national partnership for women & families
Because actions speak louder than words.

December 5, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016
Attention: CMS-9940-IFC

Submitted electronically via regulations.gov

Re: Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act [CMS-9940-IFC]

The National Partnership for Women & Families is dedicated to expanding opportunities for women and improving the well-being and economic security of our nation's families. For more than 45 years, we have promoted access to quality, affordable health care, reproductive health and rights, policies that help women and men meet the dual demands of work and family, and fairness in the workplace.

The National Partnership is committed to ensuring all individuals have seamless, affordable contraception coverage. Women's ability to control their reproductive futures is vital to their ability to finish school, remain in the workforce, control their careers, sustain their families and protect their own health and the health of their children.[1] For this reason, the National Partnership unequivocally opposes the Departments of Health and Human Services, Labor, and Treasury's ("the Departments'") efforts to undermine the Patient Protection and Affordable Care Act's ("the ACA") contraceptive coverage benefit through this Interim Final Rule ("IFR"). The ACA's women's preventive services requirement was designed to promote preventive medicine, reduce future medical costs, and improve the health, equality, and economic security of women and families.[2] More than 62 million women with private insurance now have coverage of these vital health care services, including breast and cervical cancer screening, breastfeeding services and supplies, and contraceptive care and counseling.[3]

By allowing employers or universities to deprive women of contraceptive coverage, this IFR will harm women and their health and well-being and exacerbate existing health disparities for marginalized communities. It discriminates against women in violation of multiple federal laws and the Constitution. The IFR also violates the Administrative Procedure Act. The IFR ignores Congress's explicit intent that the ACA require coverage of contraception. And the IFR is predicated upon a distorted picture of the science supporting contraception and the federal programs supporting and state laws regarding contraception. For all of these reasons, the National Partnership calls on the Departments to rescind the IFR.

I. Birth Control Is Critical to Women's Health.

Women face a unique set of health care challenges because they use more health services than men yet earn less on average than men.[4] As a result, women face a high level of health care insecurity, which leads many women to forgo necessary care because of prohibitive patient cost-sharing. Before the ACA, one in seven women with private health insurance and nearly one-third of women covered by Medicaid either "postponed or went without needed services in the past year because they could not afford it."[5] Women were spending between 30 percent and 44 percent of their total out-of-pocket health costs just on birth control.[6] Out-of-pocket costs prevented many women, not just low-income women, from accessing preventive services, including contraception.[7] The gap between men and women who struggled to access needed care was in fact widest among adults with moderate incomes.[8] The ACA's contraceptive coverage benefit has increased access to contraception without cost-sharing for women with employer-sponsored coverage.[9] Because of the birth control benefit, women saved more than $1.4 billion in out-of-pocket costs on birth control pills in 2013 alone.[10]

Contraceptive use among women is widespread, with over 99 percent of sexually active women using at least one method of contraception at some point during their lifetime.[11] And contraceptive use is common among women of all religious denominations.[12] Eighty-nine percent of sexually active Catholics and 90 percent of sexually active Protestants currently use some method of contraception.[13] Approximately 68 percent of Catholics, 73 percent of Mainline Protestants, and 74 percent of Evangelicals who are at risk of unintended pregnancy use a highly effective method (e.g., sterilization, oral contraceptives or another hormonal method, or intrauterine devices ("IUDs")).[14]

Insurance coverage of contraception is critical to ensuring women can use it. Unintended pregnancy rates are highest among those least able to afford contraception, particularly those who face additional barriers to accessing health care services including economic instability and/or discrimination based on race, ethnicity, gender identity or sexual orientation. In the first year of the ACA's contraceptive coverage benefit, the share of privately-insured women with no out-of-pocket costs for certain forms of birth control increased from 15 percent to 67 percent.[15]

The goal of preventive health care is to help people control, track, and better manage their life-long health, and the health of their families. Similarly, the goal of prevention of unintended pregnancy is to help women time and space their pregnancies, or prevent pregnancy altogether, in accordance with their own desires and to improve maternal, child, and family health.[16] Contraception enables women to prevent unintended pregnancy and control the timing of a desired pregnancy. In addition, access to birth control is particularly critical for women with underlying physical and psychological conditions or chronic conditions which can be exacerbated by pregnancy itself. These women may need to take particular care in planning their pregnancies to ensure that their health can support carrying a pregnancy to term.

Unintended pregnancies are associated with higher rates of long-term health complications for women and infants. Women with unintended pregnancies are more likely to delay prenatal care, leaving their health complications unaddressed and increasing risk of infant

mortality, birth defects, low birth weight, preterm birth and long-term physical and mental effects on children.[17] They are also at higher risk for maternal morbidity and mortality, maternal depression or experiencing physical violence during pregnancy.[18] Unintended pregnancy rates are higher in the United States than in most other developed countries, with approximately 45 percent of pregnancies unintended.[19] And the United States has the highest rate of maternal mortality in the developed world.[20] Contraceptive efficacy in preventing unintended pregnancy is well established and supported in evidence,[21] and contraception is considered a major factor in reducing rates of maternal mortality and morbidity.

Most women who use birth control do so for both contraceptive and non-contraceptive purposes.[22] Beyond the well-established evidence that contraceptives are effective in the prevention of unintended pregnancy, non-contraceptive health benefits of contraception are recognized in evidence, including decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including endometriosis, myoma, pelvic inflammatory disease and a decreased risk of endometrial and ovarian cancer.[23] Non-contraceptive health benefits also include treatment for non-gynecologic conditions.[24]

A woman and her health care providers, not politicians, should determine the right contraceptive for her health care needs. The IFR not only misrepresents the available science on contraceptive efficacy and safety, as discussed in more detail below, but also allows entities to refuse to cover the contraceptive counseling during which a woman and her health care provider could discuss her specific health history and contraceptive needs. This interferes with the relationship women have with their regular health care provider and conversations about if, and when, to become pregnant and which contraceptive to use when trying to prevent pregnancy.

In the face of these facts, the IFR not only denies how important contraceptive care and counseling are to women's health and lives, but implies that contraceptive care and counseling are not health care at all.

II. Birth Control is Critical to Gender Equality.

Birth control is vital in furthering equal opportunity for women, enabling women to be equal participants in the social, political and economic life of the nation. Unintended pregnancy is a key contributor to women's economic inequality in the United States and throughout the world. By enabling women to decide if and when to become parents, birth control allows women to access more professional and educational opportunities. The ACA's contraceptive coverage benefit helps place women on level footing with their male counterparts in their ability to participate in the workforce or pursue educational opportunities without the risk of unintended pregnancies.

Empowering women through access to contraception and allowing individual women to control if and when they will have a child plays a critical role in addressing gender inequalities including the existing pay gap between men and women. This is particularly true because pregnancy and childrearing have a significant impact on the gender pay gap.[25] While access to contraception will not fully remedy existing pay gaps between men and women, there are "clear associations between the availability and diffusion of oral contraceptives, particularly among young women, and increases in U.S. women's education,

labor force participation, and average earnings, coupled with a narrowing in the wage gap between women and men."[26] Moreover, studies focusing on the impacts of oral contraception have found that contraception is connected to significant growth of women's wages.[27] For example, one study examining the advent of the availability of oral contraception found that approximately "one-third of the total wage gains for women in their forties born from the mid-1940s to early 1950s" were attributable to oral contraception.[28] Access to oral contraceptives also accounts for an increase in college enrollment by women in the 1970s,[29] which was followed by large increases in women's presence in law, medicine, and other professions.[30] The Departments have previously acknowledged these significant benefits, noting that prior to the ACA's passage, disparities in health care coverage "place[d] women in the workforce at a disadvantage compared to their male co-workers," and that the contraceptive coverage benefit "furthers the goal of eliminating this disparity by allowing women to achieve equal status as healthy and productive members of the job force."[31]

The impacts of the IFR will fall heavily on women working in low-wage jobs. The most effective contraception options with the least chances of user error, such as an IUD or the contraceptive ring,[32] require higher upfront costs and will once again be out of reach of many women. The ability of employers to claim a religious exemption and not cover contraception for their employees will significantly limit the ability of women working low-wage jobs to access the preventive care best suited for themselves. This is important because the ability to control when and whether to get pregnant is particularly important for women in low-wage jobs.[33] The lack of pregnancy accommodations in many workplaces, particularly in low-wage jobs, means that pregnant women may be forced out of their jobs just at the time when they most need income and health insurance.

