WASHINGTON
LEGISLATIVE OFFICE

December 5, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

***Submitted electronically via regulations.gov***

**AMERICAN CIVIL LIBERTIES UNION**
WASHINGTON
LEGISLATIVE OFFICE
915 15th STREET, NW, 6TH FL
WASHINGTON, DC 20005
T/202.544.1681
F/202.546.0738
WWW.ACLU.ORG

FAIZ SHAKIR
*DIRECTOR*

NATIONAL OFFICE
125 BROAD STREET, 18TH FL.
NEW YORK, NY 10004-2400
T/212.549.2500



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

Dear Acting Secretary Hargan, Secretary Acosta, and Secretary Mnuchin:

On behalf of the American Civil Liberties Union (ACLU) and our more than two million members and supporters, we submit the following comments to the Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) in response to the Interim Final Rule (IFR) published in the Federal Register on October 13, 2017, entitled "Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act."

The ACLU has a long, proud history of vigorously defending religious liberty and reproductive freedom. We unequivocally oppose the efforts of the Departments to undermine the Patient Protection and Affordable Care Act's (ACA) contraceptive coverage benefit through this IFR. The ACA's women's preventive services requirement was designed to promote access to preventive medicine, reduce future medical costs, and improve the health, equality, and economic security of women[1] and families. Over 62 million women with private insurance now have coverage for vital health care services, including breast and cervical cancer screening, breastfeeding services and supplies, and contraceptive counseling.[2]

With this IFR, the Trump administration will allow virtually any employer or university to deprive women of contraceptive coverage, harming them and their health and well-being. In doing so, it ignores Congress's explicit intent that the ACA require coverage of contraception, discriminates against

[1] 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.

[2] Nat'l Women's L. Ctr., New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs (Sept. 2017), a*vailable at* https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

women, and infringes a woman's fundamental right to contraception in violation of the Constitution and other federal laws. The Departments' decision to publish an interim final rule, without required public input and without statutory authority, also violates the Administrative Procedure Act. In addition, 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 ACLU calls on the Departments to rescind the IFR.

## I. Birth Control Is Essential to Women's Health and Equality

Birth control is essential to women's equality and health, and the health of their families. It enables women to time and space their pregnancies—or to prevent pregnancy altogether—in accordance with their own needs, which improves maternal, child, and family health.[3] Unintended pregnancies are associated with higher rates of long-term health complications for mother and infant. Women with unintended pregnancies are more likely to delay prenatal care, leaving health complications unaddressed and increasing the risk of infant mortality, birth defects, low birth weight, and preterm birth.[4] Women with unintended pregnancies are also at a higher risk for maternal morbidity and mortality, maternal depression, or experiencing physical violence during pregnancy.[5] Unintended pregnancy rates are higher in the United States than in most other developed countries, at approximately 45%.[6] Rates are highest among those least able to afford contraception, particularly those who face additional barriers to accessing health care services such as economic instability and/or discrimination based on race, ethnicity, gender identity, or sexual orientation.[7] The U.S. also has the highest rate of maternal mortality in the developed world.[8] Access to contraception is considered a major factor in reducing rates of maternal mortality and morbidity.

Beyond the well-established evidence that contraceptives are effective at preventing unintended pregnancy, non-contraceptive health benefits include decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, such as endometriosis, myoma, pelvic inflammatory disease, and a decreased risk of endometrial and ovarian cancer.[9] Non-

---

[3] Women's Preventive Services Initiative, *Recommendations for Preventive Services for Women* 83 (2016), *available for download at* https://www.womenspreventivehealth.org/final-report/.

[4] Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA 2006;295:1809–23.

[5] Tsui AO, McDonald-Mosley R, Burke AE. Family Planning and the Burden of Unintended Pregnancies. *Epidemiologic Reviews*. 2010;32(1):152-174. doi:10.1093/epirev/mxq012.

[6] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852,

[7] Declaration of Dr. Lawrence Finer in Support of Plaintiffs' Motion for Preliminary Injunction at ¶ 46, *California v. Wright*, No. 17-cv-5783 (N.D. Cal. Nov. 9, 2017), ECF No. 28-8 [hereinafter Finer Decl.].

[8] Murray, J.L., Wang, H., Kassebaum, N., "Sharp Decline in Maternal and Child Deaths Globally, New Data Show." Institute for Health Metrics and Evaluation. University of Washington. 2016.

[9] Schindler AE. Non-contraceptive benefits of oral hormonal contraceptives. Int J Endocrinol Metab. 2013;11(1):41-7, and Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:250–5.

contraceptive health benefits also include treatment for non-gynecologic conditions.[10] Most women who use birth control do so for both contraceptive and non-contraceptive purposes.[11]

In addition, access to birth control is particularly critical for women with underlying physical and psychological conditions or chronic conditions that 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.[12]

In addition to the medical benefits of contraception, birth control enables women to be equal participants in the social, political, and economic life of the nation. By enabling women to decide if and when to become parents, birth control allows women to access more professional and educational opportunities. Studies show that access to contraception has increased women's wages and lifetime earnings.[13] In fact, the availability of the oral contraceptive pill alone is associated with roughly one-third of the total wage gains for women born from the mid-l940s to the early 1950s.[14] Access to oral contraceptives may also account for up to one-third of the increase in college enrollment by women in the 1970s,[15] which was followed by large increases in women's presence in law, medicine, and other professions.[16]

