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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA; THE STATE OF DELAWARE; THE STATE OF MARYLAND; THE STATE OF NEW YORK; THE COMMONWEALTH OF VIRGINIA; ET AL.,

Plaintiffs,

v.

ALEX M. AZAR, II, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; R. ALEXANDER ACOSTA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF LABOR; STEVEN MNUCHIN, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF THE TREASURY; U.S. DEPARTMENT OF THE TREASURY; DOES 1-100,

Defendants,

and,

THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE; MARCH FOR LIFE EDUCATION AND DEFENSE FUND,

Defendant-Intervenors.

4:17-cv-05783-HSG

DECLARATION OF KATHRYN KOST

I, Kathryn Kost, declare:

1. I am the Acting Vice President for Domestic Research at the Guttmacher Institute. I have worked for the Guttmacher Institute in a full-time or consulting capacity for nearly 30 years since joining the Institute as a Senior Research Associate in 1989. I received my BA in sociology from Reed College and my PhD in sociology from Princeton University, where I specialized in demography at the Office of Population Research.

2. The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. It produces a wide range of resources on topics pertaining to sexual and reproductive health and publishes two peer-reviewed journals. The information and analysis it generates on reproductive health and rights issues are widely used and cited by researchers, policymakers, the media and advocates across the ideological spectrum.

3. Over the course of more than 30 years, I have designed, executed, and analyzed numerous quantitative and qualitative research studies in the field of reproductive health care, including those on contraceptive use and failure, unintended pregnancy, maternal and child health, and the impact on public health and fisc associated with particular reproductive health care policies or trends. My peer-reviewed research has been published in dozens of articles, including first-authored work in *Demography*, *Perspectives on Sexual and Reproductive Health*, *Contraception*, *Studies in Family Planning* and other public health, medical and demographic journals. My education, training, responsibilities and publications are set forth in greater detail in my curriculum vitae, a true and correct copy of which is attached as Exhibit A. I submit this declaration as an expert on reproductive health care, family planning, and unintended pregnancy, and the impact on individuals, families, and the public health from access to contraception and related care, or interference with that care, in the United States.

4. I understand that this lawsuit involves a challenge to the federal government's Final Rules ("Final Rules") regarding the Affordable Care Act's ("ACA") contraceptive coverage mandate. In my expert opinion, the Final Rules would compromise women's ability to obtain contraceptive methods, services and counseling and, in particular, to consistently use the best methods for them, thus putting them at heightened risk of unintended pregnancy.

Contraception Is Widely Used and the Majority of Women Rely on Numerous Contraceptive Methods for Decades of Their Lives

5. More than 99% of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method; this is true across a variety of religious affiliations.[1] Some 61% of all women of reproductive age are currently using a contraceptive method.[2] Among women at risk of an unintended pregnancy (i.e., women aged 15–44 who have had sexual intercourse in the past three months, are not pregnant or trying to conceive, and are not sterile for noncontraceptive reasons), 90% are currently using a contraceptive method.[3]

6. A typical woman in the United States wishing to have two children will, on average, spend three decades—roughly 90% of her reproductive life—avoiding unintended pregnancy.[4]

7. Women and couples rely on a wide range of contraceptive methods: In 2014, 25% of female contraceptive users relied on oral contraceptives and 15% on condoms as their most effective method. That means that six in 10 contraceptive users relied on other methods: female or male sterilization; hormonal or copper intrauterine devices (IUDs); other hormonal methods including the injectable, the ring, the patch and the implant; and behavioral methods, such as withdrawal and fertility awareness methods.[5]

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[1] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.

[2] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[3] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[4] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

[5] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-

8. Most women rely on multiple methods over the course of their reproductive lives, with 86% having used three or more methods by their early 40s.[6] Sometimes, women and couples may try out different methods to find one that they can use consistently or that minimizes side effects. Other times, they may switch from method to method—such as from condoms to oral contraceptives to sterilization—as their relationships, life circumstances and family goals evolve.

9. Many people use two or more methods at once: 17% of female contraceptive users did so the last time they had sex.[7] For example, they may use condoms to prevent STIs and an IUD for the most reliable prevention of pregnancy. Or they may use multiple methods simultaneously—for instance, condoms, withdrawal and oral contraceptives—to provide extra pregnancy protection.

Women Need Access to the Full Range of Contraceptive Options to Most Effectively Avoid Unintended Pregnancies

10. Using any method of contraception greatly reduces a woman's risk of unintended pregnancy. Sexually active couples using no method of contraception have a roughly 85% chance of experiencing a pregnancy in a one-year period, while the risk for those using a contraceptive method ranges from 0.05% to 28%.[8,9]

11. All new contraceptive drugs and devices (just like other drugs and devices) must receive approval from the U.S. Food and Drug Administration (FDA) and must be shown to be safe and effective through rigorous scientific testing. Thus, the federal government itself provides the oversight to ensure that contraception is safe and effective in preventing pregnancy.

12. The government's effort to imply that there is doubt about whether contraception reduces the risk of unintended pregnancy is simply unfounded, as the data above illustrate. Though the

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united-states-trends-and-characteristics-between-2008-2012

[6] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.

[7] Kavanaugh ML and Jerman J, Concurrent multiple methods of contraception in the United States, poster presented at the North American Forum on Family Planning, Atlanta, Oct. 14–16, 2017.

[8] Sundaram A et al., Contraceptive failure in the United States: estimates from the 2006-2010 National Survey of Family Growth, *Perspectives on Sexual and Reproductive Health*, 2017, 49(1):7–16, https://www.guttmacher.org/journals/psrh/2017/02/contraceptive-failure-united-states-estimates-2006-2010-national-survey-family.

[9] Trussell J, Aiken A, "Contraceptive Efficacy" pp. 829–928. In Hatcher RA et al., eds., *Contraceptive Technology,* 21st ed., New York: Ayer Company Publishers, 2018.