III. The IFR Will Exacerbate Existing Health Disparities Faced by LGBTQ People, People of Color, and Other Marginalized Communities.

A. The IFR Will Increase Health Disparities Faced by LGBTQ People.

The IFR harms the LGBTQ community by restricting access to contraception for those who need it, including lesbian and bisexual women and some transgender people.[34] Furthermore, allowing employers and universities to deny coverage for an essential health care service based on religious or moral beliefs sets a dangerous precedent for access to health care for LGBTQ people more broadly.

Despite misconceptions held by policymakers and some medical providers, lesbian and bisexual women require sexual and reproductive health services similar to those needed by heterosexual women. A majority of lesbian and bisexual women have reported having had intercourse with men,[35] and according to one study, roughly one in four lesbian and bisexual women have been pregnant, 50 percent have used oral contraceptives, and 16 percent reported one or more abortions.[36] Bisexual women are also subject to an increased risk of sexual violence. One study found that 46 percent of bisexual women have been raped, compared to 17 percent of heterosexual women.[37] Broadly, studies indicate that unintended pregnancies are equally as common, if not more common, for lesbian and bisexual women as for heterosexual women.[38]

Adolescent lesbian and bisexual women are at even higher risk for unintended pregnancies. Lesbian adolescent women are less likely than bisexual and heterosexual women to use

contraception,[39] and one study found that, in surveys, bisexual and lesbian adolescent women are more likely to report a pregnancy than heterosexual adolescent women.[40] And a 2016 study by the Centers for Disease Control and Prevention found that LGBTQ high school students are more likely than other students to experience intimate partner violence and rape, which can result in unintended pregnancy.[41]

In sum, access to contraception is essential for the health and well-being of many members of the LGBTQ community, and allowing employers and universities to deny coverage of contraception for religious reasons is unsound public health policy with the potential to cause significant harm.

B. The IFR Will Increase Health Disparities Faced by People of Color.

While people of color suffer disparities in almost every area of health care, these inequities are particularly egregious for reproductive health services. Due to historic and ongoing structural racism and persistent disparities, women of color face greater barriers in accessing sexual and reproductive health services.[42] And Black women experience higher rates of reproductive cancers, unintended pregnancies,[43] and sexually transmitted infections than white women.[44] Black women are often diagnosed later than others with the same health problems and have less access to high-quality, affordable care, resulting in higher death rates from the same conditions.[45]

Similar reproductive health disparities exist in the Latina community. Latinas are more likely to be diagnosed with cervical cancer than women of any other racial or ethnic group[46] and "are more likely to live in areas with low access to family planning services."[47] One study found that "[e]ven when diagnosed at similar ages and stages and with similar tumor characteristics, Latinas are more likely to die from breast cancer than non-Latina white women."[48] Furthermore, "[a]pproximately 16 percent of Latinas have not visited a physician in the last two years," and about 25 percent reported not having a regular health care provider.[49]

Disparities in reproductive health are undeniably linked to the disparities that women of color face in health care coverage. Black women are 50 percent more likely to be uninsured than white women, and Latinas are more than twice as likely to be uninsured as white women.[50] The ongoing health disparities faced by African American women has also resulted in an increased rate of pregnancy complications and maternal mortality. Black women "are between three to four times more likely to die from pregnancy-related causes than [w]hite women."[51]

The lack of insurance coverage for contraception likely contributes to disparities among racial and ethnic groups regarding unintended pregnancies.[52] The ACA did important work in decreasing disparities, and rolling back the ACA's contraceptive coverage benefit will disproportionately hurt communities of color by limiting access to contraceptive care without cost-sharing.

IV. The IFR Undermines Congress's Express Intent that Birth Control Be Covered As A Preventive Service.

The Departments ignore Congress's express intent that birth control be covered as a preventive service under the ACA.

A. Congress Intended the ACA to Require Contraceptive Coverage.

When Congress passed the Women's Health Amendment in section 2713 of the ACA,[53] it meant "to ensure that recommended preventive services for women are covered adequately by non-grandfathered group health plans and group health insurance coverage, recogniz[ing] that women have unique health care needs and burdens."[54] Allowing more entities to deprive women of contraceptive coverage, as the IFR does, strikes at the very purpose of the contraceptive coverage benefit.

Indeed, Congress intended the Women's Health Amendment ("the Amendment"), which includes the contraceptive coverage benefit, to help alleviate 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."[55] In enacting the Amendment, Congress recognized that the failure to cover women's preventive health services meant that women paid more in out-of-pocket costs than men for necessary preventive care, and were often unable to obtain this care at all because of cost barriers:

> Women must shoulder the worst of the health care crisis, including *outrageous discriminatory practices in care and coverage*. . . . In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost. *This fundamental inequity in the current system is dangerous and discriminatory and we must act*.[56]

In considering the Amendment, Congress expressed its expectation that the preventive services covered would include family planning services. For example, Senator Gillibrand stated, "With Senator Mikulski's amendment, even more preventive screening will be covered, including for . . . family planning."[57] And Senator Franken also said in regards to the Women's Health Amendment, "[A]ffordable family planning services must be accessible to all women in our reformed health care system."[58] That contraception would be covered was clear.[59]

To meet the Amendment's objectives, the Department of Health and Human Services commissioned the Institute of Medicine ("IOM") "to convene a diverse committee of experts in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines to review existing guidelines, identify existing coverage gaps, and recommend services and screenings for [the Department of Health and Human Services] to consider in order to fill those gaps."[60] After conducting its analysis, the IOM panel recommended eight preventive services for women, including coverage of the full range of FDA-approved contraceptives and contraceptive counseling.[61] On August 1, 2011, the Health Resources and Services Administration ("HRSA") adopted the recommendations set forth in the IOM

Report.[62] These were updated in 2016 based on recommendations from the Women's Preventive Services Initiative ("WPSI") as part of a five-year cooperative agreement between the American College of Obstetricians and Gynecologists and HRSA to coordinate the development, review and update of recommendations.[63] These too were adopted by HRSA.[64]

The Department of Health and Human Services – in adopting the IOM's recommendations and promulgating the contraception regulations, and again in adopting the WPSI recommendations – carried out Congress's direction.

B. The Departments Cannot Point to Other "Exemptions" to Justify the Rule.

It is undisputed that Congress did not add any exemption to the women's preventive services provision of the type that it has included in other legislation. Yet, in order to justify the sweeping exemptions in the IFR, the Departments look to the mere existence of exemptions in *other* statutes, referencing federal laws that allow health care entities to refuse to treat a woman seeking an abortion, and other laws that allow religious refusals to provide certain health care services. Not only are these laws irrelevant to the women's preventive services provision of the ACA, but the Departments' attempt to misconstrue these existing laws further proves that there is no direct and clear authority for the Departments to create this exemption.