The Departments have previously acknowledged these significant benefits, noting that prior to the ACA's passage, disparities in healthcare 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."[17] Before the ACA, women whose insurance covered birth control pills still spent 29% of their total out-of-pocket health care expenditure on the pills.[18] Cost was also one of the reasons why "[o]nly two-thirds of the 43 million sexually active women at risk of an unintended pregnancy in 2002 were practicing contraception consistently and correctly all year."[19] Out-of-pocket costs prevented many women from

---

[10] *Id*.; *see also* Cortessis VK, Barrett M, Brown W, et. Al. Intrauterine Device Use and Cervical Cancer Risk; A Systematic Review and Meta-analysis Obstet Gynecol. 2017

[11] Jones RK. Beyond birth control: The overlooked benefits of oral contraceptive pills. New York: Guttmacher Institute, 2011.

[12] *Id*. at 103-104.

[13] See, e.g., Jennifer J. Frost & Laura Duberstein Lindberg, Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics, 87 CONTRACEPTION 465, 467 (2013); Adam Sonfield, et al., Guttmacher Inst., The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children (2013), available at http://www.guttmacher.org/pubs/social-economic-benefits.pdf.

[14] See Martha J. Bailey et al., The Opt-in Revolution? Contraception and the Gender Gap in Wages, 19, 26 (Nat'l Bureau of Econ. Research Working Paper o. 17922, 2012), http://www.nber.org/ papers/wl 7922 (last visited Feb. 9, 2016); Claudia Goldin & Lawrence F. Katz, The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions, 110 J. Pol. Econ. 730, 749 (2002).

[15] Heinrich H. Hock, The Pill and the College Attainment ofAmerican Women and Men 19 (Fla. State Univ., Working Paper 2007).

[16] Claudia Goldin & Lawrence F. Katz, The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions, 110 J. of Pol. Econ. 730, 749 (2002), https://dash.har vard.edu/handle/1 /2624453.

[17] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012).

[18] Testimony of Guttmacher Institute Submitted to the Committee on Preventive Services for Women at 8, Institute of Medicine (2011), http://www.guttmacher.org/pubs/CPSW-testimony.pdf.

[19] *Id*.

accessing preventive services, including contraception.[20] The cost of long-acting reversible contraceptives is particularly prohibitive for some women: oral contraceptives cost $15 to $80 per month, while an intrauterine device (IUD), which is effective for up to five years, can cost $500 to $1000 for the device itself, plus the cost of medical exams and insertion.[21] When cost is not an obstacle, more women choose long acting contraception methods and their rates of unintended pregnancy plummet.[22]

Eliminating cost barriers has helped increase access to contraception for women with employer-sponsored coverage.[23] As a result of the women's preventive services requirement, over 62 million women with private insurance now have coverage of vital health care services, including all FDA-approved contraceptive methods and related education and counseling without out-of-pocket costs.[24] Women saved more than $1.4 billion in out-of-pocket costs on birth control pills in 2013 alone.[25]

## II. The IFR Conflicts With Congress's Express Intent That Birth Control Be Covered as a Preventive Service Under the ACA

When Congress passed the Women's Health Amendment, 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."[26] Women face distinct healthcare challenges because they use more health services than men, yet earn less on average than men.[27] As a result, many women forgo necessary care because of prohibitive patient cost-sharing. Allowing employers and universities to deprive women of contraceptive coverage, as the IFR does, strikes at the very purpose of the contraceptive coverage requirement.

---

[20] Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills between 1996 and 2006*, 83 CONTRACEPTION 491, 531 (2010); *see also* Inst. of Med. of the Nat'l Acads., *Clinical Preventive Services for Women: Closing the Gaps* 19 (2011), https://www.nap.edu/read/13181/chapter/1. Another study of 11,000 employees with employer-sponsored coverage found that cost-sharing 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. RESEARCH 1331, 1342-43 (2000); 1342-43; *see also* David Machledt & Jane Perkins, *Medicaid Premiums & Cost-Sharing* 2-3 (2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.WgCFehNSzeQ.

[21] Finer Decl. at ¶ 26.

[22] *Id*. at ¶ 30.

[23] 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 (2014).

[24] Nat'l Women's L. Ctr., New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs (Sept. 2017), a*vailable at* https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

[25] Nora V. Becker and Daniel Polsky, Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing, Health Affairs, 34, no.7 (2015):1204-1211. Available at http://content.healthaffairs.org/content/34/7/1204.full.pdf+html.

[26] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8727 (Feb. 15, 2012).

[27] U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2008, Table A-2. 2009.

Indeed, Congress intended that the Women's Health Amendment would help alleviate the "punitive practices of insurance companies that charge women more and give [them] less in a benefit" and would "end the punitive practices of the private insurance companies in their gender discrimination."[28] 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 in some instances were 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*.[29]

In considering the Amendment, Congress expressed its expectation that the preventive services covered would include family planning services and, specifically, contraception. For example, Senator Gillibrand stated, "With Senator Mikulski's amendment, even more preventive screening will be covered, including for . . . family planning."[30] Other members of Congress also made clear that contraception would be covered under the Amendment.[31]

To fulfill its statutory mandate, HHS 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."[32] After conducting its analysis, the IOM panel recommended eight preventive services for women that should be covered, including contraceptive coverage.[33] On August 1, 2011, HRSA adopted the recommendations set forth in

---

[28] 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[.]").