Final Rules cite "conflicting evidence" for the effects of a contraceptive coverage requirement,[10] in the previous interim final rules, the government made positive arguments that contraceptive access did not reduce the risk of unintended pregnancy. This argument is flawed. For example, in the interim final rules the government argued, "In the longer term—from 1972 through 2002—while the percentage of sexually experienced women who had ever used some form of contraception rose to 98 percent, unintended pregnancy rates in the Unites States rose from 35.4 percent to 49 percent."[11]

13. However, the government's assertion in the interim final rules that unintended pregnancy rates rose between 1972 and 2002 was incorrect and based on faulty calculations and an inappropriate comparison. First, the numbers cited (35.4% and 49%) are the *percentage* of all pregnancies that were unintended, not the unintended pregnancy *rate*, which is the appropriate indicator for assessing trends in unintended pregnancy because it is not affected by changes in the incidence of *intended* pregnancy. Second, the 1972 figure includes only *births* (not all pregnancies), and then only those births that were to married women.[12] Births to unmarried women and all abortions are excluded; the proportion of both of these that were unintended were significantly higher, so excluding them results in an artificially low percentage. The 2002 figure, on the other hand, includes all pregnancies to all women. An appropriate comparison of rates based on pregnancies and on all women in the population shows a clear decline in the rate: In 1971, there were an estimated 2.041 million unintended pregnancies (including births and abortions, but excluding miscarriages),[13] and 43.6 million women of reproductive age (15–44),[14] for an unintended pregnancy rate (excluding miscarriages) of 47 per 1,000 women. By contrast, in

[10] Department of the Treasury, Department of Labor and Department of Health and Human Services, Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act, *Federal Register*, 83(221):57536–57590, https://www.gpo.gov/fdsys/pkg/FR-2018-11-15/pdf/2018-24512.pdf

[11] Department of the Treasury, Department of Labor and Department of Health and Human Services, Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act, *Federal Register*, 82(197):47838–47862, https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf.

[12] Weller RH and Heuser RL, Wanted and unwanted childbearing in the United States: 1968, 1969, and 1972 National Natality Surveys, *Vital and Health Statistics*, 1978, No. 32.

[13] Tietze C, Unintended pregnancies in the United States, 1970–1972, *Family Planning Perspectives,* 1979, 11(3):186–188.

[14] National Center for Health Statistics, Centers for Disease Control and Prevention, Population by age groups, race, and sex for 1960–1997, no date, https://www.cdc.gov/nchs/data/statab/pop6097.pdf.

2011, the unintended pregnancy rate *including* miscarriages was 45 per 1,000.[15] Even when including miscarriages in the later rate, it is lower than the earlier rate; because miscarriages typically represent about 14% of all pregnancies,[16] excluding them from the 2011 figure for comparability would result in a rate of about 38 per 1,000, substantially lower than the 1971 rate.

14. Although using any method of contraception is more effective in preventing pregnancy than not using a method at all, having access to a *limited* set of methods is far different than being able to choose from among the full range of methods to find the *best* methods for a given point in a woman's life.

15. One important consideration for most women in a choosing a contraceptive method is how well a method works for an individual woman to prevent pregnancy.[17] IUDs and implants, for example, are effective for years after they are inserted by a health care provider, and do not require women using them to think about contraception on a day-to-day basis.[18] By contrast, birth control pills must be taken every day, at approximately the same time. Nearly half of abortion patients who were users of birth control pills reported that they had forgotten to take their pills, and another quarter reported a lack of ready access to their pills (16% were away from their pills and 10% ran out).[19] Methods of contraception designed to be used during intercourse, such as condoms or spermicide, must be available, accessible, remembered, and used properly each time intercourse occurs.

16. Beyond effectiveness, there are many other features that people say are important to them when choosing a contraceptive method.[20] These include concerns about and past experience with

[15] 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.
[16] Finer LB and Henshaw SK, Disparities in rates of unintended pregnancy in the United States, 1994 and 2001, *Perspectives on Sexual and Reproductive Health*, 2006, 38(2):90–96, https://www.guttmacher.org/journals/psrh/2006/disparities-rates-unintended-pregnancy-united-states-1994-and-2001.
[17] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(2):194–200.
[18] Winner B et al., Effectiveness of long-acting reversible contraception, *New England Journal of Medicine*, 366(21):1998–2007.
[19] Jones RK, Darroch JE and Henshaw SK, Contraceptive use among U.S. women having abortions in 2000–2001, *Perspectives on Sexual and Reproductive Health*, 2002, 34(6): 294–303, https://www.guttmacher.org/journals/psrh/2002/11/contraceptive-use-among-us-women-having-abortions-2000-2001.
[20] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives*

side effects, drug interactions or hormones; affordability and accessibility; how frequently they expect to have sex; their perceived risk of HIV and other STIs; the ability to use the method confidentially or without needing to involve their partner; and potential effects on sexual enjoyment and spontaneity. For example, methods such as male condoms, fertility awareness and withdrawal require the active and effective participation of male partners. By contrast, methods such as IUDs, implants, and oral contraceptives can be more reliably used by the woman alone in advance of intercourse.[21]

17. Being able to select the methods that best fulfill a woman's needs and priorities is an important way to ensure that she will be satisfied with her chosen methods. Women who are satisfied with their current contraceptive methods are more likely to use them consistently and correctly. For example, one study found that 30% of neutral or dissatisfied users had a temporal gap in use, compared with 12% of completely satisfied users.[22] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[23]

18. Consistent contraceptive in turn use helps women and couples prevent unwanted pregnancies and plan and space those they do want. The two-thirds of U.S. women (68%) at risk of unintended pregnancy who use contraceptives consistently and correctly throughout a year account for only 5% of all unintended pregnancies. In contrast, the 18% of women at risk who use contraceptives but do so inconsistently account for 41% of unintended pregnancies, and the 14% of women at risk who do not use contraceptives at all or have a gap in use of one month or longer account for 54% of unintended pregnancies.[24]

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on Sexual and Reproductive Health, 2012, 44(2):194–200.

[21] Bailey MJ, More power to the pill: the impact of contraceptive freedom on women's life cycle labor supply, *Quarterly Journal of Economics*, 2006, 121(1): 289–320, https://academic.oup.com/qje/article-abstract/121/1/289/1849021?redirectedFrom=fulltext.

[22] Guttmacher Institute, Improving contraceptive use in the United States, *In Brief*, New York: Guttmacher Institute, 2008, https://www.guttmacher.org/report/improving-contraceptive-use-united-states.

[23] Guttmacher Institute, Improving contraceptive use in the United States, *In Brief*, New York: Guttmacher Institute, 2008, https://www.guttmacher.org/report/improving-contraceptive-use-united-states.

[24] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

19. In summary, the ability to choose from among the full range of contraceptive methods encourages consistent and effective contraceptive use, thereby helping women to avoid unintended pregnancies and to time and space wanted pregnancies.