The Departments also attempt to justify the IFR by pointing to "grandfathered" plans. But, the existence of plans that are grandfathered from the ACA's contraceptive coverage benefit does not diminish Congress's intent in maximizing the number of women who have contraceptive coverage.[65] "Federal statutes often include exemptions for small employers, and such provisions have never been held to undermine the interests served by these statutes."[66] Additionally, although qualifying grandfathered plans do not have to comply with certain of the ACA's requirements, including but not limited to coverage of preventive care services, plans lose grandfathered status if coverage is modified so that it no longer meets specified minimum coverage requirements.[67] This exemption is intended as a temporary means for transitioning employers to full compliance.[68] The number of employer-sponsored grandfathered plans has decreased steadily since 2010.[69]

V. The IFR Violates Statutory and Constitutional Protections.

By creating broad exemptions to the ACA's birth control benefit, which has expanded access to contraception for millions of women, the IFR singles out health insurance that women use and that is essential for women's health and equality.

Religious arguments have long been used in attempts to thwart women's equality, just as they have been used to thwart racial equality.[70] But those efforts have time and again been rejected. For example, in passing Title VII of the Civil Rights Act of 1964, Congress barred workplace discrimination based on a variety of factors including race and sex, over objections based on religion.[71] And as society has evolved beyond a religiously imbued vision of women as mothers and wives, courts have rejected efforts to allow religious exemptions to undermine civil rights protections for women.[72]

Like Title VII and other civil rights laws, the birth control benefit was intended to address longstanding discrimination and ensure women equal access to the preventive services that allow them to be full participants in society. In interfering with that access, the IFR targets women for adverse treatment, resulting in health insurance that covers preventive care that men need, but not care that women need. It interferes with the right to contraception encompassed by the fundamental constitutional right to liberty. As a result, the IFR discriminates against women on the basis of sex, in violation of the Due Process Clause of the Fifth Amendment, which guarantees people equal protection of the laws. And it violates Section 1557 of the ACA, which prohibits discrimination on the basis of sex in "any health program or activity, any part of which is receiving Federal financial assistance . . . or under any program or activity that is administered by an Executive Agency."[73]

Finally, the Constitution bars the Departments from crafting an exemption like this because it harms women. The Establishment Clause of the First Amendment limits the government's ability to create an exemption from generally applicable laws for religious or moral beliefs. The constitutional requirement is straightforward: "an accommodation must be measured so that it does not override other significant interests";[74] "impose unjustified burdens on other[s]";[75] or have a "detrimental effect on any third party."[76] When women are denied coverage for contraception, which is basic and essential health care, they suffer discrimination and economic harm. The exemption in the IFR clearly imposes burdens on others: it compels employees and students who need coverage for birth control to pay the substantial costs for the health care themselves if they are able (and many are unable), or else to forgo that essential health care. Thus, the IFR runs afoul of the clear mandates of the Establishment Clause.

For each of these reasons, the IFR should be rescinded.

VI. The IFR Violates the Administrative Procedure Act.

The Departments published this rule as an interim final rule, effective immediately upon publication, in violation of the procedural safeguards of the Administrative Procedure Act ("the APA"). Specifically, the issuance of this interim final rule does not comply with the APA's requirements in two key ways, because the Departments do not have good cause to skip notice and comment rulemaking and issuing this IFR is arbitrary and capricious.

The APA requires an agency to follow notice and comment procedures, which provide "interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation"[77] unless the agency can establish good cause to skip that process. Good cause is narrowly construed, and exists only where public comment is "impracticable, unnecessary, or contrary to the public interest." The APA further requires that a rule be published 30 days prior to its effective date.[78] Good cause plainly does not exist here.

The Departments justify their haste in part by arguing that the public previously commented on related regulations, and therefore has had an opportunity to engage. But the public has not had such opportunity – no prior regulation contemplated allowing any for-profit company to block access to contraceptive coverage for their employees. Relying on comments submitted during prior comment periods in response to those regulations does not absolve the Departments of the notice and comment requirements under the APA. The

Departments further argue that the interim final rule is justified by a need to "provide immediate resolution" to a number of open legal challenges to the existing scheme. But the existence of litigation alone does not create urgency, and certainly does not warrant subjugating the needs of the public at large to weigh in on such a wide-reaching regulation beneath the desires of a handful of employers and universities that are advocating for this change.

Further, the Departments' action in issuing this interim final rule constitutes arbitrary and capricious behavior. In unilaterally broadening the existing exemption and making the accommodation optional, the Departments jettisoned the careful balance that they had previously struck – with input from hundreds of thousands of commenters and numerous courts – between women's need for a critical preventive service and certain institutions' religious beliefs, and they did so without any statutory authority or even a reasoned explanation. The rule is therefore unlawful under the APA.[79]

Specifically, the IFR is in excess of statutory authority. The IFR is contrary to Section 1557 of the ACA, 42 U.S.C. § 18116, which prohibits sex discrimination in certain health programs and activities, because it sanctions sex discrimination by allowing employers and universities to direct health insurance companies to prevent their employees and students from receiving contraceptive coverage. The IFR is also contrary to Section 1554 of the ACA, which prohibits the Secretary of Health and Human Services from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[80] As discussed throughout this comment, some women have historically been unable to obtain contraception because of cost barriers. By permitting objecting institutions to deny contraceptive coverage, the IFR erects unreasonable barriers to medical care and impedes timely access to contraception. The IFR is therefore invalid in violation of 5 U.S.C. § 706(2) because they are supported by no valid justification, contradict the ACA and the U.S. Constitution, and exceed statutory jurisdiction, authority or limitations.[81]

For each of these reasons, the IFR violates the APA and should be rescinded.

VII. Justifications for the IFR Do Not Meet Basic Scientific Standards.

Public health policies and activities must be firmly based on scientifically valid and appropriate terms and evidence. The IFR does not meet the high standard of scientific evidence used by the IOM and WPSI, instead prioritizing the religious beliefs of individuals over evidence-based medical recommendations.

The Departments make false and misleading statements in this IFR to undermine the contraceptive benefit. The Departments understate the efficacy and health benefits of contraceptives and overstate the health risks of contraceptives by selectively interpreting data, overlooking well-established evidence and promoting unfounded doubt. Further, the IFR falsely asserts certain types of FDA-approved contraceptive methods are abortifacients. The IFR thus causes dual harm by undermining women's access to essential preventive health care and undermining the integrity of science in governance.

The Departments serve a critical role in collecting and managing important information and data on issues that are vital to the public. In making policy, it is essential that the

Departments enhance their credibility on issues of science and evidence, not undermine it. Thus, the Departments must take full advantage of their resources to inform their decision-making by the best available evidence and data. The IFR, however, shows that the Departments did not seriously consider these elements, which can only undermine the Departments' reputations as reliable sources of information.

A. Contraception Prevents Unintended Pregnancy and Improves the Health of Women and Children.

As an example of how the Departments are not utilizing the best available science and evidence with dire consequences for public health, the Departments make several misstatements that ignore prevailing evidence regarding the efficacy, health benefits and health risks of contraceptives. The Departments fail to acknowledge that contraceptive efficacy in preventing unintended pregnancy is well established and supported in evidence.[82] Not only does contraception prevent unintended pregnancy,[83] but the prevention of unintended pregnancy is associated with life-long health benefits for both women and children that the Departments fully ignore.