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

[30] *Id*.

[31] *Id.* at S12025 (Sen. Boxer) (preventative care "include[s] . . . family planning services"); id. (Sen. Gillibrand) (under the Amendment, "even more preventative screenings will be covered, including . . . family planning"); 155 Cong. Rec. S12114 (Dec. 2, 2009) (Sen. Feinstein) ("The amendment . . . will require insurance plans to cover at no cost basic preventive services" including "family planning."); *id.* at 12274 (Sen. Murray) (the "amendment will make sure this bill provides coverage for important preventive services for women at no cost," including "family planning services"); id. at 12277 (Sen. Nelson) ("I strongly support the underlying goal of furthering preventive care for women, including . . . family planning."); 155 Cong. Rec. S12671 (Dec. 8, 2009) (Sen. Durbin) (under the ACA "millions more women will have access to affordable birth control and other contraceptive services" and that the adopted WHA "would result in more counseling, more contraception, and fewer unintended pregnancies").

[32] Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 20-21 (2011), *available at* http://www.iom.edu/reports/2011/clinical-preventive-services-forwomen-closing-the-gaps.aspx.

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

the IOM Report.[34] These were reaffirmed and 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 the recommendations. These too were adopted by HRSA.

HHS—in adopting the IOM's recommendations and promulgating the contraception regulations, and again adopting the WPSI recommendations—had previously carried out Congress's direction. However, the IFR ignores and undermines Congress's intent.

## III. The IFR Impermissibly Discriminates Based on Sex, In Violation of the Constitution and the ACA

By creating broad exemptions to the ACA's birth control benefit, which has expanded access to contraception for millions of women, the IFR impermissibly restricts access to health insurance that women use and that is essential for women's health and equality by allowing an employer or university to withhold coverage based on religious or moral beliefs.

Religious arguments have long been used in attempts to thwart women's equality, just as they have been used to thwart racial equality.[35] 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.[36] 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.[37]

Like Title VII and other civil rights laws, the birth control benefit was intended to address longstanding discrimination and ensure that women have 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, singling out women for discriminatory treatment. Further, it interferes with the right to contraception encompassed by the fundamental constitutional right to liberty.

### A. The IFR Violates the Fifth Amendment's Guarantee of Equal Protection

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. In particular, the IFR targets and singles out a key preventive service that women need for discriminatory treatment. Contraception and contraception alone is the only covered preventive service

---

[34] *See* Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa. gov/womensguidelines (last visited Feb. 15, 2016).

[35] *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) (No. 14-1418), https://www.aclu.org/sites/default/files/field_document/02.17.16_amicus_brief_in_support_of_respondents-_aclu_et_al.pdf.

[36] *Id.* at 19.

[37] *Id.* at 24-27

employers and universities are free to deny – based on religious objection – to their employees and students. The rule provides no similar exemptions to any other covered service and no covered service that men enjoy.

The IFR sanctions disparities in income and health care costs for women by allowing employers and universities to deny women a benefit adopted to address longstanding discriminatory treatment against women. As noted above, the WHA was adopted to address discrimination in the cost and access to health care and discrimination in women's social and economic status. But with the IFR, the government is intentionally and impermissibly licensing employers to re-impose conditions of inequality. By giving third parties the right to deny women the contraceptive coverage benefit specifically adopted to address longstanding discriminatory treatment against women, the IFR intentionally burdens women in a way that will frustrate women's ability to participate equally in the workforce, education, and civic life. The Supreme Court "has repeatedly recognized" that the government violates Equal Protection when it "denies to women . . . full citizenship stature—equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities."[38]

The Court has also repeatedly made clear that the scope of an individual's liberty rights cannot be dictated by others' preferences, whether those preferences are religious, moral, or of some other nature. In applying the Due Process Clause, the courts define and enforce the liberty of all individuals, and do "not … mandate our own moral code,"[39] or cede the contours of liberty to the views or votes of other citizens.[40] Thus, neither opposition to contraception nor a desire to limit sexual activity to procreative acts – or a moral or religious articulation of any such view – can constitutionally single out some for discriminatory interference. The government cannot, for example, sanction unlimited distribution of contraceptives to married persons, but limit unmarried persons' access for reasons of morality.[41]

Finally, the IFR also sanctions and perpetuates gender stereotypes that have been used to repress women[42]—specifically that controlling fertility is immoral, that any non-procreative sex is harmful and wrong, that a woman's role is to have children and that role is more important than her equal treatment as an employee. But employers' claims to pay women less for reasons of faith have never been countenanced.[43] Indeed, through the IFR, the federal government sanctions

---

[38] *U.S. v. Virginia*, 518 U.S. 515, 532 (1996); *Lindsey v. Shalmy*, 29 F.3d 1382, 1385 (9th Cir. 1994) (the Equal Protection Clause "prohibit[s] state actors from engaging in intentional conduct designed to impede a person's career advancement because of her gender.").