Access to Contraception Does Not Increase Adolescent Sexual Activity

20. Adolescent pregnancy has declined dramatically over the past several decades: In 2013, the U.S. pregnancy rate among 15–19-year-olds was at its lowest point in at least 80 years and had dropped to about one-third of a recent peak rate in 1990.[25] The adolescent birthrate has continued to fall sharply from 2013–2016, suggesting that the underlying pregnancy rates have likely declined even further.[26] Over these decades, adolescents' sexual activity has not increased—in fact, it has declined—while their contraceptive use has increased.

21. National data limited to adolescents attending high school document long-term increases from 1991–2015 in the share of students using contraception, and decreases over the same time period in the share of students who are sexually active.[27] Several studies have validated that contraceptive access reduces adolescent pregnancy without increasing sexual activity: The vast majority (86%) of the decline in adolescent pregnancy between 1995 and 2002 was the result of improvements in contraceptive use; only 14% could be attributed to a decrease in sexual activity.[28] Further, when examining these same two factors, all of the decline in the more recent 2007–2012 period was attributable to better contraceptive use: More adolescents were using

[25] Kost K, Maddow-Zimet I and Arpaia A, Pregnancies, *Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity*, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/us-adolescent-pregnancy-trends-2013.

[26] Martin JA, Hamilton BE and Osterman MJK, Births in the United States, 2016, *NCHS Data Brief*, 2017, No. 287, https://www.cdc.gov/nchs/products/databriefs.htm.

[27] National Center for HIV/AIDS, Viral Hepatitis, TD, and TB Prevention, Centers for Disease Control and Prevention (CDC), *Trends in the Prevalence of Sexual Behaviors and HIV Testing National YRBS: 1991–2015*, Atlanta: CDC, no date, https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trends/2015_us_sexual_trend_yrbs.pdf.

[28] Santelli JS et al., Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use, *American Journal of Public Health*, 2007, 97(1): 150–156, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1716232/.

contraception, they were using more effective methods, and they were using them more consistently, while adolescent sexual activity did not change.[29]

22. Recent trends in adolescent contraceptive use buttress this point: During 2011–2015, 81% of adolescent girls used contraception the first time they had sex, up from 75% in 2002; the share of adolescent girls who were sexually active stayed stable.[30,31] Similarly, use of emergency contraception among sexually active female adolescents increased from 8% in 2002 to 22% in 2011–2013; there was no significant change in sexual activity during this time.[32] And in a 2010 review of seven randomized trials of emergency contraception, there was no increase in sexual activity (e.g., reported number of sexual partners or number of episodes of unprotected intercourse) in adolescents given advanced access to emergency contraception.[33]

23. Along the same lines, studies of the availability of contraception in high schools provide evidence that it does not lead to more sexual activity. Rather, while several studies of school-based health care centers that provide contraceptive methods have shown contraceptives' availability increases students' use of contraception,[34,35] other studies have not found any

[29] Lindberg L, Santelli J and Desai S, Understanding the decline in adolescent fertility in the United States, 2007–2012, *Journal of Adolescent Health*, 2016, 59(5): 577–583, http://www.jahonline.org/article/S1054-139X(16)30172-0/fulltext.

[30] Martinez G, Copen CE and Abma JC, Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 National Survey of Family Growth, *Vital Health Statistics*, 2011, Series 23, No. 31, https://www.cdc.gov/nchs/products/series/series23.htm.

[31] Abma JC and Martinez G, Sexual activity and contraceptive use among teenagers in the United States, 2011–2015, *National Health Statistics Reports*, 2017, No. 104, https://www.cdc.gov/nchs/products/nhsr.htm.

[32] Martinez GM and Abma JC, Sexual activity, contraceptive use, and childbearing of teenagers aged 15–19 in the United States, *NCHS Data Brief*, 2015, No. 209, https://www.cdc.gov/nchs/products/databriefs.htm.

[33] Meyer JL, Gold MA and Haggerty CL, Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature, *Journal of Pediatric and Adolescent Gynecology,* 2011, 24(1):2–9, http://www.jpagonline.org/article/S1083-3188(10)00203-2/fulltext.

[34] Minguez M et al., Reproductive health impact of a school health center, *Journal of Adolescent Health*, 2015, 56(3): 338–344, https://www.ncbi.nlm.nih.gov/pubmed/25703321.

[35] Knopf FA et al., School-based health centers to advance health equity: a Community Guide systematic review, *American Journal of Preventive Medicine*, 2016, 51(1): 114-126, http://www.ajpmonline.org/article/S0749-3797(16)00035-0/fulltext.

associated increases in sexual activity.[36] And a recent review of studies of school-based condom availability programs found condom use increased the odds of students using condoms, while none increased sexual activity.[37]

Eliminating the Cost of Contraception Leads to Improved Contraceptive Use and Reduces Women's Risk of Unintended Pregnancy

24. Extensive empirical evidence demonstrates what common sense would predict: eliminating costs leads to more effective and continuous use of contraception. That is because cost can be a substantial barrier to contraceptive choice. The contraceptive methods that can be purchased over the counter at a neighborhood drugstore for a comparatively low cost—male condoms and spermicide—are far less effective than methods that require a prescription and a visit to a health care provider,[38] which have higher up-front costs.[39]

25. The most effective methods of contraception are long-acting reversible contraceptives (LARC), such as implants and IUDs. Even with discounts for volume, the cost of these devices exceeds $500, exclusive of costs relating to the insertion procedure,[40] and the total cost of initiating one of these methods generally exceeds $1,000.[41] To put that cost in perspective, beginning to use one of these devices costs nearly a month's salary for a woman working full time at the federal minimum wage of $7.25 an hour.[42] These costs are dissuasive for many women not covered by the contraceptive coverage guarantee; one pre-ACA study concluded that women who faced high out-of-pocket IUD costs were significantly less likely to obtain an IUD than women with access to the device at low or no out-of-pocket cost. And only 25% of women

