No. 19-10754

In the United States Court of Appeals for the Fifth Circuit

RICHARD W. DEOTTE, ON BEHALF OF HIMSELF AND OTHERS SIMILARLY SITUATED, ET AL., PLAINTIFFS-APPELLEES,

v.

STATE OF NEVADA, MOVANT-APPELLANT

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS (CIV. NO. 18-825) (THE HONORABLE REED CHARLES O'CONNOR, J.)

BRIEF OF PLANNED PARENTHOOD FEDERATION OF AMERICA, NATIONAL HEALTH LAW PROGRAM, AND NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION AS AMICI CURIAE SUPPORTING MOVANT-APPELLANT

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in Fifth Circuit Rule 28.2.1, have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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INTEREST OF AMICI CURIAE[1]

Founded over 100 years ago, Planned Parenthood Federation of America ("PPFA") is the oldest and largest provider of reproductive health care in the United States, delivering medical services to approximately 2.4 million individuals each year through more than 600 health centers operated by 53 affiliates. Its mission is to provide comprehensive reproductive health care services and related educational programs, and to advocate for public policies to ensure access to health services. In particular, PPFA provides high-quality reproductive health care to individuals and communities facing serious barriers to obtaining such care—especially low-income individuals, individuals located in rural and other medically underserved areas, and communities of color.

The National Health Law Program ("NHeLP") is a 50-year-old public interest law firm that works to advance access to quality health care, including to the full range of reproductive health care services, and to protect the legal rights of lower-income people and people with disabilities. NHeLP engages in education, policy analysis, administrative advocacy, and litigation at both state and federal levels.

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

The National Family Planning and Reproductive Health Association ("NFPRHA") is a nearly 50-year-old national, nonprofit membership organization established to ensure access to voluntary, comprehensive, and culturally sensitive family planning and sexual health care services, and to support reproductive freedom for all. NFPRHA represents more than 850 health care organizations and individuals in all 50 states, the District of Columbia, and the territories. Its members include state, county, and local health departments; private, nonprofit family-planning organizations (including PPFA affiliates); family planning councils; hospital-based clinics; and Federally Qualified Health Centers ("FQHCs"). NFPRHA's members operate or fund more than 3,500 health centers that provide high-quality family planning and related health services to more than 3.7 million low-income, uninsured, or underinsured individuals each year.

SUMMARY OF ARGUMENT

Since 2012, the federal government has recognized that contraception is a key preventive health care service that, under the Patient Protection and Affordable Care Act (the "ACA"), insurers must cover for patients with no cost sharing (the "Contraceptive Coverage Benefit"). Yet Plaintiffs-Appellees—and countless anonymous employers across the nation—seeking to skirt the Contraceptive Coverage Benefit—have challenged the law under the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb ("RFRA"), as a purported

class. If allowed to stand, the judgment below (the "Permanent Injunction") would deprive large numbers of individuals nationwide of essential access to no-cost preventive health care guaranteed by the ACA. (*See* ROA.1586–88, .2083–85.) Only Nevada, the Movant-Intervenor, is willing and able to defend the Contraceptive Coverage Benefit in this appeal.

That is unsurprising. The named defendants in the court below (the "Federal Defendants") sought to accomplish the same ends as Plaintiffs-Appellees, but were blocked by injunctions granted by numerous district courts and upheld by other Courts of Appeals.[2] Specifically, in November 2018, the U.S. Department of Health and Human Services ("HHS") promulgated a pair of rules (the "Expanded Exemptions") that would have allowed broad categories of employers to opt out of the Contraceptive Coverage Benefit on the religious grounds recognized by the Permanent Injunction.[3] Like the Permanent Injunction, the Expanded Exemptions would have left employees of certain objecting employers without access to no-cost contraception guaranteed by the ACA. The Permanent Injunction provides an end-run around the adjudication of those lawsuits and, demonstrating the alignment of Plaintiffs-Appellees' and the Federal Defendants' interests, the Federal Defendants *never*

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[2] *See, e.g.*, *California* v. *U.S. Dep't Health & Human Servs.*, 941 F.3d 410 (9th Cir. 2019); *Pennsylvania* v. *President United States*, 930 F.3d 543 (3d Cir. 2019).