[39] *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 850 (1992)

[40] *Obergefell v. Hodges*, 135 S. Ct. 2584, 2606 (2015); *See also Lawrence v. Texas*, 539 U.S. 558, 571, 577-78 (2003) ('"that the governing majority … has traditionally viewed a particular practice as immoral"' is not a sufficient reason for infringement of individual liberty; recognizing that third parties' condemnation of petitioners' choices had "been shaped by religious beliefs, conceptions of right and acceptable behavior, and respect for the traditional family," including "deep convictions accepted as ethical and moral principles," but holding that those considerations did not justify law's imposition of harm)

[41] *Eisenstadt v. Baird*, 405 U.S. at 450, 453 (1972) (striking restriction on contraception access for unmarried persons that was "cast only in moral terms").

[42] *Virginia*, 518 U.S. at 541-42.

[43] *EEOC v. Fremont Christian Sch.*, 781 F.2d 1362 (9th Cir. 1986) (permitting a religiously affiliated school to deny women health insurance benefits would thwart the purpose of Title VII); *see also Dole v. Shenandoah Baptist*

employers and universities to send women a message that they are second-class citizens in the workforce and educational institutions. This it cannot do.[44] Such sex stereotyping is a form of intentional and impermissible gender discrimination.[45]

### B. The IFR Violates Section 1557 of the ACA

The IFR 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," as that phrase is understood under Title IX.[46] In addition to the reasons the IFR discriminates based on sex discussed above, which all constitute prohibited sex discrimination under Title IX, Title IX also specifically prohibits discrimination on the basis of pregnancy and reproductive capacity as specific form of sex discrimination.[47]

### C. The IFR Impermissibly Infringes on Women's Fundamental Right to Access Contraception

A woman has fundamental right to make her own decisions about whether or not to have a child.[48] Access to contraceptives is an essential part of that individual liberty.[49] This protection for contraceptives is fundamental not only to each woman's "deeply personal" choices about procreation, but also to the broader realization of women's equality in "the economic and social life of the Nation[.]"[50]

Government actions that restrict access to contraceptives must have a sufficiently compelling government interest that justifies the infringement.[51] That scrutiny applies not only to absolute prohibitions on contraceptives, but also to enactments that "dilute[] or adversely affect[]" individuals' ability to access them.[52] For example, the Supreme Court examined a restriction on retail distribution channels for contraceptives that allowed only licensed pharmacists to sell them, and ultimately held that no "compelling state interest" justified that "incursion into constitutionally protected rights."[53]

---

*Church*, 899 F. 2d 1389, 1392 (4th Cir. 1990) (permitting religiously affiliated schools to pay women less for reasons of faith would undermine the Fair Labor Standards Act).

[44] *See Romer v. Evans*, 517 U.S. at 633 (striking down a Colorado law that "singl[ed] out" gay men and lesbians for "disfavored" treatment, stripping them of non-discrimination protections and remedies); *Feeney*, 442 U.S. 256, 279 (1979) (there is discriminatory purpose when a decision maker "selected or reaffirmed a particular course of action at least in part "because of," not merely "in spite of," its adverse effects upon an identifiable group.").

[45] *Id.; see also Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989),

[46] 2 U.S.C. § 18116.

[47] *See* 34 C.F.R. 106.40(b)(1) (2017).

[48] *Carey v. Population Services Int'l*, 431 U.S. 678, 685-88 (1977).

[49] *Id.; see also Obergefell*, 135 S. Ct. at 2599; *Casey*, 505 U.S. at 852-53.

[50] *Casey*, 505 U.S. at 852-53, 856.

[51] *Carey*, 431 U.S. at 684-91.

[52] *Id.*, 431 U.S. at 689-90.

[53] *Id*. at 686, 689-90.

Here, the IFR erects an obstacle to contraceptive use for women who work or attend school at an institution that opposes contraceptive coverage on religious grounds—objecting employers and universities are permitted to deny women a benefit guaranteed by law, namely access to cost-free contraceptive services provided by third parties. The Departments contend that they "do not burden third parties to a degree that counsels against providing the exemptions" because there are "other avenues for obtaining contraception."[54] But there are no "other avenues" that ensure women who lose access to no-cost contraception will be able to obtain no-cost contraception elsewhere. As the government concedes, other government programs target only "low- income women"—women who are ineligible may not participate.[55] Accordingly, the IFR infringes on the fundamental right to contraception.

## IV. The IFR violates the Establishment Clause By Allowing Employers to Use Their Religious Beliefs to Harm Women

The IFR creates a sweeping exemption that allows employers and universities to harm women by stripping them of a right they are otherwise legally entitled to under the ACA: no-cost contraceptive services. The First Amendment protects the fundamental right to freedom of religion and belief. It forbids, however, government action that favors the free exercise of religion to the point of forcing unwilling third parties to bear the costs and burdens of someone else's faith.