[36] 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, 2007, https://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf.
[37] Wang T et al., The effects of school-based condom availability programs (CAPs) on condom acquisition, use and sexual behavior: a systematic review, *AIDS and Behavior*, 2017, https://www.ncbi.nlm.nih.gov/pubmed/28625012.
[38] Trussell J, Aiken A, "Contraceptive Efficacy" pp. 829–928. In Hatcher RA et al., eds., *Contraceptive Technology*, 21st ed., New York: Ayer Company Publishers, 2018.
[39] Trussell J et al., Cost effectiveness of contraceptives in the United States, *Contraception*, 2009, 79(1):5–14.
[40] Armstrong E et al., *Intrauterine Devices and Implants: A Guide to Reimbursement*, 2015, https://www.nationalfamilyplanning.org/file/documents----reports/LARC_Report_2014_R5_forWeb.pdf.
[41] Eisenberg D et al., Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents, *Journal of Adolescent Health*, 2013, 52(4):S59–S63, http://www.jahonline.org/article/S1054-139X(13)00054-2/fulltext.
[42] 29 U.S.C. § 206(a)(1)(C). At 40 hours a week, that amounts to $290 a week, before any taxes or deductions.

who requested an IUD had one placed after learning the associated costs.[43] Even oral contraceptives, which are twice as effective as condoms in practice, require a prescription and have monthly costs. And although some stores offer certain pill formulations at steep discounts, access to those cost savings can require a woman to change to a different formulation than the one prescribed by her clinician and increases her risk of adverse health effects.

26. The government acknowledges that without coverage, many methods would cost women $50 per month, or upwards of $600 per year, and in doing so, implies that such costs are a minimal burden. This is not true. For example, a national study found that about one-third of uninsured people and lower-income people in the United States would be unable to pay for an unexpected $500 medical bill, and roughly another third would have to borrow money or put it on a credit card and pay it back over time, with interest.[44]

27. Without insurance coverage to defray or eliminate the cost, the large up-front costs of the more-effective contraceptive methods put them out of reach for many women who want them, driving them to less expensive and less effective methods. In a study conducted prior to the contraceptive coverage guarantee, almost one-third of women reported that they would change their contraceptive method if cost were not an issue.[45] This figure was particularly high among women relying on male condoms and other less effective methods such as withdrawal. A study conducted after the enactment of the ACA had similar findings: among women in the study who still lacked health insurance in 2015, 44% agreed that having insurance would help them to afford and use birth control and 44% agreed that it would allow them to choose a better method for them; 48% also agreed that it would be easier to use contraception consistently if they had coverage.[46] Among insured women who still had a copayment using a prescription method (e.g.,

[43] Gariepy AM et al., The impact of out-of-pocket expense on IUD utilization among women with private insurance, *Contraception*, 2011, 84(6):e39–e42, https://escholarship.org/uc/item/1dz6d3cx.

[44] DiJulio B et al., Data note: Americans' challenges with health care costs, 2017, https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/?utm_campaign=KFF-2017-March-Polling-Beyond-The-ACA.

[45] Frost JJ and Darroch JE, Factors associated with contraceptive choice and inconsistent method use, United States, 2004, *Perspectives on Sexual and Reproductive Health,* 2008, 40(2):94–104, https://www.guttmacher.org/journals/psrh/2008/factors-associated-contraceptive-choice-and-inconsistent-method-use-united.

[46] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive

those in grandfathered plans), 40% agreed that if the copayment were eliminated, they would be better able to afford and use birth control, 32% agreed this would help them choose a better method, and 30% agreed this would help them to use their methods of contraception more consistently. Other studies have found that uninsured women are less likely to use the most expensive (but most effective) contraceptive methods, such as IUDs, implants, and oral contraceptives,[47] and are more likely than insured women to report using no contraceptive method at all.[48,49]

28. Reducing financial barriers is critical to increasing access to effective contraception. Before the ACA provision went into effect, 28 states required private insurers that cover prescription drugs to provide coverage of most or all FDA-approved contraceptive drugs and devices.[50] These programs gave women access at lower prices than if contraception were not covered, but (at the time) all states still allowed insurers to require cost-sharing. Experience from these states demonstrates that having insurance coverage matters.[51] Privately insured women living in states that required private insurers to cover prescription contraceptives were 64% more likely to use some contraceptive method during each month a sexual encounter was reported than

analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

[47] Culwell KR and Feinglass J, The association of health insurance with use of prescription contraceptives, *Perspectives on Sexual and Reproductive Health,* 2007, 39(4):226–230.

[48] Culwell KR and Feinglass J, The association of health insurance with use of prescription contraceptives, *Perspectives on Sexual and Reproductive Health,* 2007, 39(4):226–230.

[49] Culwell KR and Feinglass J, Changes in prescription contraceptive use, 1995–2002: the effect of insurance coverage, *Obstetrics & Gynecology*, 2007, 110(6):1371–1378, https://www.ncbi.nlm.nih.gov/pubmed/18055734.

[50] Guttmacher Institute, Insurance coverage of contraceptives*, State Policies in Brief (as of July 2012)*, 2012.

[51] The government argued in the interim final rules that the state mandates have not been effective, asserting that "Additional data indicates that, in 28 States where contraceptive coverage mandates have been imposed statewide, those mandates have not necessarily lowered rates of unintended pregnancy (or abortion) overall." The study the government relied on for this assertion was published in a law review rather than in a peer-reviewed scientific journal. [See New MJ, Analyzing the impact of state level contraception mandates on public health outcomes, *Ave Maria Law Review,* 2015, 13(2):345–369.] One basic flaw in this article is that, at the time, none of the state contraceptive coverage mandates eliminated out-of-pocket costs entirely, which is the major advance from the federal guarantee and the issue in this case. In addition, over the course of the period the article evaluated, contraceptive coverage quickly became the norm in the insurance industry—even in states without mandates—thus minimizing potential differences between states with laws and states without them. [Sonfield et al. U.S. insurance coverage of contraceptives and impact of contraceptive coverage mandates, 2002, *Perspectives on Sexual and Reproductive Health,* 2004, 36(2):72–79, https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/ 3607204.pdf.]

women living in states with no such requirement, even after accounting for differences including education and income.[52]

29. Although these state policies reduced women's up-front costs, other actions to eliminate out-of-pocket costs entirely—which is what the federal contraceptive coverage guarantee does—have even greater potential to increase women's ability to use methods effectively. For example, when Kaiser Permanente Northern California eliminated patient cost-sharing requirements for IUDs, implants, and injectables in 2002, the use of these devices increased substantially, with IUD use more than doubling.[53] Another example comes from a study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice (i.e., any method other than sterilization) at no cost for two to three years, and were "read a brief script informing them of the effectiveness and safety of" IUDs and implants.[54] Three-quarters of those women chose long-acting methods (i.e., IUDs or implants), a level far higher than in the general population. Likewise, a Colorado study found that use of long-acting reversible contraceptive methods quadrupled when offered with no out-of-pocket costs along with other efforts to improve access.[55]

