that no person other than amici or their counsel have made any monetary contributions intended to fund the preparation or submission of this brief. The parties have granted blanket consent for the filing of amicus curiae briefs.

provider of reproductive health care in the United States. Its mission is to provide comprehensive reproductive health care services and related educational programs, and to advocate for public policies to ensure access to health services. In particular, Planned Parenthood affiliates provide high-quality reproductive health care to individuals and communities facing serious barriers to obtaining such care—especially low-income individuals, 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 to 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 nearly 50-year-old national, nonprofit membership organization established 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 1,000 health care organizations and individuals in all 50 states, the District of Columbia, and the territories. Its members include state, county, and local health departments; private, nonprofit family-planning organizations (including Planned Parenthood affiliates); family-planning councils; hospital-based clinics; and Federally Qualified Health Centers ("FQHCs"). NFPRHA's members operate or fund thousands of health centers that provide high-quality family planning and related health services to millions of low-income, uninsured, or underinsured individuals each year.

Raising Women's Voices for the Health Care We Need ("RWV") is a national initiative working to ensure that the health care needs of women and families are addressed as the Affordable Care Act is implemented. It has a diverse network of 25 grassroots health advocacy organizations in 27 states. RWV has a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, and members of the lesbian, gay, bisexual, transgender, and queer community.

SUMMARY OF ARGUMENT

For almost a decade, the federal government has recognized that contraception is an essential preventive health care service that, under the Patient Protection and Affordable Care Act (the "ACA"), insurers must cover for patients without cost-sharing (the "Contraceptive Coverage Benefit").[2] 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 expanded exemptions to the requirement by allowing broad categories of employers and universities to refuse to provide some or all FDA-approved contraceptive methods in employer- and university-provided health insurance plans.[3] These Expanded Exemptions threaten to deprive large numbers of individuals nationwide of essential access to contraception without cost sharing guaranteed by the ACA.

This brief debunks arguments advanced by the Petitioners and some amici. Attempting to minimize the harm that will befall individuals who lose coverage due to the

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[2] C.A. App. 984–986; 77 Fed. Reg. 8725, 8725 (Feb. 15, 2012) (*Coverage of Preventive Services*).

[3] See 45 C.F.R. 147.132; 45 C.F.R. 147.133.

Expanded Exemptions, they misrepresent the extent of individuals' access to free or discounted contraceptive services through Title X and Medicaid. Those programs simply could not fill the gap in contraceptive coverage caused by the Expanded Exemptions.

First, this brief describes the background of the Contraceptive Coverage Benefit and why it was deemed an essential preventive health care service under the ACA. *Second*, it explains why federal safety-net programs are insufficient to fill the gap in no-cost-sharing contraceptive coverage caused by the Expanded Exemptions. In particular, recent changes to Title X have drained resources from the program, hindering its ability to serve the individuals it is meant to serve, and proposed changes to Medicaid threaten to do the same. *Third*, this brief explores how placing additional demands on Title X and Medicaid will only harm the neediest patients who already rely on these programs to get care and have nowhere else to turn. *Fourth*, putting aside capacity issues, this brief describes the logistical barriers that patients seeking to enroll in the safety-net programs would confront, which will result in individuals foregoing needed care.

For these and other reasons, *amici* submit this brief in support of Respondents and affirmance of the Third Circuit Court of Appeals' decision.

ARGUMENT

I. CONTRACEPTIVE COVERAGE WITHOUT COST SHARING IS AN ESSENTIAL COMPONENT OF PREVENTIVE HEALTHCARE.

The ACA, among other things, aimed to shift the focus of health care away from reactive medical care toward

preventive health care.[4] To that end, the ACA requires most private insurance plans to cover certain preventive health care services without additional costs to patients.[5] Contraceptive services are critical preventive services for individuals because they help to avoid unintended pregnancies and promote healthy birth spacing, resulting in improved maternal, child, and family health.[6] Contraceptive use also confers other preventive health benefits, such as reduced menstrual bleeding and pain, and decreased risk of endometrial and ovarian cancer.[7] Accordingly, since 2011, the Health Resources and Services Administration has included all FDA-approved contraceptive methods in its preventive services guidelines.[8] Thus, under the ACA, insurers must cover these services at no additional cost for patients.[9]

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

[5] See, *e.g.*, 42 U.S.C. 300gg-13(a).