The Supreme Court has been clear that any religious accommodation must be "measured so that it does not override other significant interests"[56] or "impose unjustified burdens on other[s]."[57] For example, the Court struck down a statute that granted employees a blanket right not to work on any day they observed as their Sabbath because of the burden and inconvenience it imposed on the employer and fellow workers,[58] and a sales tax exemption for religious periodicals because it increased nonbeneficiaries' tax bills.[59] Moreover, the Supreme Court and lower courts have consistently rejected free exercise challenges when the relief requested would harm non-believers.[60]

---

[54] 82 Fed. Reg. 47807, 47849.

[55] *Id.* at 47807, 47849.

[56] E.g., *Cutter v. Wilkinson*, 544 U.S. 709, 722, 726 (2005); *see also Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985).

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

[58] *Estate of Thornton*, 472 U.S. at 703.

[59] *Texas Monthly, Inc.*, 480 U.S. at 2.

[60] *See, e.g.*, *Bob Jones University v. United States*, 461 U.S. 574, 603-04 (1983) (rejecting free exercise claim of universities with racially discriminatory policies that were based on sincere religious beliefs because the harm caused by race discrimination in education "substantially outweighs whatever burden denial of tax benefits places on petitioners' exercise of their religious beliefs"); *United States v. Lee*, 455 U.S. 252, 261 (1982) (rejecting employer's claimed religious exemption that would "impose the employer's religious faith on ... employees"); *Newman v. Piggie Park Enter., Inc.*, 390 U.S. 400, 402 n.5 (1968) (rejecting as "frivolous" a free exercise challenge to the federal public accommodations law brought by a restaurant owner who refused to serve African Americans based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392, 1397-99 (4th Cir. 1990); *EEOC v. Fremont Christian Sch.*, 781 F.2d 1362, 1364, 1368-69 (9th Cir. 1986).

*Hobby Lobby* and *Zubik* are consistent with these precedents and recognize the Court's concern that religious accommodations should not burden third parties.[61] In *Hobby* Lobby, the Court explained that the effect of its holding "on the women employed by Hobby Lobby . . . would be precisely zero" because employees would still be entitled to "all FDA-approved contraceptives without cost sharing" under the accommodation.[62] In *Zubik*, the Court once again stressed the importance of finding an approach that "accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans receive full and equal health coverage, including contraceptive coverage."[63] The IFR clearly fails this constitutional do-no-harm test, by imposing significant harm on women who do not share their bosses' beliefs.

## V. 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 Administrative Procedure Act (APA). Specifically, the Departments failed to comply with the APA's requirements in three key ways: by skipping notice and comment rulemaking without good cause, by promulgating the IFR without statutory authority, and by acting arbitrarily and capriciously in issuing this IFR.

### A. The Departments Fail to Comply With Notice and Comment Rulemaking Procedure

The APA requires an agency to follow notice and comment procedures, including publishing a rule 30 days prior to its effective date,[64] to provide "interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments."[65] Here, the Departments failed to publish a Notice of Proposed Rule Making, failed to solicit comments on the rules they were considering, and failed to consider all relevant comments before finalizing the rules. Instead, they made the rules effective immediately—a full week before publication in the Federal Register—and before they even requested public comment.

An agency can skip the notice and comment process only if it can establish good cause to do so. Good cause is narrowly construed,[66] existing only where public comment is "impracticable, unnecessary, or contrary to the public interest."[67] It plainly does not exist here.

The Departments argue that the public previously commented on related regulations, and therefore has already had an opportunity to engage. But relying on comments submitted during prior comment periods in response to related regulations does not meet the notice and comment

---

[61] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014); *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

[62] *Hobby Lobby*, 134 S. Ct. at 2760. 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 2781 n.37.; *id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n.8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting).

[63] *Zubik*, 136 S. Ct. at 1560.

[64] 5 U.S.C. § 553(d).

[65] 5 U.S.C. § 553(b), (c).

[66] *Util. Solid Waste Activities Grp. v. E.P.A.*, 236 F.3d 749, 754 (D.C. Cir. 2001)

[67] 5 U.S.C. § 553(b)(3)(B).

requirements under the APA, because no prior regulatory proposal contemplated allowing any religiously affiliated non-profit or for-profit company to completely block access to contraceptive coverage for their employees without providing a seamless alternative to ensure that impacted women continue to receive no-cost contraceptive services. The ACLU has submitted comments during every previous notice and comment periods, and none provided an opportunity to address the specific issues raised by the current IFR.

The Departments also argue that the IFR 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 the desires of a handful of employers and universities that are advocating for this change certainly does not eliminate the needs of the public at large to weigh in on such a wide-reaching regulation. Moreover, while the IFR may have resolved some cases it has spawned at least seven *new* lawsuits.

### B. The Departments Lack Statutory Authority for the IFR

Further, the IFR exceeds statutory authority. The Departments cannot create broad exemptions to a validly enacted law without authorization from Congress, and it is undisputed that Congress did not include a broad exemption of the kind created by the IFR in the women's preventive services provision of the ACA. Congress in fact rejected just such an exemption in 2012, when Senator Blunt introduced an amendment to allow any health plan or provider to opt out of providing any ACA-required health service—including but not limited to contraception—because of "religious beliefs or moral convictions."[68] Congress's refusal to pass that amendment, which would have achieved the result the Departments now seek with the IFR, should "weigh[] heavily against the Government's interpretation."[69]

Yet, in order to justify the IFR's sweeping exemption, the Departments reference the mere existence of religious and moral exemptions in *other* statutes—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. These laws are irrelevant to the women's preventive services provision of the ACA, and the Departments' attempt to misconstrue them further proves that there is no direct and clear authority to create this exemption.