[3] *See* 45 C.F.R. § 147.132 (2019); 45 C.F.R. § 147.133 (2019).

even answered the complaint in the District Court. The Permanent Injunction should not evade scrutiny when there is an intervenor with standing to defend the Contraceptive Coverage Benefit.

In addition to addressing Nevada's intervenor standing, this brief dispels arguments advanced by opponents of the Contraceptive Coverage Benefit that only *de minimis* harm will befall individuals who lose coverage due to the Permanent Injunction. Some—including, at one time, HHS[4]—have claimed that safety net programs, such as Title X and Medicaid, could fill the gap in no-cost contraceptive coverage caused by exempting objecting employers from the requirement. They cannot.

First, this brief describes the background of the Contraceptive Coverage Benefit and why it was deemed an essential preventive health care service under the ACA. *Second*, it explains why safety net programs are insufficient to fill the gap in no-cost contraceptive coverage caused by the Permanent Injunction, particularly in light of recent changes to Title X and Medicaid that have diverted resources even from the individuals these programs are meant to serve.

For these and other reasons, *amici* submit this brief in support of Movant-Appellant and reversal of the decisions below.

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

ARGUMENT

I. NEVADA HAS STANDING TO DEFEND THE CONTRACEPTIVE MANDATE.

Nevada easily demonstrates a concrete and constitutionally sufficient "stake in the outcome of the controversy" that confers standing to bring this appeal. *See Susan B. Anthony List* v. *Driehaus*, 573 U.S. 149, 158 (2014). In the court below, Nevada submitted undisputed evidence that between 600 and 1,200 of its residents would be harmed by the nationwide relief the District Court granted. (ROA.1596.) Even HHS estimated that the Expanded Exemptions would deprive up to 120,000 women of contraceptive coverage nationwide,[5] including some in Nevada. Plaintiffs-Appellees cannot credibly suggest that there is any daylight between the employers who would avail themselves of the Expanded Exemptions and those who are now included in the nationwide class.

For reasons described *infra*, many of those Nevada residents who lose coverage due to the Permanent Injunction will be unable to turn to federal safety net programs like Medicaid and Title X for no-cost contraceptive health care. That, in turn, will increase the strain on Nevada's publicly funded services, necessitating further state expenditures. (ROA.1597.) That economic

[5] *See Proposed Religious Exemptions*, 82 Fed. Reg. at 47,823.

injury confers Article III standing. *Texas* v. *United States*, 809 F.3d 134, 155 (5th Cir. 2015), *aff'd by an equally divided Court*, 136 S. Ct. 2271 (2016).

Far from counseling against finding that Nevada has standing, any uncertainty as to the quantifiable impact of the Permanent Injunction on Nevada flows from its overbroad and vague nature. Plaintiffs-Appellees have secured a remedy that goes far beyond what is necessary to redress their purported injury. *Gill* v. *Whitford*, 138 S. Ct. 1916, 1934 (2018) (citation omitted) ("A plaintiff's remedy must be tailored to redress the plaintiff's particular injury."). The problematic scope of this relief is compounded by the District Court's certification of an amorphous class of unidentifiable employers across the nation. Their claims are inappropriate for class-wide adjudication because, as this Court has recognized, the legal question of whether an employer's religious belief qualifies for protection under the RFRA "turns on its particular facts." (ROA.1147 (quoting *Tagore* v. *United States*, 735 F.3d 324, 328 (5th Cir. 2013)).) As the Federal Defendants recognized in the District Court, when evaluating a claim under the RFRA, "[t]he specific religious practice must be examined rather than the general scope of applicable religious tenets, and the plaintiff's 'sincerity' in espousing that practice is largely a matter of individual credibility." (*Id.* (quoting *Tagore*, 735 F.3d at 328).)