As described above, contraceptive efficacy at preventing unintended pregnancy is supported by decades of rigorous evidence and by the government itself.[84] The U.S. Food and Drug Administration ("FDA") must approve all new drugs and devices by showing that they are safe and effective through rigorous scientific testing. The federal government itself has thus approved contraceptives for safely and effectively preventing unintended pregnancies.[85] The Departments' misrepresentation of "complexity and uncertainty in the relationship between contraceptive access, contraceptive use, and unintended pregnancy"[86] is false and relies heavily on cherry-picked citations instead of accurately reflecting the weight of the evidence.

In truth, contraception enables women, including teens, to prevent unintended pregnancy and control the timing of a desired pregnancy.[87] The Centers for Disease Control and Prevention named family planning one of the ten great public health achievements of the past century,[88] and family planning is widely credited for contributing to women's societal, educational and economic gains.[89] The ACA's contraceptive coverage benefit has contributed to a dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[90]

B. The Health Risks of Contraceptives Are Overstated and Misrepresented.

The Departments go further, selectively interpreting data in order to overstate "negative health effects" associated with contraceptives.[91] This includes misleading assertions of an association between contraceptive use, breast cancer and cervical cancer, as well as vascular events and "risky sexual behavior."[92] The Departments ignore substantial evidence to the contrary, and ignore the balance of significant non-contraceptive health benefits associated with contraceptive use. Certainly it is true that, as with any medication, some types or methods of contraception may be contraindicated for patients with certain medical conditions, including high blood pressure, lupus or a history of breast cancer.[93] Some women may also want to avoid side effects, such as changes to menstrual flow.[94] But the Departments fail to recognize that this means that patients and health care providers, not

employers and agencies, should determine the right contraceptive for an individual woman's health care needs.

C. Contraceptives Do Not Increase Sexual Activity Among Adolescents.

The Departments' claim that contraceptives may lead to "risky sexual behavior"[95] is similarly unfounded. Increased access to contraception is not associated with a change or increase in sexual behaviors.[96] Instead, research has shown that school-based health centers that provide access to contraceptives are proven to increase use of contraceptives by already sexually active students, not to increase prevalence of sexual activity.[97] In the "CHOICE Project," a large-scale U.S. study aimed at reducing unintended pregnancy by providing no-cost contraception, participants reported no change in their sexual activities after receiving contraceptives.[98] Thanks in part to the ACA's contraceptive coverage benefit, the teen pregnancy rate is at its lowest point in at least 80 years.[99]

D. Contraceptives Do Not Interfere with an Existing Pregnancy.

The IFR refers to the false assertion that some FDA-approved methods of contraception "prevent implantation of an embryo," and are thus abortifacients.[100] This is inaccurate and goes against longstanding medical evidence.

Policies that restrict women's access to preventive health care should not be based on falsehoods that are not supported by science, regardless of who "believes" them. The IFR takes issue with the ACA's coverage of the full range of FDA-approved contraceptive methods because it includes "certain drugs and devices . . . that many persons and organizations believe are abortifacient – that is, as causing early abortion." [101] FDA-approved contraceptive methods are not abortifacients. Every FDA-approved contraceptive acts before implantation, does not interfere with a pregnancy, and is not effective after a fertilized egg has implanted successfully in the uterus, which is when pregnancy begins. [102]

By making the false claim that some FDA-approved methods of contraception may cause abortion, the Departments sideline science in favor of ideology.

VIII. The Departments' Explanation that Other Programs Can Meet the Need for Birth Control Coverage Is Faulty.

The Departments assert that existing government-sponsored programs, such as Medicaid and Title X, and state coverage requirements can serve as alternatives for individuals who will lose access to contraceptive coverage without cost-sharing as a result of this IFR.[103] This assertion fails to recognize that Medicaid and Title X are not designed to absorb the needs of higher income, privately-insured individuals, and do not have the capacity to meet the needs of current enrollees *and* those seeking care at Title X health centers. Further, the existence of these programs is currently threatened by legislative and administrative proposals. With respect to the state laws, the Departments' claim misconstrues the scope and protections of state contraceptive coverage laws, which cannot fill in the coverage gaps caused by this IFR.

A. Medicaid and Title X Programs Are Not Designed to Meet The Needs of Individuals Who Will Lose Contraceptive Coverage and Do Not Have Capacity to Do So.

Safety-net programs like the Title X family planning program and Medicaid are not designed to absorb the unmet needs of higher-income, insured individuals. Title X is the nation's only dedicated source of federal funding for family planning services, and federal law requires Title X-funded health centers to give priority to "persons from low-income families."[104] Low-income individuals receive services at these health centers at low or no cost depending on their family income.[105] Furthermore, Congress did not design Title X as a substitute for employer-sponsored coverage. The Title X statute and regulations contemplate how Title X and third-party payers, including employer-sponsored coverage, will work together to pay for care, directing Title X-funded agencies to seek payment from such third-party payers.[106]

Further, the IFR argues that Title X-funded health centers could fill the gap in contraceptive coverage it creates, and provide care to more patients than are currently served by the program. However, with current funding and resources, the Title X provider network cannot meet the existing need for publicly-funded family planning, let alone absorb the increase in demand that would result from the Departments' IFR. Reductions in funding for Title X already limit the number of patients Title X-funded providers are able to serve.[107] Since 2010, the reported annual number of clients served at Title X sites has dropped from approximately 5.2 million patients to just over 4 million.[108] This decline corresponds to more than $30 million in cuts to Title X's annual appropriated amount over the same period.[109] Requiring otherwise higher-income, privately-insured individuals to use Title X-funded health centers would deplete resources from an already overburdened and underfunded program.

Similarly, Medicaid is a source of coverage designed to meet the unique health care needs of individuals who are low-income. However, unlike Title X, which requires the health centers it funds to take all patients, Medicaid has income and other eligibility requirements for individuals to participate.[110] Many individuals enrolled in Medicaid have extremely low incomes and minimal savings at hand. These individuals also often have complex health needs and lack any resources to address these issues on their own. Medicaid was not built to fill the gaps created by this IFR.

Medicaid enrollees have robust access to health care, including family planning services and supplies, and Medicaid already operates as a very lean program. In spite of this, provider shortages have persisted. The majority (two-thirds) of state Medicaid programs face challenges to securing an adequate number of providers to furnish services to patients.[111] This is particularly true with respect to specialty providers, including OB/GYNs.[112] Given this provider shortage and Medicaid's eligibility requirements discussed above, Medicaid does not have capacity to serve individuals who lose coverage as a result of this IFR.

For many women who will lose access to the contraceptive coverage benefit, Title X and Medicaid will not be real alternatives for securing contraceptive care and counseling.

B. The Political Assault on Medicaid, Title X and Planned Parenthood Health Centers Threaten Women's Access to Contraceptive Care.