The IFR is also contrary to Section 1554 of the ACA, which prohibits the Secretary of HHS from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[70] As discussed throughout this comment, some women have historically been unable to obtain contraception because of cost barriers. By the government's own conservative estimate, more than 120,000 women will face substantial economic barriers to contraception access—a $70.1 million economic impact as a result of lost contraceptive coverage averaging more than $500 per woman— as a result of this new rule. Women may also now forgo longer-acting, more expensive but more effective forms of contraception as a result of this rule.[71]

[68] S. Amdt. 1520 § (b)(1), amendment to S. 1813, 158 Cong. Rec. S539 (Feb. 9, 2012).
[69] *Hamdan v. Rumsfeld*, 548 U.S. at 579-80.
[70] 42 U.S.C. § 18114(1).
[71] Finer Decl. at ¶ 40.

By permitting objecting institutions to deny no-cost contraceptive coverage, the rule erects unreasonable barriers to medical care and impedes timely access to contraception for women.

The Departments also point to the fact that Congress excluded certain "grandfathered" plans as evidence of precedent for the IFR. But, the existence of plans that are grandfathered from the ACA's contraceptive coverage requirement does not diminish Congress's intent to maximize the number of women who have contraceptive coverage.[72] Federal statutes "often include exemptions for small employers, and such provisions have never been held to undermine the interests served by these statutes."[73] Additionally, this exemption was intended as a temporary means for transitioning employers to full compliance,[74] and the number of employer-sponsored grandfathered plans has decreased steadily since 2010.[75]

### C. The Departments Have Acted Arbitrarily and Capriciously

Finally, the Departments' action in issuing this IFR constitutes arbitrary and capricious behavior. In unilaterally broadening the existing exemption and making the accommodation optional, the Departments jettisoned the approach that was reached after input from hundreds of thousands of commenters and numerous courts. The Departments eliminated this approach without any statutory authority or even a reasoned explanation.

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

## VI. The IFR Is Not Required by the Religious Freedom Restoration Act

The Departments claim that the accommodation, which until the IFR was published ensured that women would receive contraception coverage regardless of their employers' or universities' objections, violated the Religious Freedom Restoration Act (RFRA), making the IFR immediately necessary "to cure such violations."[76] This argument is not supported by the law. RFRA prohibits the government from placing a substantial burden on a person's exercise of religion, unless the government demonstrates that it has a compelling interest to do so, and is using the least restrictive means of furthering that compelling governmental interest.[77]

---

[72] *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.").

[73] *Hobby Lobby*, 134 S. Ct. at 2800 (2014) (Ginsburg, J., dissenting); *see, e.g.*, 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, Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202, 81 Stat. 605 (1967), 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).

[74] Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. at 39,887 n.49; *Hobby Lobby*, 134 S. Ct. at 2800-01 (Ginsburg, J., dissenting).

[75] Gary Claxton et al., KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2017 ANNUAL SURVEY 204 (2017), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.

[76] 82 Fed. Reg. 47,814-15; 82 Fed. Reg. 47,848.

[77] 42 U.S.C. §§ 2000bb-1(a), (b).

Here, the accommodation, which only requires an employer to fill out a single page form to notify the government of its objections, did not substantially burden[78] any entity's exercise of religion. In fact, the Departments concede that "a majority of Federal appeals courts have held that the accommodation does not impose a substantial burden" on objecting religious entities.[79] Indeed, eight of the nine federal courts of appeal to address the issue held that the accommodation does not substantially burden the religious exercise of any objecting entity.[80] The Departments, which for years explained that the accommodation does not impose a substantial burden under RFRA,[81] now reverse course without a sufficient basis to do so.

Even if the accommodation could be construed to impose a substantial burden on an employer's exercise of religion, courts have found that ensuring seamless contraception coverage furthers compelling government interests, including "promoting public health and gender equality."[82] In the Departments' own words, failing to "adequately serve the unique health needs of women" places "women in the workforce at a disadvantage compared to their male co-workers," while "researchers have shown that access to contraception improves the social and economic status of women."[83]

RFRA does not justify, and certainly does not require, the Departments' actions in promulgating the IFR.

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

As the nation's health policy center, HHS 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 over evidence-based medical recommendations. The Departments make several false and misleading statements to undermine the contraceptive benefit, including assertions of doubt that contraception reduces the risk of unintended pregnancy, which are entirely unfounded and unsupported by evidence.[84]

### A. Contraceptives Do Not Interfere With an Existing Pregnancy

[78] A "substantial burden" on religious exercise exists "when government action puts 'substantial pressure on an adherent to modify his behavior and to violate his beliefs.'" *Kaemmerling v. Lappin*, 553 F.3d 669, 678 (D.C. Cir. 2008) (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 718 (1981)). A burden is not substantial when it places only "[a]n inconsequential or *de minimis* burden on religious practice[. . . .]" *Kaemmerling*, 553 F.3d at 678. A "religious adherent's distaste for what the law requires of a third party is not, in itself, a substantial burden; that is true even if the third party's conduct … offends the religious adherent's sincere religious sensibilities." *Priests for Life v. HHS*, 772 F.3d 229, 256 (D.C. Cir. 2014).