Nevada's *parens patriae* interests provide an independent basis for its standing. In *Alfred L. Snapp & Sons* v. *Puerto Rico*, the Supreme Court explained that states may assert their *parens patriae* standing to vindicate quasi-sovereign interests, including "in the health and well-being . . . of its residents." 458 U.S. 592, 602, 607 (1982). Nevada has demonstrated a commitment to supporting access to contraceptive care (*see* ROA.1486–88), and its challenge to the Permanent Injunction is in furtherance of that same quasi-sovereign interest.

The District Court erroneously held that Nevada is barred from asserting *parens patriae* interests under *Massachusetts* v. *Mellon*, 262 U.S. 447 (1923). (ROA.2069 n.4.) Not so. *Mellon* and its progeny preclude *parens patriae* suits against the federal government—they do not speak to suits in which a State seeks to protect its interest in the health and welfare of its residents against a private party's invasion. *Snapp*, 458 U.S. at 610 n.16 (citing *Mellon*, 262 U.S. at 485-86); *accord Massachusetts* v. *EPA*, 549 U.S. 497, 539 (2007) (Roberts, C.J., dissenting) (explaining that Supreme Court precedents "cast significant doubt on a State's standing to assert a quasi-sovereign interest . . . *against the Federal Government*" (emphasis added) (citing *Mellon*)).[6]

[6] The District Court characterized Nevada's argument as seeking "to protect [its] citizens from the operation of federal statutes," namely, the RFRA. (ROA.2069 n.4 (quoting *Massachusetts* v. *EPA*, 549 U.S. at 520 n.17).) That framing misses the mark. Rather, Nevada seeks to protect the federal benefits afforded to its residents under the ACA, which the Supreme Court has

To the extent it is a close call (it is not), the lack of "concrete adverseness which sharpens the presentation of issues" for adjudication militates in favor of Nevada's intervention. *Baker* v. *Carr*, 369 U.S. 186, 204 (1962). Despite the significant legal issues of national importance presented by this lawsuit, the Federal Defendants offered no defense on the merits in the District Court and have withdrawn their appeal challenging issues affecting Nevada residents. Recognizing Nevada's standing to defend the Contraceptive Coverage Benefit based on injuries to its economic and quasi-sovereign interests, therefore, furthers the principles underlying Article III standing.

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

The ACA, among other things, aimed to shift the focus of health care away from reactive medical care toward preventive health care.[7] To that end, the ACA requires most private insurance plans to cover certain preventive health care services, including contraceptive care, without patient cost sharing.[8] Contraceptive care helps to avoid unintended pregnancies and promotes healthy birth spacing, resulting in improved maternal, child, and family

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recognized as a basis for *parens patriae* standing. *See, e.g.*, *Snapp*, 458 U.S. at 609; *Georgia* v. *Pa. R.R. Co.*, 324 U.S. 439, 447 (1945).

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

[8] *See, e.g.*, 42 U.S.C. § 300gg-13(a)(4).

health.[9] Contraceptive care also has other preventive health benefits, including reduced menstrual bleeding and pain, and decreased risk of endometrial and ovarian cancer.[10] Accordingly, since 2011, HHS has defined essential preventive health services for women to include all FDA-approved contraceptive methods.[11]

The Contraceptive Coverage Benefit, which, since 2012, has required private insurers to cover contraception with no cost sharing, increases access to contraceptive services by ensuring that women can access them seamlessly through their insurance without co-pays or other cost—an important consideration that impacts contraceptive method choice and use. Prior to the ACA, 1 in 7 women with private health insurance either postponed or went without needed health care services because they could not afford them.[12] Those who

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[9] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 615: Access to Contraception* 2 (Jan. 2015, reaffirmed 2019), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co615.pdf?dmc=1&ts=20180918T1848086165.

[10] *Id.*

[11] *Id.* at 3; *see also Women's Preventive Services Guidelines*, Health Resources & Servs. Admin., https://www.hrsa.gov/womens-guidelines/index.html (last updated Oct. 2019).