30. Government-funded programs to help low-income people afford family planning services provide further evidence that reducing or eliminating cost barriers to women's contraceptive choices has a dramatic impact on women's ability to choose and use the most effective forms of contraception. Each year, among the women who obtain contraceptive services from publicly funded reproductive health providers, 57% select hormone-based contraceptive methods, 18% use implants or IUDs, and 7% receive a tubal ligation.[56] It is estimated that without publicly

[52] Magnusson BM et al., Contraceptive insurance mandates and consistent contraceptive use among privately insured women, *Medical Care*, 2012, 50(7):562–568.
[53] Postlethwaite D et al., A comparison of contraceptive procurement pre- and post-benefit change, *Contraception*, 2007, 76(5): 360–365
[54] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.
[55] Ricketts S, Klinger G and Schwalberg G, Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women, *Perspectives on Sexual and Reproductive Health,* 2014, 46(3):125–132.
[56] Frost JJ and Finer LB, Unintended pregnancies prevented by publicly funded family planning services: Summary of results and estimation formula, memo to interested parties, New York: Guttmacher Institute, June 23, 2017, https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-

supported access to these methods at low or no cost, nearly half (47%) of those women would switch to male condoms or other nonprescription methods, and 28% would use no contraception at all.[57]

The ACA's Contraceptive Coverage Guarantee Has Had a Positive Impact

31. By ensuring coverage for a full range of contraceptive methods, services and counseling at no cost, the ACA's contraceptive coverage mandate has had its intended effect of removing cost barriers to obtaining contraception. Between fall 2012 and spring 2014 (during which time the coverage guarantee went into wide effect), the proportion of privately insured women who paid nothing out of pocket for the pill increased from 15% to 67%, with similar changes for injectable contraceptives, the vaginal ring and the IUD.[58] Similarly, another study found that since implementation of the ACA, the share of women of reproductive age (regardless of whether they were using contraception) who had out-of-pocket costs for oral contraceptives decreased from 21% in 2012 to just 4% in 2014.[59] These trends have translated into considerable savings for U.S. women: one study estimated that pill and IUD users saved an average of about $250 in copayments in 2013 alone because of the guarantee.[60]

32. Before the ACA, contraceptives accounted for between 30–44% of out-of-pocket health care spending for women.[61] Individual women themselves say that the ACA's contraceptive coverage guarantee is working for them. In a 2015 nationally representative survey of women aged 18–39, two-thirds of those who had health insurance and were using a hormonal contraceptive method reported having no copays; among those women, 80% agreed that paying

Pregnancies-Prevented-June-2017.pdf.

[57] Frost JJ and Finer LB, Unintended pregnancies prevented by publicly funded family planning services: Summary of results and estimation formula, memo to interested parties, New York: Guttmacher Institute, June 23, 2017, https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-Pregnancies-Prevented-June-2017.pdf.

[58] Sonfield A et al. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update, *Contraceptive*, 2015, 91(1):44–48.

[59] Sobel L, Salganicoff A and Rosenzweig C, *The Future of Contraceptive Coverage*, Kaiser Family Foundation (KFF) Issue Brief, Menlo Park, CA: KFF, 2017, https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/.

[60] Becker NV and Polsky D, Women saw large decrease in out-of-pocket spending for contraceptives after ACA mandate removed cost sharing, *Health Affairs*, 2015, 34(7):1204–1211.

[61] Becker NV and Polsky D, Women saw large decrease in out-of-pocket spending for contraceptives after ACA mandate removed cost sharing, *Health Affairs*, 2015, 34(7):1204–1211.

nothing out of pocket helped them to afford and use their birth control, 71% agreed this helped them use their birth control consistently, and 60% agreed that having no copayment helped them choose a better method for them.[62]

33. Demonstrating the population-level impact of the ACA's coverage provision (e.g., a change in unintended pregnancy rates) is complicated, because the provision affects only a subset of U.S. women, and because there are so many additional variables that affect women's pregnancy intentions, contraceptive use and ultimately the unintended pregnancy rate in the population. The evidence on whether the ACA's provision has affected contraceptive use at the population level is not definitive, but some studies suggest the guarantee has had an impact on contraceptive use, among those benefiting from the provision.

34. A study using claims data from 30,000 privately insured women in the Midwest found that the ACA's reduction in cost sharing was tied to a significant increase in the use of prescription methods from 2008 through 2014 (before and after the ACA provision went into effect), particularly long-acting methods.[63] Another study of health insurance claims from 635,000 privately insured women nationwide showed that rates of discontinuation and inconsistent use of contraception declined from 2010 to 2013 (again, before and after the ACA provision went into effect) among women using generic oral contraceptive pills after the contraceptive guarantee's implementation (among women using brand-name oral contraceptives, only the discontinuation rate declined).[64]

35. Two other studies, looking at the broader U.S. population, found no change in overall use of contraception or an overall switch from less-effective to more-effective methods among

[62] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

[63] Carlin CS, Fertig AR and Down BE, Affordable Care Act's mandate eliminating contraceptive cost sharing influenced choices of women with employer coverage, *Health Affairs,* 2016, 35(9):1608–1615.

[64] Pace LE, Dusetzina SB and Keating NL, Early impact of the Affordable Care Act on oral contraceptive cost sharing, discontinuation, and nonadherence, *Health Affairs,* 2016, 35(9):1616–1624.

women at risk of unintended pregnancy before and after the guarantee's implementation.[65,66] However, both studies identified some positive trends among key groups. One of them found that between 2008 and 2014, among women aged 20–24 (the age group at highest risk for unintended pregnancy), LARC use more than doubled, from 7% to 19%, without a proportional decline in sterilization.[67] The other study showed that between 2012 and 2015, use of prescription contraceptive methods, and birth control pills in particular, increased among sexually inactive women, suggesting that more women were able to start a method before becoming sexually active or use a method such as the pill for noncontraceptive reasons after implementation of the contraceptive coverage guarantee.[68]

36. There is also considerable empirical data from controlled experiments to confirm that the concept of removing cost as a barrier to women's contraceptive use is a major factor in reducing their risk for unintended pregnancy, and the abortions and unplanned births that would otherwise follow. For example, a study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice at no cost found that the number of abortions performed at St. Louis Reproductive Health Services declined by 21%.[69] Study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[70] Similarly, when access to both contraception and abortion increased in Iowa, the abortion rates actually declined.[71] Starting in 2006, the state expanded

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[65] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

[66] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[67] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[68] Bearak JM and Jones RK, Did contraceptive use patterns change after the Affordable Care Act? A descriptive analysis, *Women's Health Issues*, 2017, 27(3):316–321, http://www.whijournal.com/article/S1049-3867(17)30029-4/fulltext.