[6] Comm. on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 615: Access to Contraception* 2 (Jan. 2015, reaffirmed 2017), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf.

[7] *Ibid.*

[8] *Id.* at 3; see also C.A. App. 984–986 (2011 version); *Women's Preventive Services Guidelines*, Health Resources & Servs. Admin., https://www.hrsa.gov/womens-guidelines-2019 (last updated Dec. 2019).

[9] 42 U.S.C. 300gg-13(a)(4); see also 45 C.F.R. 147.130(a)(1)(iv); *Coverage of Preventive Services*, 77 Fed. Reg. at 8725.

The Contraceptive Coverage Benefit increases access to contraceptive services by ensuring that women can access them seamlessly through their insurance without any out-of-pocket costs—an important protection that impacts 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.[10] Those who could afford contraceptive services were devoting between 30% and 44% of their annual out-of-pocket health care costs to that end,[11] and women were more likely to forego more effective long-acting reversible contraceptive ("LARC") methods (such as IUDs) due to their higher upfront out-of-pocket costs.[12]

And the Contraceptive Coverage Benefit is working: More than 61 million women now have access to contraceptive services without cost sharing.[13] Out-of-pocket spending on contraceptive services has decreased, more

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[10] 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/wp-content/uploads/2013/01/8164.pdf.

[11] 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).

[12] 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).

[13] Nat'l Women's Law Ctr., *New Data Estimates 61.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs* 1 (2019), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/12/preventativeservices2019.pdf.

women are choosing the more effective LARC methods,[14] and recent data show that the percentage of unintended pregnancies in the United States is at a 30-year low.[15]

II. FEDERAL SAFETY-NET PROGRAMS ARE NOT ADEQUATE SUBSTITUTES FOR THE CONTRACEPTIVE COVERAGE BENEFIT.

Contrary to Petitioners' misleading arguments (U.S. Pet. Br. 26–27; Little Sisters Pet. Br. 39–40), federal safety-net programs are not adequate substitutes for the loss of no-copay contraceptive coverage through private insurance. Title X is not designed to provide no-cost care to individuals who lose access to coverage for contraceptives through their insurance,[16] and many of these individuals are simply not eligible for Medicaid.

Title X and Medicaid are inadequate substitutes for the Contraceptive Coverage Benefit for the additional reason that these programs are facing drastic cuts to covered services, funding, and eligibility. Adding an influx of new patients as a result of the Expanded Exemptions would further stretch the resources of Title X and Medicaid and risk diverting resources away from those individuals the programs are primarily intended to serve: low-

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[14] Snyder et al., 28 Women's Health Issues at 219; Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1293 (2012).

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

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

income individuals and families who are in the greatest need of publicly funded health care services.[17]

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

Title X was enacted to make modern methods of contraception available to all, especially low-income women,[18] and answer President Richard M. Nixon's call that "no

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[17] In addition to discussing Title X and Medicaid, the Little Sisters Petitioner suggests (at 39) that community health center grants and Temporary Assistance for Needy Families ("TANF") grants may be adequate substitutes to make up for the loss of contraceptive coverage without cost sharing through private insurance. They are not.

Community health centers are not required to offer all of the FDA-approved contraceptive methods; indeed, "the law and implementing regulations and guidelines do not define the exact scope of services that must be provided to patients." Susan F. Wood et al., Henry J. Kaiser Family Found., *Community Health Centers and Family Planning in an Era of Policy Uncertainty* 4 (2018), http://files.kff.org/attachment/Report-Community-Health-Centers-and-Family-Planning-in-an-Era-of-Policy-Uncertainty.

For their part, state-run TANF programs are not required to cover contraceptive services, and many individuals will not qualify for any assistance. 42 U.S.C. 608(a)(1) (prohibiting the use of TANF funds to provide any assistance to individuals who are neither pregnant nor caring for a minor child who lives with them); see Kinsey Hasstedt et al., Guttmacher Inst., *Public Funding for Family Planning and Abortion Services, FY 1980–2015*, at 8 (2017) (Hasttedt et al.) (explaining that only twelve states use either TANF grants or social security block grants for family-planning services), https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf.

[18] 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)).