[12] Usha Ranji & Alina Salganicoff, Henry J. Kaiser Family Found., *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* 4, 30 (2011), https://www.kff.org/wp-content/uploads/2013/01/8164.pdf.

could purchase contraception were allocating between 30% and 44% of their annual out-of-pocket health care costs to that end,[13] and women were more likely to forego more effective long-acting reversible contraceptive ("LARC") methods (such as IUDs) due to their higher upfront costs.[14]

Recognizing that *no-cost* contraceptive coverage is an integral component of preventive health care, the Contraceptive Coverage Benefit eliminated the cost of contraceptive services for women with private insurance. **As a result, more than 62 million women now have access to contraceptive services at no cost.**[15] And the Contraceptive Coverage Benefit is working: out-of-pocket spending on contraceptive care has decreased, more women are choosing LARCs,[16] and the percentage of unintended pregnancies in the United States is at a 30-year low.[17]

[13] Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Aff. 1204, 1208 (2015).

[14] *See* Ashley H. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs Among Privately Insured Women*, 28 Women's Health Issues 219, 219 (2018).

[15] Nat'l Women's Law Ctr., *New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs* 1 (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf.

[16] Snyder, *supra* note 14, at 219.

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

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

Safety net programs, particularly Title X and Medicaid, are not adequate fail-safes for the loss of no-cost contraceptive coverage through private insurance. HHS specifically rejected these options when it adopted the Contraceptive Coverage Benefit because "requiring [women] to take steps to learn about, and to sign up for, a new health benefit" through a government program imposed unnecessary obstacles to access.[18] Moreover, Title X is not designed to meet the needs of individuals who lose access to no-cost contraceptives through their insurance,[19] and many of these individuals are simply not eligible for Medicaid.

Title X and Medicaid are inadequate substitutes for the Contraceptive Coverage Benefit for the additional reason that these programs are facing drastic cuts to covered services, funding, and eligibility. Adding an influx of new patients would further stretch the resources of Title X and Medicaid and

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F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1291 (2012).

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

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

take resources away from those individuals the programs are intended to serve: low-income individuals and families who are in the greatest need of publicly funded health care services.

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

Title X was enacted to provide family-planning services to low-income persons.[20] Through a competitive process, HHS awards Title X grants to public and private nonprofit agencies "to assist in the establishment and operation of voluntary family planning projects which . . . offer a broad range of acceptable and effective family planning methods and services," including contraception.[21] Those grants, in turn, fund "projects" intended to serve "persons from low-income families."[22] Generally, only individuals whose annual income is at or below the federal poverty level ("FPL") are entitled to receive no-cost Title X services.[23]

Title X was designed to provide no- or low-cost family planning health care to individuals with financial need, not to serve as substitute coverage for individuals who have private insurance through an employer. The governing

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

[21] 42 U.S.C. § 300(a); *see also* 42 C.F.R. § 59.5(a)(1).

[22] 42 U.S.C. § 300a-4(c)(1).

[23] 42 C.F.R. § 59.5(a)(7).

statute and regulations contemplate that Title X and third-party payers will work together to pay for care, and direct Title X-funded agencies to seek payment from such third-party payers. Thus, if a patient has private insurance, the Title X clinic generally must bill the insurance.[24] In the absence of insurance, if a Title X patient does not qualify for no- or low-cost services, the patient is responsible for the cost of care.

Following a recent amendment to the Title X regulations[25] (the "Title X Final Rule"), Title X project directors may, *at their discretion*, provide care to individuals employed by religious or moral objectors who lack access to contraceptive coverage.[26] That is a far cry from a solution to the coverage gap created by the Permanent Injunction. *First*, the individual's ability to receive any relief at all under the Title X Final Rule is subject entirely to the discretion of a Title X project director. *Second*, HHS has not provided additional funding to compensate Title X projects for bearing the costs of contraceptive services for individuals that previously were covered by employer-sponsored insurance plans, making it less likely that such discretion could be feasibly exercised.[27]

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[24] *Id.* § 59.5(a)(7).

[25] Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) [hereinafter *Title X Final Rule*] (to be codified at 42 C.F.R. pt. 59).