[69] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.

[70] Peipert JF et al., *Preventing unintended pregnancies by providing no-cost contraception*, *Contraception*, 2012, 120(6):1291–1297.

[71] Biggs MA, Did increasing use of highly effective contraception contribute to declining abortions in Iowa? *Contraception*, 2015, 91(2):167–173.

access to low- or no-cost family planning services through a Medicaid expansion and a privately funded initiative serving low-income women. Despite a simultaneous increase in access to abortion—the number of clinics offering abortions in the state actually doubled during the study period—the abortion rate dropped by over 20%.

Expanding Exemptions Would Harm Women

37. The Final Rules would make it more difficult, once again, for those receiving insurance coverage through companies or schools that use the exemption (i.e., employees, students and dependents) to access the methods of contraception that are most acceptable and effective for them. That, in turn, would increase those women's risk of unintended pregnancy and interfere with their ability to plan and space wanted pregnancies. These barriers could therefore have considerable negative health, social and economic impacts for those women and their families.

38. Allowing employers or schools to exclude all contraceptive methods, services and counseling from insurance plans—or to cover some contraceptive methods, services and information but not others—would prevent women from selecting and obtaining the methods of contraception that will work best for them. For example, Hobby Lobby objected to providing four specific contraceptive methods, including copper and hormonal IUDs, which are among the most effective forms of pregnancy prevention and also have among the highest up-front costs.

39. Allowing employers to restrict access to the full range of contraceptive methods and to approve coverage only for those they deem acceptable would place inappropriate constraints on women who depend on insurance to obtain the methods best suited to their needs. Moreover, in the absence of coverage, the financial cost of obtaining a method, and the fact that some methods have higher costs than others, would incentivize women to select methods that are inexpensive, rather than methods that are best suited to their needs and that they are therefore most likely to use consistently and effectively (see 10–19, above).

40. Excluding coverage for some or all contraceptive methods, services and counseling could deny women the ability to obtain contraceptive counseling and services from their desired

provider at the same time they receive other primary and preventive care.[72,73] A woman going to her gynecologist for an annual examination, for example, may have to go to a different provider to be prescribed (or even discuss) contraception. This disjointed approach increases the time, effort and expense involved in getting needed contraception and interferes with her ability to obtain care from the provider of her choice.

41. Isolating contraceptive coverage in this way also would interfere with the ability of health care providers to treat women holistically. A woman's choice of contraception can be affected by her other medical conditions (e.g., diabetes, HIV, depression/mental health), and certain medications can significantly reduce the effectiveness of some methods of contraception, so a woman's chosen provider should be able to manage all health conditions and needs at the same time.[74,75]

42. To the extent that expanding the exemptions would burden women's contraceptive use in these ways, it would be harmful to women's health. Contraception allows women to avoid unintended pregnancies and to time and space wanted pregnancies, which has been demonstrated to improve women's health and that of their families. Specifically, pregnancies that occur too early in a woman's life or that are spaced too closely are associated with negative maternal health outcomes and/or adverse birth outcomes, including preterm birth, low birth weight, stillbirth, and early neonatal death.[76,77,78,79] Contraceptive use can also prevent preexisting health conditions

[72] Leeman L, Medical barriers to effective contraception, *Obstetrics and Gynecology Clinics of North America,* 2007, 34(1):19–29.
[73] World Health Organization, Selected Practice Recommendations for Contraceptive Use, Third Ed., 2016, WHO: Geneva, Switzerland, http://apps.who.int/iris/bitstream/10665/252267/1/9789241565400-eng.pdf.
[74] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.
[75] Centers for Disease Control and Prevention, U.S. medical eligibility criteria for contraceptive use, 2010, *Morbidity and Mortality Weekly Report,* May 28, 2010, Vol. 59, https://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf.
[76] Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers,* New York: Guttmacher Institute, 2013, http://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers.
[77] Wendt A et al., Impact of increasing inter-pregnancy interval on maternal and infant health, Paediatric and Perinatal Epidemiology, 2012, 26(Suppl. 1):239–258.
[78] Conde-Agudelo A, Rosas-Bermúdez A and Kafury-Goeta AC, Birth spacing and risk of adverse perinatal outcomes: a meta-analysis, Journal of the American Medical Association, 2006, 295(15):1809–1823.
[79] Gipson JD, Koenig MA and Hindin MJ, The effects of unintended pregnancy on infant, child, and parental health:

from worsening and new health problems from occurring, because pregnancy can exacerbate existing health conditions such as diabetes, hypertension and heart disease.[80] Unintended pregnancy also affects women's mental health; notably, it is a risk factor for depression in adults.[81,82] For these reasons, the Centers for Disease Control and Prevention (CDC) included the development of and improved access to methods of family planning among the 10 great public health achievements of the 20th century.[83]

43. In the Final Rules, the government implies that there is debate about whether contraception may have negative health consequences that outweigh its benefits. In the previous interim final rules, the government implied that putative negative health consequences of contraception may outweigh its benefits. On the contrary, the government itself provides the oversight to ensure that the health benefits of contraception outweigh any potential negative consequences. Notably, the FDA's approval processes require that drugs and devices, including contraceptives, be proven safe and effective through rigorous controlled trials. In addition, the CDC publishes extensive recommendations to help clinicians and patients identify potential contraindications and decide which specific contraceptive methods are most appropriate for each patient's needs and health circumstances.[84,85] Medical experts, such as the American College of Obstetricians and Gynecologists, concur that contraception is safe and has clear health benefits that outweigh any potential risks.[86]

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a review of the literature, *Studies in Family Planning,* 2008, 39(1):18–38.

[80] Lawrence HC, Testimony of American Congress of Obstetricians and Gynecologists, submitted to the Committee on Preventive Services for Women, Institute of Medicine, 2011, http://www.nationalacademies.org/hmd/~/media/8BA65BAF76894E9EB8C768C01C84380E.ashx.

[81] Herd P et al., The implications of unintended pregnancies for mental health in later life, *American Journal of Public Health,* 2016, 106(3):421–429.