American woman should be denied access to family planning assistance because of her economic condition."[19] Through a competitive process, HHS awards Title X 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.[20] Those grants, in turn, fund "projects" intended to prioritize "persons from low-income families."[21] Thus, historically, only individuals whose annual income is at or below the federal poverty level ("FPL") have been entitled to receive no-cost Title X services,[22] while others whose income is below 250% of the FPL are typically eligible for discounted, low-cost services based on their ability to pay.[23]

Additionally, Title X was not designed to provide free or reduced cost care to individuals who have private insurance through an employer or university. To the contrary, the governing 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.[24] Thus, if a patient has private insurance, the Title X health center generally must bill the insurance. In the event of a gap in insurance coverage, a patient whose income exceeds 100% of the

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[19] Special Message to the Congress on Problems of Population Growth, Pub. Papers 521 (July 18, 1969).

[20] 42 U.S.C. 300(a); see also 42 C.F.R. 59.5(a)(1).

[21] 42 U.S.C. 300a-4(c)(1).

[22] 42 C.F.R. 59.5(a)(7).

[23] 42 C.F.R. 59.5(a)(9).

[24] 42 C.F.R. 59.5(a)(7).

FPL would typically still be required to pay some or all of the cost of the services received.[25]

The Little Sisters Petitioner nevertheless misleadingly contends (at 39–40)[26] that, through a recent change to the Title X regulations, the federal government "itself" has "assume[d]" the additional costs of providing "subsidized" contraceptive coverage to insured individuals denied the Contraceptive Coverage Benefit as a result of the Expanded Exemptions.[27] Not so. Under the referenced change (the "Title X Final Rule"), project directors may, *at their discretion*, consider an individual's insurance coverage status and its effect on income and overall ability to pay for contraceptive services as a "good reason" to provide no- or low-cost care to individuals who lose coverage because of the Expanded Exemptions.[28] That is a far cry from a solution to the coverage gap created by the Expanded Exemptions, for several reasons.

First, the individual's ability to receive any relief at all under the Title X Final Rule is subject entirely to the discretion of a Title X project director.

Second, HHS has provided no additional funding to compensate Title X projects for bearing the costs of contraceptive services for individuals who lose the Contra-

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[25] 42 C.F.R. 59.5(a)(7), (9).

[26] This misconception is shared by numerous amici in support of Petitioners. See Am. Ctr. for Law & Justice Amicus Br. 23 n.15; Catholic Benefits Ass'n Amicus Br. 20, 24–26; March for Life Educ. & Def. Fund Amicus Br. 11; Women Scholars Amicus Br. 34; State of Texas et al. Amicus Br. 29 & n.9.

[27] 84 Fed. Reg. 7714 (Mar. 4, 2019) (*Title X Final Rule*) (codified in scattered subsections of 42 C.F.R. 59).

[28] See *id.* at 7734 (amending the definition of "low-income family").

ceptive Coverage Benefit due to the Expanded Exemptions. Instead, the entire financial burden of providing free or discounted services to such individuals would be borne by the Title X project rather than being "absorbed" by the federal government.[29]

Third, the Title X program rules significantly restrict the exercise of discretion by the project director. The Title X Final Rule merely allows the Title X project director to consider a patient's insurance coverage status as "one factor" bearing on the ability to pay for Title X contraceptive services,[30] while expressly requiring that the director "also consider other circumstances affecting [the individual's] ability to pay," such as "total income."[31] In conducting the ordinary inquiry into whether the individual is part of a "low income family" that qualifies for no-cost contraceptive services or is eligible for a discount under the existing Title X schedules, the director may reduce an individual's total annual income either by the estimated

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[29] Indeed, after promulgating the Expanded Exemptions, HHS sought no additional funds to pay for any aspirational expansion of services to cover persons denied the Contraception Coverage Benefit. For both FY 2020 and 2021, HHS proposed budgets of approximately $286 million for family-planning services under Title X—the same level of funding it received for FY 2019. See Dep't of Health & Human Servs., *FY2020 Budget in Brief* 30 (2019), https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf; Dep't of Health & Human Servs., *FY2021 Budget in Brief* 29 (2020) (*FY2021 Budget in Brief*), https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf. The recently enacted FY 2020 budget appropriated $286.5 million to family-planning services. Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, 133 Stat. 2558 (2019).

[30] See *Title X Final Rule*, 84 Fed. Reg. at 7736.