[79] 82 Fed. Reg. 47800.

[80] Although these decisions were vacated and remanded by the Supreme Court in *Zubik* to allow the parties to come to an agreement, because the Supreme Court "[e]xpress[ed] no view on the merits," *Zubik*, 136 S. Ct. at 1560, these decisions' discussion of the merits continue to be persuasive authority, and we cite them herein.

[81] *See, e.g.*, 78 Fed. Reg. 39,886-87.

[82] *Priests for Life*, 772 F.3d at 263; *see also* 78 Fed. Reg. 39,873.

[83] 77 Fed. Reg. 8728.

[84] Finer Decl at. ¶ 10-14.

Policies that restrict women's access to preventive health care should not be based on falsehoods. The Rule takes issue with the IOM recommended coverage of the full range of U.S. Food and Drug Administration (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."[85] 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.[86]

### B. Contraceptives Are Medication and Carry Risks Like *Any* Medication

The Rule raises concerns about the "negative health effects" of contraception.[87] As with any medication, certain types of contraception may be contraindicated for patients with particular medical conditions.[88, 89] However, the Rule suggests that contraception increases the risk of venous thromboembolism (VTE). In fact, VTE among oral contraceptive users is very low and is much lower than the risk of VTE during pregnancy or in the immediate postpartum period.[90] The Rule also suggests contraception increases the risk of breast cancer, but there is no proven increased risk of breast cancer among contraceptive users, particularly those under 40 years old.[91]

### C. Contraceptives Do Not Increase Sexual Activity Among Adolescents

The Rule suggests that contraceptive coverage could "affect risky sexual behavior in a negative way."[92] Increased access to contraception is not associated with increased unsafe sexual behavior or increased sexual activity.[93] In fact, research has shown school-based health centers that provide access to contraceptives are proven to increase use of contraceptives by already sexually

---

[85] 82 Fed. Reg. 47,792, 47,749 (Oct. 13, 2017).

[86] Brief for Physicians for Reproductive Health, American College of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Respondents, *Sebelius v. Hobby Lobby*, 573 U.S. XXX (2014) (No. 13-354), available at acog.org/~/media/Departments/Government%20Relations%20and%20Outreach/20131021AmicusHobby.pdf?. Moreover, the Department of Health and Human Services defines pregnancy as beginning at implantation. 45 C.F.R. § 46.202(f) (2017).

[87] 82 Fed. Reg. 47,792, 47,804 (Oct. 13, 2017).

[88] Progestin-only hormonal birth control: pill and injection. FAQ No. 86. American College of Obstetricians and Gynecologists. July 2014.

[89] Combined hormonal birth control: pill, patch, and ring. FAQ No. 185. American College of Obstetricians and Gynecologists. July 2014.

[90] Risk of venous thromboembolism among users of drospirenone-containing oral contraceptive pills. Committee Opinion No. 540. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:1239–42.

[91] Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.

[92] 82 Fed. Reg. 47,792, 47,805 (Oct. 13, 2017).

[93] Finer Decl. at ¶ 2-24; Kirby D. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. 2009; *see also* Meyer JL, Gold MA, Haggerty CL. Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature. J Pediatr Adolesc Gynecol. 2011;24(1):2–9).

active students, not to increase onset of sexual activity.[94] On the other hand, young women who did not use birth control at first sexual intercourse were twice as likely to become teen mothers.[95] Overall, increased access to and use of contraception has contributed to a dramatic decline in rates of adolescent pregnancy.[96]

The Departments should rescind the IFR because it is not evidence-based and does not withstand basic scientific scrutiny.

## 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.[97] 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 those currently enrolled in private insurance *and* those already seeking care at Title X health centers. Further, the existence of the programs is 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."[98] Low-income individuals receive services at these health centers at low or no cost depending on their family income.[99] 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,

[94] Minguez M, Santelli JS, Gibson E, Orr M, & Samant, S. Reproductive health impact of a school health center. Journal of Adolescent health, 2015;56(3), 338-344; *see also* Knopf JA, Finnie RKC, Peng Y, et al. Community Preventive Services Task Force. School-based health centers to advance health equity: a Community Guide systematic review. American Journal of Preventive Medicine 2016;51(1):114–26.

[95] *Id*.

[96] Lindberg L, Santelli J, Desai S. Understanding the Decline in Adolescent Fertility in the United States, 2007–2012. J Adolesc health. 2016;59(5):577-583. DOI: 10.1016/j.jadohealth.2016.06.024.

[97] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47803 (Oct. 13, 2017) (to be codified at 45 C.F.R. 147, pt. 147).

[98] *See* Fam. Plan. Servs. & Population Res. Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504, and 42 CFR § 59.5 (a)(6-9).