[82] U.S. Preventive Services Task Force, Screening for depression in adults: recommendation statement, *American Family Physician,* 2016, 94(4):340A–340D, http://www.aafp.org/afp/2016/0815/od1.html.

[83] Centers for Disease Control and Prevention, Achievements in public health, 1900–1999: family planning, *Morbidity and Mortality Weekly Report,* 1999, 48(47): 1073–1080.

[84] Centers for Disease Control and Prevention, *US Medical Eligibility Criteria for Contraceptive Use, 2016,* https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/summary.html.

[85] Centers for Disease Control and Prevention, U.S. medical eligibility criteria for contraceptive use, 2010, *Morbidity and Mortality Weekly Report,* May 28, 2010, Vol. 59, https://www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf.

[86] Brief of *Amici Curiae,* American College of Obstetricians and Gynecologists, Physicians for Reproductive Health, American Academy of Family Physicians, American Nurses Association, et al., *Zubik v. Burwell,* 2016, http://www.scotusblog.com/wp-content/uploads/2016/02/Docfoc.com-Amicus-Brief-Zubik-v.-Burwell.pdf.

44. Expanding the exemptions to the contraceptive coverage requirement would also have negative social and economic consequences for women, families and society. By enabling them to reliably time and space wanted pregnancies, women's ability to obtain and effectively use contraception promotes their continued educational and professional advancement, contributing to the enhanced economic stability of women and their families.[87] Economic analyses have found positive associations between women's ability to obtain and use oral contraceptives and their education, labor force participation, average earnings and a narrowing of the gender-based wage gap.[88] Moreover, the primary reasons women give for why they use and value contraception are social and economic: In a 2011 study, a majority of women reported that access to contraception had enabled them to take better care of themselves or their families (63%), support themselves financially (56%), stay in school or complete their education (51%), or get or keep a job or pursue a career (50%).[89]

45. The government contends that expanding the exemption would not impose any real harm, suggesting that the women most at risk for unintended pregnancy are not likely to be covered by employer-based group health plans or by student insurance sponsored by a college or university. That argument is misleading. Low-income women, women of color and women aged 18–24 are at disproportionately high risk for unintended pregnancy,[90] and millions of these women rely on private insurance coverage—particularly following implementation of the ACA. In fact, from 2013 to 2017, the proportion of women overall and of women below the poverty level who were uninsured dropped by more than one-third nationwide, declines driven by substantial increases in both Medicaid and private insurance coverage.[91] In addition, the ACA specifically expanded

[87] Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children,* New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children.

[88] Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children,* New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children.

[89] Frost JJ and Lindberg LD, Reasons for using contraception: perspectives of U.S. women seeking care at specialized family planning clinics, 2012, *Contraception,* http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf.

[90] 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.

[91] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, *News in Context,*

coverage for people aged 26 and younger, allowing them to remain covered as dependents on their parents' plans, regardless of whether the young woman is working herself or attending college or university.

Medicaid, Title X and State Coverage Requirements Cannot Substitute for the Federal Contraceptive Coverage Guarantee

46. State and federal programs and laws—such as the Title X national family planning program, Medicaid, and state contraceptive coverage requirements—cannot replicate or replace the gains in access made by the contraceptive coverage guarantee. In the interim final rules, the government claimed that "[i]ndividuals who are unable to obtain contraception coverage through their employer-sponsored health plans because of the exemptions created in these interim final rules…have other avenues for obtaining contraception…."[92]

47. Many women who have the benefit of the ACA's contraceptive coverage mandate are not eligible for free or subsidized care under Title X. Title X provides no-cost family planning services to people living at or below 100% of the federal poverty level ($12,060 for a single person in 2017),[93] and provides services on a sliding fee scale between 100% and 250% of poverty; women above 250% of poverty must pay the full cost of care. By contrast, the federal contraceptive coverage guarantee eliminates out-of-pocket costs for contraception regardless of income.

48. Funding for Title X has not increased sufficiently for the program even to keep up with the increasing number of women in need of publicly funded care;[94] therefore, Title X cannot sustain additional beneficiaries as a result of the Final Rules. From 2010 to 2014, even as the

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Dec. 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

[92] Department of the Treasury, Department of Labor and Department of Health and Human Services, Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act, *Federal Register*, 82(197):47838–47862, https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf.

[93] Office of the Assistant Secretary for Planning and Evaluation, U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs, 2017, https://aspe.hhs.gov/poverty-guidelines.

[94] Women in need of publicly funded contraceptive services are defined as those women who a) are younger than 20 or are poor or low-income (i.e., have a family income less than 250% of the federal poverty level) and b) are sexually active and able to become pregnant but do not want to become pregnant. See Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

number of women in need of publicly funded contraceptive care grew by 5%, representing an additional one million women in need,[95] Congress cut funding for Title X by 10%.[96] With its current resources, Title X is able to serve only one-fifth of the nationwide need for publicly funded contraceptive care.[97] Still, the government has proposed diverting already insufficient Title X funding to help cover the cost of care for any women affected by the Final Rules,[98] an action that would inevitably hurt patients who rely on publicly funded services.

49. Similarly, many women who would lose private insurance coverage of contraception under the federal government's expanded exemption would not be eligible for Medicaid. Eligibility for Medicaid varies widely from state to state, particularly in states that have not expanded Medicaid eligibility under the ACA. In almost all of those states, nondisabled, nonelderly childless adults do not qualify for Medicaid at any income level, and eligibility for parents is as low as 18% of the federal poverty level in Alabama and Texas.[99] Several of these states have expanded eligibility specifically for family planning services to people otherwise ineligible for full-benefit Medicaid; those income eligibility levels also vary considerably.[100,101] Again, by contrast, the federal contraceptive coverage guarantee applies regardless of income. And because the U.S. Supreme Court has ruled that states cannot be compelled by the federal government to expand Medicaid eligibility, the federal government cannot rely on Medicaid to fill in gaps in coverage that would result from expanding the exemption.

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[95] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[96] Department of Health and Human Services, Office of Population Affairs, Funding history, 2017, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html.

[97] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[98] Department of Health and Human Services, Compliance with statutory program integrity requirements, *Federal Register*, 83(106):25502–25533, https://www.gpo.gov/fdsys/pkg/FR-2018-06-01/pdf/2018-11673.pdf.