Within the last year, as part of the numerous, failed attempts to repeal the ACA, policymakers have sought to radically alter the financial structure of Medicaid.[113] Policymakers continue to try to impose steep cuts to the Medicaid program through the budget process and to undermine the program through regulatory measures. The Department of Health and Human Services has made clear its intent to approve "innovations" to the Medicaid program.[114] These "innovations" may very well include provisions that undermine the ability of individuals eligible to enroll in Medicaid to receive the coverage and health care they need. Finally, Congress and the Trump administration have blatantly threatened women's health by attempting to block Planned Parenthood from participating in Medicaid despite the outsized role that Planned Parenthood plays in delivering family planning care to people with Medicaid coverage. In fact, in 57 percent of counties with a Planned Parenthood health center, Planned Parenthood serves at least half of all safety-net family planning patients with Medicaid coverage.[115]

Unfortunately, Medicaid is not the only health care program that has faced administrative and congressional attacks despite playing a critical role in the health care safety net; Title X has also been targeted. Title X-funded health centers play a particularly important role in serving communities of color.[116] In addition to severe cuts to Title X's budget since 2011, political opponents of reproductive health have repeatedly sought to defund or interfere with patients' access to care under the program.[117] The administration has not only signaled its support for these efforts, but has also put forth its own proposals to restrict access to publicly funded family planning under Title X.[118]

Needless to say, these dangerous proposals would severely limit access to high-quality family planning care for the populations that turn to Title X-funded providers and those who provide care to individuals enrolled in the Medicaid program, including low-income and uninsured women, LGBTQ individuals, communities of color and young people. Indeed, it is puzzling – to say the least – that the Department would specifically mention Title X and Medicaid as fail-safes for those who will lose coverage as a consequence of its IFR given the administration's clear record of hostility toward these programs.

C. Most State Coverage Requirements Fail to Guarantee the Full Range of Contraceptive Methods, Services and Counseling With No Cost-Sharing.

Similarly, the IFR suggests that the existence of state-level contraceptive coverage requirements somehow diminishes the need for a federal requirement. This suggestion ignores the fact that 22 states do not have contraceptive coverage laws at all, and that the federal contraceptive coverage benefit made several important advances over laws in the other 28 states.[119] Only four state laws currently match the federal requirement to cover contraception without cost-sharing such as copayments, deductibles and other out-of-pocket costs.[120] Moreover, few state laws match the federal requirement in terms of the breadth and specificity of the contraceptive methods, services and counseling that are included.[121] And in any event, no state has the authority to regulate plans offered by employers that self-insure, which cover 60 percent of covered workers nationwide.[122]

The Departments are wrong that other programs and legal requirements can meet the gaps in contraceptive coverage created by this rule.

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This IFR will cause people to lose contraceptive coverage, and harm their health and economic well-being. It will exacerbate existing health disparities for marginalized communities. It is discriminatory, violates multiple federal statutes, ignores Congress's intent that birth control be covered by the ACA, and is based on a distorted picture of the science supporting contraception and the federal programs supporting and state laws regarding contraception. For all of these reasons the National Partnership for Women & Families calls on the Departments to rescind the IFR.

If you have any questions regarding these comments, please contact Sarah Lipton-Lubet, Vice President for Reproductive Health and Rights at slipton-lubet@nationalpartnership.org or (202) 986-2600.

Sincerely,

National Partnership for Women & Families

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[1] *See generally* Brief for the National Women's Law Center and Sixty-Eight Other Organizations as *Amicus Curiae* in Support of the Government, Sebelius v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014) (Nos. 13-354, 13-356), https://nwlc.org/wp-content/uploads/2015/08/nwlcsupremecourtamicusbriefcontraceptivecoveragebenefit_1-28-2014.pdf.

[2] This comment uses the term "women" because women are targeted by the IFRs. We recognize, however, that the denial of reproductive health care and insurance coverage for such care also affects people who do not identify as women, including some gender non-conforming people and some transgender men.

[3] NAT'L WOMEN'S L. CTR., NEW DATA ESTIMATES 62.4 MILLION WOMEN HAVE COVERAGE OF BIRTH CONTROL WITHOUT OUT-OF-POCKET COSTS (2017), https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

[4] *See* CARMEN DENAVAS-WAIT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008 TABLE A-2, 36–37 (2009), https://www.census.gov/prod/2009pubs/p60-236.pdf.

[5] USHA RANJI ET AL., KAISER FAMILY FOUND. WOMEN'S HEALTH CARE CHARTBOOK: KEY FINDING FROM THE KAISER WOMEN'S HEALTH SURVEY 4 (2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8164.pdf.

[6] 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, 1206 (2015).

[7] *See, e.g.,* Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills Between 1996 and 2006*, 83 CONTRACEPTION 528, 531 (2011). *See also* INSTITUTE OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (Nat'l Acads. Press, 2011) [hereinafter *Closing the Gaps*]. Another study of nearly 11,000 employees with employer-sponsored coverage found that cost-sharing was associated with reduced use of Pap smears, preventive counseling, and mammography. Geetesh Solanki et al., *The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services*, 34 HEALTH SERVS. RES. 1331, 1342–43 (2000). *See also* DAVID MACHLEDT & JANE PERKINS, NHELP (NAT'L HEALTH L. PROGRAM), MEDICAID PREMIUMS AND COST SHARING 2–3 (2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.WiVrpkpKuUl.

[8] SHEILA D. RUSTGLI ET AL., THE COMMONWEALTH FUND, WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE 3 (2009), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf (finding that, in a given year, 65 percent of women with incomes between $20,000 and $39,999 experienced problems accessing health care services because of cost).

[9] Adam Sonfield et al., *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 CONTRACEPTION 44, 45–47 (2015).

[10] Becker & Polsky, *supra* note 6, at 1206.

[11] Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, 62 NAT'L HEALTH STATS. REP. 1, 3 (2013)

[12] RACHEL K. JONES & JOERG DREWEKE, GUTTMACHER INSTITUTE, COUNTERING CONVENTIONAL WISDOM: NEW EVIDENCE ON RELIGION AND CONTRACEPTIVE US (2011), https://www.guttmacher.org/sites/default/files/report_pdf/religion-and-contraceptive-use.pdf.

[13] *Id*., at 8.

[14] *Id*.

[15] Sonfield et al., *supra* note 9, at 45.

[16] *See, e.g.,* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, WOMEN'S PREVENTIVE SERVS. INITIATIVE, RECOMMENDATIONS FOR PREVENTIVE SERVICES FOR WOMEN FINAL REPORT TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES & SERVICES ADMINISTRATION 85 (2016), https://www.womenspreventivehealth.org/final-report/ [hereinafter *WPSI Final Report*].

[17] *See generally* Agustin Conde-Aguedelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 JAMA 1809 (2006).

[18] *See generally* Amy O. Tsui et al., *Family Planning and the Burden of Unintended Pregnancies*, 32 EPIDEMIOLOGIC REVS. 152 (2010).

[19] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 NEW ENG. J. MED. 843, 845 (2016).

[20] *See* Nicholas J. Kassebaum et al., *Global, Regional, and National Levels and Causes of Maternal Mortality During 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013*, 385 LANCET 980 (2014).

[21] James Trussell, *Contraceptive Failure in the United States,* 83 CONTRACEPTION 397 (2011).

[22] *E.g.,* RACHEL K. JONES, GUTTMACHER INSTITUTE, BEYOND BIRTH CONTROL: THE OVERLOOKED BENEFITS OF ORAL CONTRACEPTIVE PILLS 8 (2011), https://www.guttmacher.org/sites/default/files/report_pdf/beyond-birth-control.pdf.

[23] Adolf E. Schindler, *Non-Contraceptive Benefits of Oral Hormonal Contraceptives*, 11 INT'L J. ENDOCRINOLOGY & METABOLISM 41 (2013). *See also* Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 615: Access to Contraception*, 125 OBSTETRICS & GYNECOLOGY 250 (2015).

[24] *See, e.g.,* Victoria K. Cortessis et al., *Intrauterine Device Use and Cervical Cancer Risk: A Systematic Review and Meta-analysis*, 130 OBSTETRICS & GYNECOLOGY 1226 (2017).