[99] 42 U.S.C. § 300a-4(c)(2); 42 C.F.R. § 59.5(a)(7)-(8).

including employer-sponsored coverage, will work together to pay for care, directing Title X-funded agencies to seek payment from such third-party payers.[100]

Additionally, 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 Department's rules. Reductions in funding for Title X already limit the number of patients Title X-funded providers are able to serve.[101] 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.[102] This decline corresponds to over $30 million in cuts to Title X's annual appropriated amount over the same period.[103] Requiring otherwise higher-income, privately insured individuals to use Title X-funded health centers would deplete resources from an already overburdened and underfunded program.

Like Title X, Medicaid is a source of coverage designed to meet the unique health care needs of individuals who are low-income. However, unlike Title X, Medicaid has income and other eligibility requirements for individuals to participate.[104] Many individuals enrolled in Medicaid have extremely low incomes and minimal savings at hand. These individuals also face severe health problems and lack any resources to address these issues on their own, unlike individuals with higher incomes and employer-sponsored coverage.

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.[105] This is particularly

---

[100] 42 U.S.C. § 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).

[101] August, Euna M. et al., "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (2016), available at http://doi.org/10.2105/AJPH.2015.302928. Congress would have to increase federal funding for Title X by over $450 million to adequately address the existing need for publicly funded contraception.

[102] *See* Fowler, CI, Lloyd, SW, Gable, J, Wang, J, and Krieger, K, *Family Planning Annual Report: 2010 National Summary*, RTI International (Sept. 2011), available at https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf; Fowler, C.I, Gable, J., Wang, J., & Lasater, B, *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[103] U.S. Dept. of Health and Human Servs., Funding History HHS.Gov (2017), available at https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html (last visited Nov 3, 2017).

[104] 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 Henry J. Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, (2017), https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[105] U.S. Government Accountability Office. "States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance." (Nov. 2012). http://www.gao.gov/assets/650/649788.pdf; U.S. Department of Health and Human Services. Office of Inspector General. "Access to Care: Provider Availability in Medicaid Managed Care." (Dec. 2014). http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

true with respect to specialty providers, including OB/GYNs.[106] 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.[107] Policymakers continue to try to impose steep cuts to the Medicaid program through the budget process and to undermine the program through regulatory measures. HHS has made clear its intent to approve "innovations" to the Medicaid program.[108] These "innovations" may very well include provisions that undermine the ability of individuals qualified 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 family planning patients with Medicaid coverage.[109]

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. In fact, Title X-funded health centers play a particularly important role in serving

---

[106] 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. U.S. Department of Health and Human Services, supra at note 7.

[107] The most recent legislative proposal sponsored by Senators Lindsey Graham and Bill Cassidy would have decimated the Medicaid program by cutting over 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, (Sept. 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, Nat'l Health Law Program, Top 10 Changes to Medicaid Under the Graham-Cassidy Bill, (Sept. 14, 2017), http://www.healthlaw.org/publications/browse-all-publications/top-10-changes-to-medicaid-under-graham-cassidy-bill#.Wft9mmhSzIV.

[108] Letter from Secretary Tom E. Price and CMS Administrator, Seema Verma, to Governors (on file with NHeLP-DC), https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf and 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=.0513a6c28c8e.

[109] Kinsey Hasstedt, Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net, Guttmacher Policy Review, (2017), https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net.

communities of color.[110] 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.[111] 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.[112]

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 Departments would specifically mention Title X and Medicaid as failsafes 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 diminish the need for a federal requirement. This suggestion ignores the fact that twenty-two states do not have contraceptive coverage laws at all, and that the federal contraceptive coverage requirement made several important advances over laws in the other twenty-eight states.[113] Only four state laws currently match the federal requirement to cover contraception without copayments, deductibles and other out-of-pocket costs.[114] Moreover, few state laws match the federal requirement in terms of the breadth and specificity of the

---

[110] 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, C. I., Gable, J., Wang, J., & Lasater, B., *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[111] 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. *Title X, Budget & Appropriations*, Nat'l Family Planning & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations, (last updated 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.").

[112] The White House, Statement Of Administration Policy: H.R. 3354 — Make America Secure and Prosperous Appropriations Act, 2018 (Rep. Frelinghuysen, R-NJ) (Sept. 5, 2017), available at 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, *Guttmacher Policy Review*, (Aug. 2017), available at https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x, and White House, Office of Management and Budget, The President's Fiscal Year 2018 Budget: Overview (May 2017), available at 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).

[113] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of October 2017)*, 2017, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[114] *Id*. Several additional states have enacted new requirements that will take effect in 2018 or 2019.

contraceptive methods, services, and counseling that are included.[115] And in any event, no state has the authority to regulate plans offered by employers that self-insure, which cover 60% of covered workers nationwide.[116]

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

---

This IFR will cause people to lose contraceptive coverage, and harm their health and well-being. It is discriminatory, violates multiple federal statutes and the Constitution, 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 ACLU calls on the Departments to rescind the IFR.

Should you have any additional questions or require additional information, please contact Georgeanne Usova at gusova@aclu.org.

Sincerely,

Faiz Shakir
Director, Washington Legislative Office

Georgeanne M. Usova
Legislative Counsel

[115] *Id.* 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.

[116] Claxton G et al., *Employer Health Benefits: 2017 Annual Survey*, Menlo Park, CA: Kaiser Family Foundation; and Chicago: Health Research & Educational Trust, 2017, https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/.