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

[27] Indeed, HHS sought no additional funds to pay for the necessary expansion of services, proposing a FY 2020 budget of approximately $286 million

In short, although some individuals who lose coverage because of the Permanent Injunction may obtain care from a Title X provider, many of them will still incur out-of-pocket costs—or forego care entirely.

What is more, the Title X Final Rule significantly altered the landscape of Title X-funded family planning providers, drastically reducing existing Title X patients' access to reliable and effective contraceptive care. *First*, the Title X Final Rule bars medical providers from referring patients to abortion care providers, even in response to a patient inquiry, and requires them instead to direct patients towards carrying their pregnancies to term.[28] *Second*, it requires "physical separation" between Title X projects and any activities prohibited by the Title X Final Rule, such as abortion care.[29] *Third*, it seeks to redirect Title X funding to sites that promote less reliable, non-evidence based methods of family planning, such as abstinence counseling and "fertility awareness," in part by eliminating a requirement that family-planning methods be "medically approved."[30]

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which is the same level of funding as FY 2019. *See* Dep't of Health & Human Servs., *FY2020 Budget in Brief* 30 (2019), https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf. The recently enacted FY 2020 budget appropriated $286.5 million to family planning services. Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, 133 Stat. 2534, 2558 (2019).

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

[29] *See id.* at 7715, 7763–68.

[30] *Id.* at 7740–44.

Taken together, these changes to the Title X regulations have upended the network of approximately 4,000 clinics nationwide who received grants through the program.[31] Since the Title X Final Rule took effect on July 15, 2019, HHS has required grantees to submit compliance plans documenting the steps they have taken to comply with the final rule.[32] This requirement forced providers into an ethical quandary of acceding to the rule's unethical provisions or leaving the Title X program. As of October 2019, 1,041 clinics across more than 30 states, including all Planned Parenthood affiliates, were no longer in the program due to the Title X Final Rule.[33] Six states currently

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

[32] Although several preliminary injunctions precluded enforcement of the Title X Final Rule, the Fourth and Ninth Circuits stayed the injunctions pending review on the merits. *California ex rel. Becerra* v. *Azar*, 928 F.3d 1153 (9th Cir. 2019); *Mayor of Balt.* v. *Azar*, 778 F. App'x 212 (4th Cir. 2019). As a result, HHS has begun to enforce the Title X Final Rule. *See Compliance with Statutory Program Integrity Requirements*, U.S. Dep't of Health & Hum. Servs. (Aug. 9, 2019), https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/compliance-with-statutory-program-integrity-requirements/index.html.

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

have no Title X providers *at all* due to the rule.[34] Even those grantees who submitted plans for HHS review may ultimately have to withdraw from the Title X program if the agency concludes that such plans do not comply with the Title X Final Rule.[35]

Planned Parenthood affiliates' exclusion from Title X is especially harmful because they previously served approximately *41%* of the almost 4 million Title X patients served annually.[36] Past exclusions of Planned Parenthood from publicly funded programs illustrate their dire effects on access to contraception and health outcomes: After Planned Parenthood affiliates were excluded from Texas's family planning program in 2013, claims for more effective LARC and injectable contraceptives dropped more than 30%, contraception continuation went down, and Medicaid-covered child-birth rates went

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

[35] *See Status of Participation*, *supra* note 33.

[36] Kinsey Hasstedt, *Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X*, 20 Guttmacher Pol'y Rev. 86, 86 (2017).

up.[37] Without Planned Parenthood affiliates in the Title X network, it is estimated that other Title X-funded providers would need to increase their Title X patient caseload by an average of 70% to cover the same number of patients: federally qualified health centers ("FQHCs") would need to boost their capacity to provide contraceptive services by 116%; health department sites by 31%; hospital-operated sites by 77%; and other sites, such as independent agencies, by 101%.[38]

Together, these revisions threaten to undermine the very purpose of Title X: "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," primarily for "persons from low-income families."[39] They also impose substantial barriers to Title X's ability to absorb the increased needs created by the Permanent Injunction.