[25] Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages* 27 (Nat'l Bureau of Econ. Research, Working Paper No. 17922, 2012), http://www.nber.org/papers/w17922 ("Our main estimates, therefore, imply that 10 percent of the narrowing in the gender gap during the 1980s and 31 percent during the 1990s can be attributed to early access to the Pill . . . . [T]he effects of the Pill may be larger than we find, but it is not clear how much larger. Even these conservative estimates, however, suggest that the Pill's power to transform childbearing from probabilistic to planned shifted women's career decisions and compensation for decades to come.").

[26] Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception: Perspectives of U.S. Women Seeking Care at Specialized Family Planning Clinics*, 87 CONTRACEPTION 465, 465 (2013) (citations omitted).

[27] While research has primarily focused on oral contraception because it has been an established contraceptive option longer, longer-lasting contraception options that are covered by the contraceptive coverage policy eliminate chances of user error and are generally more effective.

[28] Bailey et al., *supra* note 25, at 26.

[29] *E.g.,* Heinrich Hock, The Pill and the College Attainment of American Women and Men 19 (unpublished manuscript), http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.594.6229&rep=rep1&type=pdf.

[30] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. POL. ECON. 730, 748–51 (2002).

[31] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,728 (Feb. 15, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pr. 147).

[32] Ctrs. for Disease Control & Prevention, *Effectiveness of Family Planning Methods*, https://www.cdc.gov/reproductivehealth/unintendedpregnancy/pdf/contraceptive_methods_508.pdf.

[33] NAT'L WOMEN'S L. CTR., IT SHOULDN'T BE A HEAVY LIFT: FAIR TREATMENT FOR PREGNANCY WORKERS (2013), https://nwlc.org/wp-content/uploads/2015/08/pregnant_workers.pdf.

[34] *See, e.g.,* NAT'L LGBTQ TASK FORCE, BIRTH CONTROL ACCESS FOR LGBTQ PEOPLE: HOW EMPLOYERS WANT TO USE RELIGION TO HARM LGBTQ REPRODUCTIVE RIGHTS, http://www.thetaskforce.org/static_html/downloads/reports/fact_sheets/factsheet_birth_control_access.pdf.

35 Elizabeth M. Saewyc et al., *Sexual Intercourse, Abuse and Pregnancy Among Adolescent Women: Does Sexual Orientation Make a Difference?*, 41 FAM. PLAN. PERSPS. 127, 127 (1999) (citations omitted).

[36] Jeanne M. Marrazzo & Kathleen Stine, *Reproductive Health History of Lesbians: Implications for Care*, 190 AM. J. OBSTETRICS & GYNECOLOGY 1298 (2004).

[37] JEN KATES ET AL., KAISER FAMILY FOUND., HEALTH AND ACCESS TO CARE AND COVERAGE FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER INDIVIDUALS IN THE U.S. 8 (2016), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[38] *See, e.g.,* Caroline Sten Hartnett et al., *Congruence Across Sexual Orientation Dimensions and Risk for Unintended Pregnancy Among Adult U.S. Women*, 27 WOMEN'S HEALTH ISSUES 145 (2017).

[39] Brittany M. Charlton et al., *Sexual Orientation Differences in Teen Pregnancy and Hormonal Contraceptive Use: An Examination Across 2 Generations*, 209 AM. J. OBSTETRICS & GYNECOLOGY 204.e1, e5 (2013).

[40] *Id.* (citation omitted).

[41] Laura Kann et al., Ctrs. for Disease Control & Prevention, *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 – United States and Selected Sites, 2015,* 65 MORBIDITY & MORTALITY WKLY. REP. 1, 17–18 (2017). *See also* Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AM. J. PUB. HEALTH 1379 (2015).

[42] PLANNED PARENTHOOD FED'N OF AM., ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH DISPARITIES AMONG AFRICAN AMERICANS 1 (2015), https://www.plannedparenthood.org/files/3614/2773/6927/AA_Disparities.pdf.

[43] *Id.* (citing Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001–200*, 104 AM. J. PUB. HEALTH S43 (2014)).

[44] *Id.* (citations omitted).

[45] *Id.* (citations omitted).

[46] PLANNED PARENTHOOD FED'N OF AM., ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH DISPARITIES AMONG LATINOS 1 (2015), https://www.plannedparenthood.org/files/2814/2773/6927/Latino_Disparities.pdf (citing AM. CANCER SOC'Y, CANCER FACTS & FIGURES 2015 (2015), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2015/cancer-facts-and-figures-2015.pdf).

[47] *Id.* at 2 (citing LIZA FUENTES ET AL., NAT'L LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, REMOVING STIGMA: TOWARDS A COMPLETE UNDERSTANDING OF YOUNG LATINAS' SEXUAL HEALTH (2010), http://www.latinainstitute.org/sites/default/files/NLIRH-HPWhite-5310-F2.pdf).

[48] *Id.* at 1 (citing AM. CANCER SOC'Y, CANCER FACTS & FIGURES FOR HISPANICS/LATINOS 2012–2014 (2012), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-hispanics-and-latinos/cancer-facts-and-figures-for-hispanics-and-latinos-2012-2014.pdf).

[49] *Id.* (citing ALINA SALGANICOFF ET AL., KAISER FAMILY FOUND., WOMEN AND HEALTH CARE IN THE EARLY YEARS OF THE AFFORDABLE CARE ACT: KEY FINDINGS FROM THE 2013 KAISER WOMEN'S HEALTH SURVEY (2014), www.kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-theearly-years-of-the-affordable-care-act.pdf).

[50] NAT'L P'SHIP FOR WOMEN & FAMILIES, WOMEN'S HEALTH COVERAGE: SOURCES AND RATES OF INSURANCE (2017), http://www.nationalpartnership.org/research-library/health-care/womens-health-coverage-sources-and-rates-of-insurance.pdf (citing *U.S. Census Bureau, Current Population Survey,* https://www.census.gov/cps/data/cpstablecreator.html; U*.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement (CPS-ASEC),* https://www.census.gov/topics/health/health-insurance/guidance/cps-asec.html).

[51] BLACK MAMAS MATTER, CTR. FOR REPRODUCTIVE RIGHTS, RESEARCH OVERVIEW OF MATERNAL MORTALITY AND MORBIDITY IN THE UNITED STATES 2 (2016), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf (citations omitted).

[52] Christine Dehlendorf et al., *Disparities in Family Planning*, 202 AM. J. OBSTETRICS & GYNECOLOGY 214 (2010).

[53] 42 U.S.C. § 300gg–13(a)(4).

[54] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,727 (Feb. 15, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pr. 147).

[55] 155 CONG. REC. S12,021, S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski); *see also id.* at S12,030 (statement of Sen. Dodd) (". . . I support the effort by Senator Mikulski on her efforts to see to it that women are treated equally, and particularly in preventive care[.]").

[56] *Id.* at S12,027 (statement of Sen. Gillibrand) (emphasis added).

[57] *Id.* at S12,027 (statement of Sen. Gillibrand).

[58] 155 CONG. REC. S12,033, S12,052 (daily ed. Dec. 1, 2009) (statement of Sen. Franken). *See also,* 155 CONG. REC. S12,106, S12,114 (daily ed. Dec. 2, 2009) (statement of Sen. Feinstein) ("[The Amendment] will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include . . . family planning . . .").