[31] 42 C.F.R. 59.2(2); see also *Title X Final Rule*, 84 Fed. Reg. at 7734, 7736.

annualized contraception-related out-of-pocket costs or by $600 per year.[32] But in the end, the director must still determine whether an individual whose income exceeds the FPL "cannot, in fact, afford to pay for family planning"; if the individual "can afford" to pay for contraceptive services despite the added financial strain due to the loss of the Contraceptive Coverage Benefit, "the project director should conclude that [the individual] is not from a low income family."[33] And HHS further made clear that Title X project directors should use the existing Title X fee schedules, which entirely depend on income, to determine how much an individual who lost the Contraceptive Coverage Benefit due to the Expanded Exemptions should pay—up to the full cost of contraceptive services received.[34]

In short, although some individuals who lose coverage because of the Expanded Exemptions may obtain care from a Title X provider (if one is available), most of them will still incur out-of-pocket costs; indeed, many may not qualify for any discount at all.

B. Medicaid Serves a Limited Subset of Low-Income Individuals.

Nor can Medicaid fill the gap to serve individuals who lose contraceptive coverage through private insurance as a result of the Expanded Exemptions. Medicaid is a joint

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[32] See 42 C.F.R. 59.2(2); *Title X Final Rule*, 84 Fed. Reg. at 7787.

[33] See *Title X Final Rule*, 84 Fed. Reg. at 7736.

[34] *Id.* at 7739 (citation omitted).

federal-state program designed to provide health insurance coverage for a limited population of individuals.[35] Eligibility is based on financial need.[36] Precisely because only a limited population is eligible for Medicaid, Medicaid cannot serve as a substitute for the Contraceptive Coverage Benefit.

Prior to the ACA, only certain groups of low-income individuals could receive Medicaid coverage: children, parents and caretaker relatives, pregnant women, seniors, and individuals with a disability. To address the health needs of low-income individuals nationwide, the ACA expanded Medicaid eligibility by requiring states to cover adults[37] with incomes at or below 133% of the FPL,[38]

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[35] 42 U.S.C. 1396-1 (noting that Medicaid's purpose is to enable states to furnish medical assistance to 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.

[36] 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 (2019) (Rudowitz et al.), http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

[37] Notably, Medicaid eligibility is limited to U.S. citizens and qualified noncitizens, such as legal permanent residents who have completed a five-year waiting period and certain humanitarian immigrants (*e.g.*, refugees and asylees). See 8 U.S.C. 1611, 1613 (a)–(b), 1641. By contrast, many employment-eligible noncitizens who are not "qualified" noncitizens for Medicaid purposes, such as certain work-visa holders, would be eligible for employer-provided insurance without waiting periods. See, *e.g.*, 20 C.F.R. 655.731(a).

[38] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 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% of the FPL because the legislation disregards up to 5% of a

equivalent to an annual income of $16,971 for an individual in 2020.[39]

In 2012, however, the Supreme Court held that HHS could not terminate federal Medicaid funding to states that do not extend Medicaid coverage to this larger population,[40] effectively leaving the decision whether to expand Medicaid, in the first instance, to the states. As of March 2020, fourteen states (including Texas and Florida, the second- and third-most populous states) have not expanded Medicaid coverage.[41] The median income limit for Medicaid-eligible parents in those states was just 39.5% of the FPL in 2019, which is less than one-third the income limit for the ACA's Medicaid expansion and corresponds to an annual income of $8,425 for a three-person household in the continental United States in 2020.[42] Thus, in

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household's income. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1036 (codified at 42 U.S.C. 1396a(e)(14)(I)); see also Rudowitz et al. 3.

[39] See 85 Fed. Reg. 3060, 3060 (Jan. 17, 2020) (*2020 Poverty Guidelines*).

[40] *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 575–588 (2012).

[41] *Status of State Medicaid Expansion Decisions: Interactive Map*, Henry J. Kaiser Fam. Found. (Mar. 13, 2020) (*Status of Expansion Decisions*), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. A fifteenth state, Nebraska, has adopted, but not fully implemented, the Medicaid expansion. See *ibid.*; *Nebraska State Plan Amendment # 19-0002*, Medicaid.gov (approved Mar. 10, 2020), https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-19-0002.pdf (adding coverage for the expansion population as of October 1, 2020).