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

Nor can Medicaid fill the gap to serve individuals who lose contraceptive coverage through private insurance as a result of the Permanent Injunction. Medicaid is a joint federal-state program designed to provide health insurance

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[37] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 New Eng. J. Med. 853, 856–59 (2016).

[38] Gold & Cross, *supra* note 333.

[39] 42 U.S.C. §§ 300(a), 300a-4(c)(1).

coverage for a limited population of low-income individuals.[40] Eligibility is largely based on financial need.[41] Precisely because only a limited population is eligible for Medicaid, Medicaid cannot serve as a substitute for the Contraceptive Coverage Benefit.

To address the health needs of low-income individuals nationwide, the ACA expanded Medicaid eligibility to include *all individuals* with incomes at or below 133% of the FPL,[42] equivalent to an annual income of $16,612 for an individual in 2019.[43]

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[40] 42 U.S.C. § 1396-1 (noting that Medicaid's purpose is to enable states to furnish medical assistance to certain individuals "whose income and resources are insufficient to meet the costs of necessary medical services"); *Program History*, Medicaid.gov, https://www.medicaid.gov/about-us/program-history/index.html (last visited Dec. 23, 2019).

[41] 42 U.S.C. § 1396a(a)(10)(A), (C); *see also* Robin Rudowitz et al., Henry J. Kaiser Family Found., *10 Things to Know About Medicaid: Setting the Facts Straight* 1, 3 (2019), http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight.

[42] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)). Some publications report that the ACA expanded Medicaid eligibility to include all individuals at or below 138% of the FPL because the legislation disregards up to 5% of a household's income. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I)); *see also* Rudowitz et al., *supra* note 41, at 3.

[43] *See* Annual Update of the HHS Poverty Guidelines, 84 Fed. Reg. 1167, 1168 (Feb. 1, 2019).

In 2012, however, the Supreme Court barred HHS from terminating federal Medicaid funding to states that do not extend Medicaid coverage to this larger population,[44] effectively leaving the decision whether to expand Medicaid, in the first instance, to the states. As of December 2019, 14 states (including Texas and Florida, the second- and third-most populous states) have not expanded Medicaid coverage.[45] The median income limit for Medicaid-eligible parents in those states was just 40% of the FPL in 2019, which would correspond to an annual income of $8,532 for a three-person household—less than one-third the income limit under the ACA's Medicaid expansion.[46] In these non-expansion states, Medicaid does not cover: (1) nonelderly adults who have no children, are not pregnant, and do not have a disability; or (2) parents whose annual income is, on average, more than 46% of the FPL.[47]

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[44] *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, at 575–88 (2012).

[45] *Status of State Medicaid Expansion Decisions: Interactive Map*, Henry J. Kaiser Fam. Found. (Nov. 15, 2019), https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision. Three additional states have adopted, but not fully implemented, the Medicaid expansion. *Id.*

[46] *See* Annual Update of the HHS Poverty Guidelines, 84 Fed. Reg. at 1168; *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, Henry J. Kaiser Fam. Found. (as of Jan. 1, 2019), https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

[47] There are exceptions. Wisconsin, which has not adopted the Medicaid expansion, nevertheless provides Medicaid coverage to individuals who would fall within the expansion population and whose income is under the FPL. *See*

But even in Medicaid expansion states, where coverage is not contingent on membership in a covered group, Medicaid would not serve as a backstop for most individuals whose annual income is more than 138% of the FPL.[48] Like Title X, Medicaid is not designed to serve as a viable alternative to the ACA's guarantee of seamless access to no-cost contraceptive care to individuals who lose it because of the Permanent Injunction.

Furthermore, continued access to Medicaid-covered services overall is by no means secure, even for those who currently qualify for them. The President's 2020 federal budget called for nearly $1.5 trillion in cuts to the program

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Letter from Seema Verma, Adm'r, Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to Casey Himebauch, Deputy Medicaid Dir., Wis. Dep't of Health Servs., 3 (Oct. 31, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf. So does Utah, one of the three states that have yet to fully implement the Medicaid expansion following its adoption. *See* Letter from Seema Verma, Adm'r, Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to Nathan Checketts, Dir., Utah Dep't of Health, 4 (Mar. 29, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/Primary-Care-Network/ut-primary-care-network-community-engagement-amndmnt-appvl-03292019.pdf.