[59] *See also* 155 CONG. REC. S12,021, S12,025 (daily ed. Dec. 1, 2009) (Sen. Boxer) (stating that preventive care "include[s] . . . family planning services"); 155 CONG. REC. S12,227, 12,277 (daily ed. Dec. 3, 2009) (Sen. Nelson) ("I strongly support the underlying goal of furthering preventive care for women, including . . . family planning."); 155 CONG. REC. S12,664, S12,671 (daily ed. Dec. 8, 2009) (Sen. Durbin) (providing that under the ACA "millions more women will have access to affordable birth control and other contraceptive services.").

[60] *Closing the Gaps, supra* note 7, at 20–21.

[61] *Id*. at 109-10.

[62] *See* Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, https://www.hrsa.gov/womens-guidelines/index.html (last updated Oct. 2017).

[63] *See generally WPSI Final Report, supra* note 16.

[64] Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, https://www.hrsa.gov/womens-guidelines/index.html (last updated Oct. 2017).

[65] *See* Priests for Life v. U.S. Dep't of Health & Human Servs., 772 F.3d 229, 266 (D.C. Cir. 2014) ("The government's interest in a comprehensive, broadly available system is not undercut by . . . the exemptions for religious employers,

small employers and grandfathered plans. The government can have an interest in the uniform application of a law, even if that law allows some exceptions.").

[66] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2800 (2014) (Ginsburg, J., dissenting) (citing "Family and Medical Leave Act of 1993, 29 U. S. C. §2611(4)(A)(i) (applicable to employers with 50 or more employees); Age Discrimination in Employment Act of 1967, 29 U. S. C. §630(b) (originally exempting employers with fewer than 50 employees, 81 Stat. 605, the statute now governs employers with 20 or more employees); Americans With Disabilities Act, 42 U. S. C. §12111(5)(A) (applicable to employers with 15 or more employees); Title VII, 42 U. S. C. §2000e(b) (originally exempting employers with fewer than 25 employees, *see* Arbaugh v. Y & H Corp., 546 U. S. 500, 505, n. 2 (2006), the statute now governs employers with 15 or more employees).").

[67] 42 U.S.C. § 18011; Final Rules for Grandfathered Plans, 80, Fed. Reg. 72,192, 72,191–93 (Nov. 18, 2015) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 144, 146, 147).

[68] *See* Coverage of Certain Preventive Services Under the Affordable Care Act, 80 Fed. Reg. 41,318, 41,319 (July 14, 2015) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pts. 2510, 2590, 45 C.F.R. pt. 147).

[69] GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TRUST , EMPLOYER HEALTH BENEFITS: 2017 ANNUAL SURVEY (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.

[70] *See, e.g.,* Brief *Amicus Curiae* of the American Civil Liberties Union et al., In Support of Respondents at 21, Zubik v. Burwell, 136 S. Ct. 1557 (2016) (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), https://www.aclu.org/sites/default/files/field_document/02.17.16_amicus_brief_in_support_of_respondents-_aclu_et_al.pdf.

[71] *Id.* at 19.

[72] *Id.* at 24–27.

[73] 42 U.S.C. § 18116.

[74] Cutter v. Wilkinson, 544 U.S. 709, 722 (2005); *see also* Estate of Thornton v. Caldor, Inc., 472 U.S. 703, 709-10 (1985).

[75] *Cutter*, 544 U.S. at 726; *see also* Texas Monthly, Inc. v. Bullock, 480 U.S. 1, 18 n.8 (1989).

[76] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2781 n.37 (2014). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that the burdens on third parties must be considered. *See id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790 n.8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting). *See also* Holt v. Hobbs, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

[77] 5 U.S.C. § 553(b), (c).

[78] *Id.* § 553(d).

[79] *Id.* § 706.

[80] *Id.* § 18114(1).

[81] Under the APA, a reviewing court shall "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," *id.* § 706(2)(A), "contrary to a constitutional right," *id*. § 706(2)(B), or "in excess of statutory jurisdiction," *id*. § 706(2)(C).

[82] *See generally WPSI Final Report,* supra note 16. See *also* Trussell, *supra* note 21; Finer & Zolna, *supra* note 19.

[83] *See, e.g.,* Finer & Zolna, *supra* note 19, at 851 ("A likely explanation for the decline in the rate of unintended pregnancy is a change in the frequency and type of contraceptive use over time.").

[84] *See, e.g WPSI Final Report,* supra note 16; Trussell, *supra* note 21; ROBERT A. HATCHER ET AL., CONTRACEPTIVE TECHNOLOGY (Bridging the Gap Commc'ns, 20th ed. 2011); Declaration of Dr. Lawrence Finer in Support of Plaintiffs' Motion for Preliminary Injunction at 4–5, California v. Wright, No. 4:17-cv-05783-HSG (Nov. 9, 2017) [hereinafter *Declaration of Dr. Lawrence Finer*] ("Sexually active couples using no method of contraception have a roughly 85% chance of experiencing a pregnancy in a one-year period, while the risk for those using a contraceptive method ranges from 0.05% to 28%.") (citing Aparna Sundaram et al., *Contraceptive Failure in the United States: Estimates from the 2006–2010 National Survey of Family Growth*, 49 PERSPS. ON SEXUAL & REPRODUCTIVE HEALTH 7 (2017)); Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291(2012);

Finer & Zolna, *supra* note 19; Cynthia C. Harper et al., *Reductions in Pregnancy Rates in the USA with Long-Acting Reversible Contraception: A Cluster Randomised Trial*, 386 LANCET 562 (2015); J. Joseph Speidel & Cynthia C. Harper, *The Potential of Long-Acting Reversible Contraception to Decrease Unintended Pregnancy*, 78 CONTRACEPTION 197 (2008).

[85] *Declaration of Dr. Lawrence Finer*, *supra* note 84, at 5.

[86] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,804 (Oct. 13, 2017) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[87] *See, e.g.,* Heather D. Boonstra, *What is behind the declines in teen pregnancy rates?* 17 GUTTMACHER POL'Y REV. 15 (2014); Laura Lindberg et al., *Understanding the Decline in Adolescent Fertility in the United States, 2007–2012*. 59 J. ADOLESCENT HEALTH 577 (2016).

[88] Ctrs. for Disease Control & Prevention, *Ten Great Public Health Achievements in the 20th Century* (2013), https://www.cdc.gov/about/history/tengpha.htm.

[89] *See, e.g.,* ADAM SONFIELD ET AL., GUTTMACHER INSTITUTE, THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN (2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[90] GUTTMACHER INSTITUTE, UNINTENDED PREGNANCY IN THE UNITED STATES 2 (2016), https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf.

[91] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. at 47,804.

[92] *Id.* at 47,805.

[93] *See, e.g.,* Am. Coll. of Obstetricians & Gynecologists. *FAQ No. 86: Progestin-Only Hormonal Birth Control: Pill and Injection* (2014), https://www.acog.org/Patients/FAQs/Progestin-Only-Hormonal-Birth-Control-Pill-and-Injection; Am. Coll. of Obstetricians & Gynecologists. *FAQ No. 185: Combined Hormonal Birth Control: Pill, Patch, and Ring* (2014), https://www.acog.org/Patients/FAQs/Combined-Hormonal-Birth-Control-Pill-Patch-and-Ring.

[94] JONES, *supra* note 22.

[95] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. at 47,805.

[96] *See, e.g.,* DOUGLAS KIRBY, NAT'L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY, EMERGING ANSWERS 2007: RESEARCH FINDINGS ON PROGRAMS TO REDUCE TEEN PREGNANCY AND SEXUALLY TRANSMITTED DISEASES (2007), https://thenationalcampaign.org/resource/emerging-answers-2007%E2%80%94full-report; Jennifer L. Mayer et al., *Advance Provision of Emergency Contraception Among Adolescent and Young Adult Women: A Systematic Review of Literature*, 24 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 2 (2011).