[42] See *2020 Poverty Guidelines*, 85 Fed. Reg. at 3060; *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, Henry J. Kaiser Fam. Found. (as of Jan. 1, 2020),

these non-expansion states, Medicaid does not cover: (1) nonelderly adults who have no children, are not pregnant, and do not have a disability; or (2) parents whose annual income is, on average, more than 46% of the FPL.[43]

Twenty-six states (including nine non-expansion states) have implemented Medicaid family-planning expansion programs that provide family planning services to certain individuals who are not otherwise eligible for Medicaid coverage.[44] The income ceiling for most of these programs is at or near 200% of the FPL, with the highest—in Wisconsin—reaching 306% of the FPL.[45] Further, two Medicaid family-planning programs—in Rhode Island and Wyoming—only cover patients who become ineligible for Medicaid after the end of their pregnancies.[46]

Given the restrictive eligibility requirements, Medicaid family-planning programs likely cannot serve as a

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https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

[43] There is one exception. Wisconsin, which has not adopted the Medicaid expansion, nevertheless provides 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] Compare *Medicaid Family Planning Eligibility Expansions*, Guttmacher Inst. (as of Apr. 1, 2020) (*Medicaid Family Planning*), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions, with *Status of Expansion Decisions*.

[45] See *Medicaid Family Planning*.

[46] *Ibid.*

substitute for most individuals who lose contraceptive coverage through their employer- and university-sponsored insurance due to the Expanded Exemptions.

C. The Federal Safety-Net Programs Are Not Positioned to Meet an Increased Demand Because They Have Been Undermined by Regulatory Changes, Are Under Budgetary Strain, and/or Are at Risk of Detrimental Restructuring.

Although the Government now suggests (at 26–27) that the federal reproductive health safety net can act as a backstop for the loss of the Contraceptive Coverage Benefit, it is simultaneously hindering those programs' ability to do the work Congress intended. 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.[47] Far from providing supplemental, much-needed funding to the two programs that account for 85% of national family-planning spending,[48] the federal government has either allowed funding streams to remain stagnant or proposed further budgetary cuts to Title X and Medicaid. Coupled with detrimental program reforms, the prospect of added financial strain threatens these already underfunded programs' ability to serve the neediest patients that currently rely on them, let alone to accommodate an influx of new ones.

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[47] 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).

[48] Hasstedt et al. 8.

1. Title X Is Being Undermined and Faces Threats to Its Already Stagnant Funding.

The suggestion that the Title X program could serve as a substitute for the Contraceptive Coverage Benefit ignores the fact that recent changes to the program significantly altered the landscape of Title X-funded family-planning providers, drastically reducing access to reliable and effective contraceptive services even for existing Title X patients.

The Title X Final Rule, which took effect last summer, bars Title X providers from providing pregnant patients with full information about their options, and further requires complete physical and financial separation between Title X projects and any abortion-related services.[49]

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[49] HHS began enforcing the rule last summer after securing two stays pending appeal of preliminary injunctions entered by district courts in the Fourth and Ninth Circuits. See *Compliance with Statutory Program Integrity Requirements*, U.S. Dep't Health & Hum. Servs. (Aug. 9, 2019), https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/compliance-with-statutory-program-integrity-requirements/index.html.

The Title X Final Rule is currently in effect everywhere except in the State of Maryland, where it was permanently enjoined after plaintiffs prevailed on summary judgment. *Mayor of Balt.* v. *Azar*, No. 19 Civ. 1103, 2020 WL 758145, at *17 (D. Md. Feb. 14, 2020), appeal pending, No. 20-1215 (4th Cir. filed Feb. 24, 2020). Several preliminary injunctions were recently vacated by an *en banc* panel of the Ninth Circuit, which improperly reached the merits of Plaintiffs' arbitrary and capricious claims under the Administrative Procedure Act. *California ex rel. Becerra* v. *Azar*, 950 F.3d 1067, 1104 (9th Cir. 2020). Plaintiffs in *Becerra* and consolidated and related actions, which include Amici PPFA and NFPRHA, intend to seek full Ninth Circuit review of the panel's ruling.

Taken together, these changes to the Title X regulations have upended the prior network of approximately 4,000 health centers nationwide that received grants through the program in 2018.[50] The new eligibility requirements forced providers into an ethical quandary: either abide by the Final Rule's provisions or leave the Title X program and forgo its much-needed funding. As a result, there are currently "wide gaps" in the national network of Title X family-planning health centers, as HHS's Deputy Assistant Secretary for Population Affairs has acknowledged.[51] As of October 2019, 1,041 health centers across more than 30 states, including all Planned Parenthood affiliates, were no longer in the program due to the Title X Final Rule.[52] Six states currently have no

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[50] Christina Fowler et al., RTI Int'l, *Title X Family Planning Annual Report*: *2018 National Summary* 7–8 (2019) (*2018 Annual Report*), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2018-national -summary.pdf.