[48] Twenty-six states have expanded coverage of family-planning services under Medicaid, but coverage is still based on income in 23 of these states, with the highest eligible income in any state being 306% of the FPL. *See Medicaid Family Planning Eligibility Expansions*, Guttmacher Inst. (as of Dec. 1, 2019), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions. And, two states only cover patients in the postpartum period. *Id.*

over the course of a decade,[49] accomplished in part by eliminating the Medicaid expansion and converting Medicaid from an entitlement program into a program under which states receive either (i) a fixed amount per Medicaid enrollee, irrespective of the individual's actual health care costs (the "per capita cap"); or (ii) a fixed amount that would not vary by the number of Medicaid enrollees (the "block grant" model).[50] Either model would dramatically reduce federal funding available to states to cover individuals of reproductive age who would otherwise rely on Medicaid for contraceptive access.

Consequently, there is no guarantee that even those currently enrolled will be able to maintain Medicaid, much less that individuals who lose access to no-cost contraceptive services through their private insurance will have access to those services through Medicaid.

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

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

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

Putting aside the purpose of the safety net programs outlined above, the federal reproductive health safety net cannot replace the Contraceptive Coverage Benefit because it is already stretched thin. An influx of new patients who previously obtained no-cost contraceptive care through their insurers would interfere with providers' ability to serve the neediest patients.

A recent study found that the cost of providing family-planning services for all low-income women of reproductive age who need such services would range from $628 to $763 million annually.[51] Title X is budgeted to receive just $286.5 million in FY 2020—a fraction of that estimated cost, and a level of funding that has not increased since 2011.[52] In fact, between 2010 and 2016, Con-

[51] *See* Euna M. August et al., *Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act*, 106 Am. J. Pub. Health 334, 336 (2016).

[52] *Dep't of Health & Human Servs.*, *supra* note 27, at 30; *Title X Budget & Appropriations*, Nat'l Fam. Plan. & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Dec. 25, 2019).

gress cut funding for Title X by 10%, even as the need for publicly funded contraceptive services increased over that same period.[53] Accounting for inflation, Title X's 2016 funding was about 30% of what it was in 1980.[54]

At the same time, two-thirds of state Medicaid programs face challenges in securing an adequate number of providers,[55] particularly for specialty services like obstetrics and gynecology ("OB/GYN"). A government report found that only 42% of in-network OB/GYN providers were able to offer appointments to new Medicaid patients in 2014.[56] Many FQHCs have struggled to fill persistent staff vacancies and shortages.[57]

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[53] *See* Joerg Dreweke, *"Fungibility": The Argument at the Center of a 40-Year Campaign to Undermine Reproductive Health and Rights*, 19 Guttmacher Pol'y Rev. 53, 58 (2016).

[54] *Id.*

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

[56] *See Access to Care*, *supra* note 55, at 21.

[57] Nat'l Ass'n of Cmty. Health Ctrs., *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers* 2–4 (2016), http://www.nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf.

Cuts to funding for federally funded reproductive care have a direct impact on the number of individuals who can access reproductive health services. In 2010, the number of clients served at Title X-funded health centers was approximately 5.2 million,[58] but it dropped to just over 4 million in 2016.[59] This decline coincides with more than $30 million in cuts to Title X's annual appropriation over the same period,[60] and it did not occur because fewer individuals were in need of these services. To the contrary, the number of individuals in need of publicly funded care has *increased*: In 2014, of the 38.3 million women estimated to be in need of contraceptive services, 20.2 million needed publicly funded contraceptive services because they were either teenagers or adult women whose family income was below 250% of the FPL.[61] That is an overall increase of 5% between 2010 and 2014.[62]

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

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

[60] *Compare id.* at 1, *with 2010 Annual Report*, *supra* note 58, at 1.