[97] Mara Minguez et al., *Reproductive Health Impact of a School Health Center*, 56 J. ADOLESCENT HEALTH 338 (2015). *See also* John A. Knopf et al., *School-Based Health Centers to Advance Health Equity*, 51 AM. J. PREVENTIVE MED. 114 (2016).

[98] Gina M. Secura et al., *Change in Sexual Behavior with Provision of No-Cost Contraception*, 123 OBSTETRICS & GYNECOLOGY 771 (2014). *See also* Gretchen Goldman, *The Trump Administration Fakes Science to Justify Restrictions on Birth Control Access,* UNION OF CONCERNED SCIENTISTS BLOG (Oct. 11, 2017, 10:56 AM), http://blog.ucsusa.org/gretchen-goldman/the-trump-administration-fakes-science-to-justify-restrictions-on-birth-control-access.

[99] *Declaration of Dr. Lawrence Finer, supra* note 84, at 8 ("In 2013, the U.S. pregnancy rate among 15–19 year olds was at its lowest point in at least 80 years and had dropped to about one-third of a recent peak rate in 1990.") (citing KATHRYN KOST ET AL., GUTTMACHER INSTITUTE, PREGNANCIES, BIRTHS AND ABORTIONS AMONG ADOLESCENTS AND YOUNG WOMEN IN THE UNITED STATES, 2013: NATIONAL AND STATE TRENDS BY AGE, RACE AND ETHNICITY (2017), https://www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf).

[100] Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. at 47,840.

[101] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,749 (Oct. 13, 2017) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[102] *See, e.g.,* Brief of *Amici Curiae* Physicians for Reproductive Health, et al. in Support of Petitioners at 12, Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014) (No. 13-354).

[103] *See generally* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47803 (as incorporated by Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. at 47,848).

[104] *See* Fam. Plan. Servs. & Population Res. Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504; 42 C.F.R. § 59.5 (a)(6)–(9).

[105] 42 U.S.C. § 300a-4(c)(2); 42 C.F.R. § 59.5(a)(7)–(8).

[106] *Id.* § 300a-4(c)(2) (prohibiting charging persons from a "low-income family" for family planning services "except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge"); 42 CFR § 59.5(a)(7), (9).

[107] 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 (2016). Congress would have to increase federal funding for Title X by more than $450 million to adequately address the existing need for publicly funded contraception.

[108] *See* CHRISTINA FOWLER ET AL., RTI INT'L, FAMILY PLANNING ANNUAL REPORT: 2010 NATIONAL SUMMARY (2011), https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf; CHRISTINA FOWLER ET AL., RTI INT'L, FAMILY PLANNING ANNUAL REPORT: 2016 NATIONAL SUMMARY (2016), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf.

[109] Office of Population Affairs, *Funding History,* https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html (last updated Feb. 21, 2017).

[110] In states that have not expanded Medicaid, income eligibility for this program is quite limited. The median income limit for parents in these states is an annual income of $8,985 a year for a family of three in 2017, and in most states that have not expanded Medicaid, childless adults remain ineligible for this program. Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, KAISER FAMILY FOUND. (Nov. 1, 2017), https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[111] U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICAID: STATES MADE MULTIPLE PROGRAM CHANGES, AND BENEFICIARIES GENERALLY REPORTED ACCESS COMPARABLE TO PRIVATE INSURANCE (2012), http://www.gao.gov/assets/650/649788.pdf; U DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., ACCESS TO CARE: PROVIDER AVAILABILITY IN MEDICAID MANAGED CARE (2014), https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

[112] A recent report from the HHS Office of Inspector General found that many Medicaid managed care plans had provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments to new patients. *Id.* at n.7.

[113] The most recent legislative proposal sponsored by Senators Lindsey Graham and Bill Cassidy would have decimated the Medicaid program by cutting more than one trillion dollars to the program over the next ten years. CONG. BUDGET OFFICE, PRELIMINARY ANALYSIS OF LEGISLATION THAT WOULD REPLACE SUBSIDIES FOR HEALTH CARE WITH BLOCK GRANTS 6 (2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf. The proposal would have repealed Medicaid expansion, converted Medicaid's financing structure to a per capita cap, and would have permitted states to block grant their Medicaid programs for certain communities, resulting in drastic cuts to coverage and services that individuals enrolled in Medicaid need and deserve. MARA YOUDELMAN & KIM LEWIS, NHELP (NAT'L HEALTH L. PROGRAM), TOP 10 CHANGES TO MEDICAID UNDER THE GRAHAM-CASSIDY BILL (2017), https://medicaid.publicrep.org/wp-content/uploads/2017/09/TenChangesMedicaidGrahamCassidy-FINAL.pdf.

[114] Letter from Thomas E. Price, Secretary, U.S. Health & Human Srvs., & Seema Verma, CMS Administrator, to Governors (on file with NHeLP-DC), https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf; Paige Winfield Cunningham, *States Will Be Allowed to Impose Medicaid Work Requirements, Top Federal Official Says*, WASH. POST (Nov. 7, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/11/07/states-will-be-allowed-to-impose-medicaid-work-requirements-top-federal-official-says/?utm_term=.e7af5e014934.

[115] Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 GUTTMACHER POL'Y REV. (2017), https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net.

[116] In 2016, 21 percent of Title X clients identified as Black or African American, 3 percent identified as Asian, and 1 percent identified as either Native Hawaiian, Pacific Islander, American Indian or Alaska Native. Also, 32 percent of Title X patients identified as Hispanic or Latina/o. FOWLER ET AL., 2016 NATIONAL SUMMARY, *supra* note 108.

[117] In 2011, the House voted for the first time in the history of the Title X program to defund the program and the House has proposed to defund it once again for FY 2018. Nat'l Fam. Planning & Reproductive Health Ass'n, *Title X Budget & Appropriation*, https://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Nov. 3, 2017); Make America Secure and Prosperous Appropriations Act, 2018, H.R. 3354, 115th Cong. (2017) ("None of the funds appropriated in this Act may be used to carry out title X of the PHS Act.").

[118] Statement of Administration Policy, White House, H.R. 3354 – Make America Secure and Prosperous Appropriations Act, 2018 (Sept. 5, 2017), https://www.whitehouse.gov/the-press-office/2017/09/05/hr-3354-make-america-secure-and-prosperous-appropriations-act-2018. For instance, the President's FY 2018 budget plan proposed blocking low-income and uninsured patients from obtaining federally-funded health care services, including Title X-funded care, at Planned Parenthood health centers, even though Planned Parenthood health centers currently serve 41 percent of patients that access contraception through Title X nationwide. Kinsey Hasstedt, *Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X*, 20 GUTTMACHER POL'Y REV. (2017), https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x; WHITE HOUSE OFFICE OF MGMT. & BUDGET, THE PRESIDENT'S FISCAL YEAR 2018 BUDGET: OVERVIEW, https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/fact_sheets/2018%20Budget%20Fact%20Sheet_Budget%20Overview.pdf (last visited Nov. 3, 2017).

[119] Guttmacher Institute, *State Laws and Policies: Insurance Coverage of Contraceptives* (2017), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[120] Several additional states have enacted new requirements that will take effect in 2018 or 2019. *See id.*

[121] For example, only three states currently require coverage of female sterilization, and only two states currently require coverage of methods sold over the counter (such as some types of emergency contraception). Several additional states have enacted new requirements that will take effect in 2018 or 2019. *See id.*

[122] GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2017 ANNUAL SURVEY (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.