[51] Dan Diamond et al., *Politico Pulse*, Politico (Mar. 4, 2020), https://www.politico.com/newsletters/politico-pulse/2020/03/04/today-house-expected-to-vote-on-coronavirus-emergency-funding-785842 (reporting on Deputy Assistant Secretary Diane Foley's remarks at an Association of Health Care Journalists workshop). In an attempt to address a portion of these "wide gaps," the Office of Population Affairs has indicated it intends to provide an additional $18 million in grants to providers in States that lost all or most of their Title X health centers as a result of the Title X Final Rule. *Ibid.*

[52] *The Status of Participation in the Title X Federal Family Planning Program*, Henry J. Kaiser Fam. Found. (Dec. 20, 2019) (*Status of Participation*), https://www.kff.org/interactive/the-status-of-participation-in-the-title-x-federal-family-planning-program/; Rachel Benson Gold & Lauren Cross, Guttmacher Inst., *The Title X Gag Rule Is Wreaking Havoc—Just as Trump Intended* (Aug. 29, 2019) (Gold & Cross), https://www.guttmacher.org/article/2019/08/title-x-gag-rule-wreaking-havoc-just-trump-intended.

Title X providers *at all*.[53] And even those grantees who submitted plans for compliance for HHS review may ultimately have to withdraw from the Title X program if the agency concludes that such plans do not comply with the Title X Final Rule.[54]

Planned Parenthood affiliates' exclusion from Title X is especially harmful because they previously served approximately *41%* of the almost 4 million Title X patients served annually.[55] Past exclusions of Planned Parenthood from publicly funded programs have had dire effects on access to contraception and health outcomes: After Planned Parenthood affiliates were excluded from Texas's family-planning program in 2013, claims for more effective LARC and injectable contraceptives dropped more than 30%, contraception continuation went down, and Medicaid-covered child-birth rates went up.[56] Without Planned Parenthood affiliates in the Title X network,

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[53] Title X's sole grantees in five states (Maine, Oregon, Utah, Vermont, and Washington) have withdrawn from the program. Additionally, none of the family-planning clinics in Hawaii are currently using Title X funds, though they formally remain in the Title X program. Brittni Frederiksen et al., *Data Note: Is the Supplemental Title X Funding Awarded by HHS Filling in the Gaps in the Program?*, Henry J. Kaiser Fam. Found. (Oct. 18, 2019), https://www.kff.org/womens-health-policy/issue-brief/data-note-is-the-supplemental-title-x-funding-awarded-by-hhs-filling-in-the-gaps-in-the-program.

[54] See *Status of Participation*.

[55] 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), https://www.guttmacher.org/sites/default/files/article_files/gpr2008617.pdf.

[56] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. Med. 853, 857–859 (2016).

it is estimated that other Title X-funded providers would need to increase their Title X patient caseload by an average of 70% to cover the same number of patients: federally qualified health centers ("FQHCs") would need to boost their capacity to provide contraceptive services by 116%; health department sites by 31%; hospital-operated sites by 77%; and other sites, such as independent agencies, by 101%.[57]

Further, even if the Title X Final Rule had not altered the Title X landscape, the program would still be unable to adequately provide coverage for all individuals who require assistance. Title X is budgeted to receive just $286.5 million in FY 2021[58]—a level of funding that has been stagnant since 2014.[59] In fact, since Title X's funding peak in 2010,[60] Congress has cut funding for the program by 10% even as the need for publicly funded contraceptive services has increased[61]—a more than 25% decrease in

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[57] Gold & Cross.

[58] *FY2021 Budget in Brief* 29; *Title X Budget & Appropriations*, Nat'l Fam. Plan. & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations.

[59] *Funding History*, U.S. Dep't Health & Hum. Servs. (Apr. 4, 2019), https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html.