[61] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2014 Update* 8 (2016), https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

[62] *Id.*

The increased need for publicly funded contraceptive services is particularly acute among individuals who come from under-served populations. The largest increases in the need for family-planning services between 2010 and 2014 were among poor and low-income women (11% and 7%, respectively) and Hispanic women (8%).[63] Between 2000 and 2014, the proportion of women who were considered "poor" increased as a share of all women in need of publicly funded services by 6%.[64] Similarly, the proportion of black women who need publicly supported care increased by 6%, and for Hispanic women it increased by 9%.[65] Rural populations are also in great need of contraceptive services.[66]

Consequently, the resources of the family-planning safety net are both acutely needed and wholly insufficient even for the populations of individuals

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

[64] *Id.* at 8.

[65] *Id.* at 9.

[66] Among the 14 states ranked highest in percentage of women of reproductive age in need of publicly funded contraceptive services, nine have rural populations exceeding 33% of the state population. *See* Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 586: Health Disparities in Rural Women* 2 (Feb. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc =1&ts=20180519T0125239210dmc=1&ts=20180514T1322391916.

it was designed to serve; they could not possibly support the needs of additional individuals, regardless of means, whose employers opt out of the Contraceptive Coverage Benefit.

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

Even if individuals no longer covered by private insurance for contraceptive services due to the Permanent Injunction were eligible for no-cost services through Medicaid or under Title X, and *even if* those programs *could* serve an expanded population of patients, the shift would still impose significant burdens on this population that would interfere with access to seamless contraceptive coverage without cost sharing. They would face the logistical challenges of enrolling in, or obtaining benefits from, one of these government-funded programs. They may also have to seek out new providers that accept Medicaid or provide services through Title X, and some may have difficulty locating providers within a reasonable distance.[67] These choices will present challenges to affected individuals, including the potential loss of the continuity of care with their preferred health care providers.

[67] *See* Henry J. Kaiser Family Found., *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians* 7 (2011), https://www.kff.org/wp-content/uploads/2013/01/8178.pdf; *Publicly Funded Contraceptive Services at U.S. Clinics: Clinics Providing Publicly Funded Contraceptive Services by County, 2015*, Guttmacher Inst., https://gutt.shinyapps.io/fpmaps/ (last visited Dec. 25, 2019).

As a result of these challenges, some individuals may choose less effective contraceptive methods, or forego contraceptive care entirely, which increases the likelihood of unintended pregnancy and the health risks that go along with it. All of this would contribute to the overall decline of individuals' health.

CONCLUSION

The Permanent Injunction, if allowed to stand, will harm many individuals, including Nevada citizens, by depriving them of the no-cost contraceptive coverage that is an essential element of the ACA's integrated strategy to ensure access to fundamental preventive care. Federal government safety net programs are simply not substitutes for employer-sponsored insurance plans, and such programs lack the resources to accommodate individuals who stand to lose coverage under the Permanent Injunction. Further, current attacks on those programs combined with an influx of new patients would interfere with the safety net programs' ability to serve the patients of limited means for whom these programs were designed.

For these reasons, *amici* urge this Court to reverse the decisions below granting the Permanent Injunction and denying Nevada's motion to intervene.

Respectfully submitted,

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DECEMBER 26, 2019

CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and 32(a)(6) because it has been prepared in a 14-point proportionally spaced serif font.

2. I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because it contains 5,998 words, excluding the parts of the brief exempted under Rule 32(f).

S/ Claudia Hammerman
CLAUDIA HAMMERMAN

DECEMBER 26, 2019

CERTIFICATE OF SERVICE

I, Claudia Hammerman, a member of the Bar of this Court and counsel for Amici Curiae Planned Parenthood Federation of America, National Health Law Program, and National Family Planning & Reproductive Health Association certify that, on December 26, 2019, a copy of the attached Brief of Amici Curiae Supporting Movants-Appellants was filed with the Clerk through the Court's electronic filing system. I further certify that all parties required to be served have been served.

S/ Claudia Hammerman
CLAUDIA HAMMERMAN

December 26, 2019