[60] See *ibid.*

[61] 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) (Dreweke), https://www.guttmacher.org/sites/default/files/article_files/gpr1905316.pdf.

funding once adjusted for inflation.[62] Indeed, by that adjusted metric, Title X's 2016 funding was about 30% of what it was in 1980.[63]

Given the current "wide gaps" in the Title X network and the stagnant funding that calls into question its ability to expand, it is unreasonable to suggest that Title X is in a position to absorb increased needs created by the Expanded Exemptions. As it is, the Title X Final Rule has already made it more difficult for the program to serve its existing patient population, threatening to undermine the congressional intent behind the program: "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," primarily for "persons from low-income families."[64]

2. Medicaid Faces Threats of Significant Cuts to Its Budget and Other Expansive Structural Reforms.

The argument that individuals who lose insurance coverage for contraception because of the Expanded Exemptions may look to Medicaid as a substitute ignores the fact that even for those who currently qualify for Medicaid coverage, continued access to those services is by no means secure.

The President's proposed 2021 federal budget provided for $920 billion in cuts to Medicaid funding over the

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[62] Jennifer J. Frost et al., Guttmacher Inst., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, at 21 (2019) (Frost et al.) (adjusting for inflation through 2016), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf.

[63] Dreweke 58.

[64] 42 U.S.C. 300(a), 300a-4(c)(1).

course of a decade.[65] In parallel, the proposed budget included a placeholder for the President's "Vision of Health Care Reform,"[66] which aspires to reduce the deficit by $844 billion over the next decade. While the proposal did not include details about how those savings would be accomplished (or about the extent to which they may overlap with other cuts already contemplated in the budget), analysts predict that the envisioned "reforms" would involve cuts to Medicaid and ACA subsidies.[67]

If past proposals are any indication, the anticipated "reforms" could seek to radically alter the structure of the Medicaid program. Indeed, President Trump's past federal budgets have called for the elimination of the Medicaid expansion and the conversion of 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"); or (ii) a fixed amount that would not vary by the number of Medicaid enrollees (the "block grant" model).[68] Either model would dramatically reduce federal funding available to states to cover individuals of reproductive age who rely on Medicaid for contraceptive

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[65] Office of Mgmt. & Budget, Exec. Office of the President, *A Budget for America's Future: Budget of the U.S. Government, Fiscal Year 2021*, at 111, 112 (2020).

[66] *Id.* at 119.

[67] See Comm. for a Responsible Fed. Budget, *Analysis of the President's FY 2021 Budget* 6 (2020), http://www.crfb.org/sites/default/files/Analysis_of_the_Presidents_FY_2021_Budget.pdf.

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

access. And, whether or not these proposals can be successfully advanced through legislation, HHS has already invited States to apply for Medicaid waiver projects that use these models.[69]

Consequently, there is no guarantee that even those currently enrolled will be able to maintain Medicaid coverage for contraceptive services, much less that individuals who lose access to contraceptive services without cost sharing through their private insurance will have access to those services through Medicaid.

III. INCREASING RELIANCE ON THE UNDERMINED AND UNDERFUNDED SAFETY NET WILL DISPROPORTIONATELY AND NEGATIVELY AFFECT THE INDIVIDUALS WHO NEED IT MOST.

Even if Congress had intended for Medicaid and Title X to enlarge their focused mandates to substitute for the Contraceptive Coverage Benefit, these programs cannot serve as replacements because they are already stretched thin. Additional demands would only make it more likely that those who rely on these programs for critical care would see delays and barriers to access the services they need.

Over two-thirds of state Medicaid programs face challenges in securing an adequate number of providers, par-

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[69] Letter from Calder Lynch, Dir. of Medicaid & CHIP Servs., U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs., 1 (Jan. 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf; see also Ctr. on Budget & Policy Priorities, *Trump Administration's Harmful Changes to Medicaid* 1 (Feb. 4, 2020), https://www.cbpp.org/sites/default/files/atoms/files/6-12-19health.pdf.

ticularly for specialty services like obstetrics and gynecology ("OB/GYN").[70] A government report found that only 42% of in-network OB/GYN providers were able to offer appointments to new Medicaid patients in 2014.[71] Many FQHCs have struggled to fill persistent staff vacancies and shortages.[72]

The Title X network is also taxed at its limits. In 2010, the number of clients served at Title X-funded health centers was approximately 5.2 million,[73] but it dropped to 3.9 million in 2018.[74] This decline coincides with more than $30 million in cuts to Title X's annual appropriation over the same period,[75] and it did not occur because fewer individuals were in need of these services.

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[70] U.S. Gov't Accountability Office, *Report to the Secretary of Health and Human Services: Medicaid—States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance* 19 (2012), http://www.gao.gov/assets/650/649788.pdf.

[71] See Daniel R. Levinson, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Access to Care: Provider Availability in Medicaid Managed Care* 21 (2014), http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

[72] 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.

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

[74] *2018 Annual Report* 8.

[75] Compare *id.* at 1, with *2010 Annual Report* 1.

To the contrary, the number of individuals in need of publicly funded care has *increased*: In 2016, of the 40.2 million women estimated to be in need of contraceptive services,[76] 20.6 million needed publicly funded contraceptive services because they were either (i) teenagers or (ii) adult women whose family income was below 250% of the FPL.[77] That is an overall increase of 8% between 2010 and 2016.[78]

The increased need for publicly funded contraceptive services is particularly acute among individuals who come from under-served populations. One of the largest increases in the need for family-planning services between 2010 and 2016 was experienced by adult women with family incomes below 250% of the FPL (12%).[79] In that same period, the number of adult women with family incomes below 100% of the FPL that were in need of publicly funded contraceptive services also rose by 12%.[80] Similarly, between 2010 and 2016, the number of Black women who needed publicly supported contraceptive care increased by 10%, while the number of Hispanic women in need increased by 11%.[81] Rural populations are also in great need of contraceptive services.[82]

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[76] Frost et al. 5, 49.

[77] Frost et al. 5, 11, 26.

[78] *Id.* at 12.

[79] *Ibid.*

[80] *Id.* at 26.

[81] *Id.* at 12, 26.

[82] Among the 14 states ranked highest in percentage of women of reproductive age in need of publicly funded contraceptive services, nine have rural populations exceeding 33% of the state population. See Comm. on Health Care for Underserved Women, Am. Coll. of

Consequently, the resources of the family-planning safety net are acutely needed for the populations of individuals it was designed to serve; they could not possibly support the needs of additional individuals, regardless of means, whose employers and universities opt out of the Contraceptive Coverage Benefit.

IV. INDIVIDUALS WHO LOSE PRIVATE COVERAGE OF CONTRACEPTIVES FACE ADDITIONAL BURDENS.

Even if (contrary to fact) all individuals no longer covered by private insurance for contraceptive services due to the Expanded Exemptions were eligible for no-cost services through Medicaid or under Title X, and *even if* (contrary to fact) those programs *could* serve an expanded population of patients without cost sharing, the shift would still impose significant burdens on this population that would interfere with access to seamless contraceptive coverage without cost sharing. Indeed, when HHS adopted the Contraceptive Coverage Benefit, it specifically rejected the idea that government programs could easily provide the same benefit because "requiring [individuals] to take steps to learn about, and to sign up for, a new health benefit" imposed unnecessary obstacles to access.[83]

These individuals would face the logistical challenges of enrolling in, or obtaining benefits from, one of these government-funded programs. They may also have to seek out new providers that accept Medicaid or provide

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Obstetricians & Gynecologists, *Committee Opinion No. 586: Health Disparities in Rural Women* 2 (2014), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf.

[83] 78 Fed. Reg. 39,870, 39,888 (July 2, 2013).

services through Title X, and some may have difficulty locating providers within a reasonable distance.[84] These challenges to affected individuals will almost certainly deprive many of continuity of care with their preferred health care providers.

As a result of these challenges, it is likely that many individuals will choose less effective contraceptive methods, or forego contraceptive services entirely. This in turn puts individuals at increased risk of unintended pregnancy and the health risks that go along with it.

CONCLUSION

The Expanded Exemptions, if allowed to stand, will harm many individuals by depriving them of contraceptive coverage without cost sharing that is an essential element of the ACA's integrated strategy to ensure access to fundamental preventive care. Federal safety-net programs are simply not substitutes for employer- and university-sponsored insurance plans, and such programs lack the resources to accommodate individuals who stand to lose coverage under the Expanded Exemptions. Further, current attacks on those programs combined with an influx of new patients would interfere with the safety-net programs' ability to serve the patients of limited means for whom these programs were designed.

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[84] See Henry J. Kaiser Family Found., *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians* 7 (2011), https://www.kff.org/wp-content/uploads/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/.

For these reasons, amici urge this Court to affirm the decision below.

Respectfully submitted.

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