[99] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[100] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[101] Kaiser Family Foundation, Status of state action on the Medicaid expansion decision, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

50. The federal government's assertion that Title X and Medicaid can replace or replicate the ACA's contraceptive coverage guarantee is additionally problematic given that the government itself is at the same time moving to undermine Title X and Medicaid. For example, the government's recent budget proposals have sought to exclude Planned Parenthood Federation of America and its affiliates from Title X, Medicaid and other federal programs,[102] and have called for massive cuts to Medicaid.[103] The Department of Health and Human Services has proposed sweeping changes to Title X regulations that would undermine quality of care and access to providers,[104] and it has encouraged states to revamp their Medicaid programs in ways that would restrict program eligibility (e.g., by imposing work requirements) and thereby interfere with coverage and care.[105] The administration has strongly backed similar congressional proposals for cutting and limiting access to Title X and Medicaid.

51. In addition, proposed changes to Title X would make it even more unsuitable as a substitute for contraceptive coverage under the ACA. The recent proposed rule for Title X removes the requirement that the contraceptive methods offered by a Title X provider be "medically approved."[106] At the same time, the proposed rule seemingly opens the door to allow Title X funding to go to antiabortion counseling centers (also called "crisis pregnancy centers"), which do not offer the broad range of FDA-approved methods of contraception and may offer only abstinence-until-marriage counseling and fertility awareness–based methods. These proposed changes, if implemented, would shift the Title X program away from its mission of offering access to a broad range of family planning methods.[107]

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[102] Hasstedt K, Beyond the rhetoric: the real-world impact of attacks on Planned Parenthood and Title X, *Guttmacher Policy Review,* 2017, 20:86–91, https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x.

[103] Luhby T, Not even the White House knows how much it's cutting Medicaid, *CNN,* May 24, 2017, http://money.cnn.com/2017/05/24/news/economy/medicaid-budget-trump/index.html.

[104] Department of Health and Human Services, Compliance with statutory program integrity requirements, *Federal Register*, 83(106):25502–25533, https://www.gpo.gov/fdsys/pkg/FR-2018-06-01/pdf/2018-11673.pdf.

[105] Sonfield A, Efforts to transform the nature of Medicaid could undermine access to reproductive health care, *Guttmacher Policy Review,* 2017, 20:97–102, https://www.guttmacher.org/gpr/2017/10/efforts-transform-nature-medicaid-could-undermine-access-reproductive-health-care.

[106] Department of Health and Human Services, Compliance with statutory program integrity requirements, *Federal Register*, 83(106):25502–25533, https://www.gpo.gov/fdsys/pkg/FR-2018-06-01/pdf/2018-11673.pdf.

[107] Hasstedt K, A Domestic gag rule and more: the administration's proposed changes to Title X, *Health Affairs* Blog, June 18, 2018, https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-

52. Policymakers in many states have also restricted publicly funded family planning programs and providers, further undermining the ability of these programs to serve those affected by the expanded exemption.[108]

53. Neither can state-specific contraceptive coverage laws replicate or replace the increase in access to contraception provided by the ACA's contraceptive coverage guarantee. Twenty-one have no such laws at all.[109] Of the 29 states and the District of Columbia that do have contraceptive coverage requirements, only 10 currently bar copayments and deductibles for contraception (and another four states have new requirements not yet in effect). Additionally, the federal requirement limits the use of formularies and other administrative restrictions on women's use of contraceptive services and supplies, by making it clear that health plans may seek to influence a patient's choice only within a specific contraceptive method category (e.g., to favor one hormonal IUD over another) and not across methods (e.g., to favor the pill over the ring).[110] Few of the state laws include similar protections. Similarly, most of the state requirements do not specifically require coverage of all the distinct methods that the federal requirement encompasses. For example, only eight states currently require coverage of female sterilization, and few state laws make explicit distinctions between methods that some insurance plans have attempted to treat as interchangeable (such as hormonal versus copper IUDs, or the contraceptive patch versus the contraceptive ring).[111] Finally, state laws cannot regulate self-insured employers at all, and those employers account for 60% of all workers with employer-sponsored health coverage.[112]

changes-title-x.

[108] Gold RB and Hasstedt K, Publicly funded family planning under unprecedented attack, *American Journal of Public Health,* 2017, 107(12):1895–1897, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304124.

[109] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of December 2018),* 2018, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[110] Department of Labor, FAQs about Affordable Care Act implementation (part XXVI), May 11, 2015, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf.

[111] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of December 2018),* 2018, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[112] 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/.

State-Specific Impacts

54. The Final Rules would have public health and fiscal consequences in states across the country. If unable to access contraceptive coverage through their employer or university, some lower-income women who meet the strict income requirements of public programs would rely on publicly funded services to access this beneficial service. Many women who lose or lack contraceptive coverage because their employer or university objects, however, would not meet the strict income and eligibility requirements of public programs, and if as a result they are not using their preferred or the most effective methods for them, or if cost forces them to forgo contraceptive use periodically or altogether, they would be at increased risk of unintended pregnancy. The costs of the resulting unintended pregnancies often then fall to the states because the federal government cannot or will not withstand these costs. Examples of this impact are included below for the plaintiff states. Data for all 50 states and the District of Columbia are included in a table as Exhibit B.

California

55. In California, some women impacted by the Final Rules would not qualify for Medicaid, the state's Medicaid family planning expansion (Family PACT) or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

56. For example, in California, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal poverty level,[113] and individuals are eligible for coverage of family planning services specifically under Family PACT up to 200% of poverty.[114] This means that affected women who lose coverage as a result of the rules may not be eligible.

[113] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[114] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

57. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

58. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid, Family PACT and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

59. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 2.6 million women were in need of publicly funded family planning in California, and the state's family planning network was able to only meet 50% of this need.[115]

60. Another indicator of the existing unmet need for contraception in California is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 393,000 unintended pregnancies occurred among California residents, a rate of 50 per 1,000 women aged 15–44.[116]

[115] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[116] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

61. Of those unintended pregnancies that ended in birth, 64% were paid for by Medicaid and other public insurance programs.[117] Unintended pregnancies cost the state approximately $689 million and the federal government approximately $1.06 billion in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

62. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of California or its residents.

Connecticut

63. In Connecticut, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

64. For example, in Connecticut, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[118] and individuals are eligible for coverage of family planning services specifically up to 263% of poverty.[119] This means that affected women who lose coverage as a result of the rules may not be eligible.

[117] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[118] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[119] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

65. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

66. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

67. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 183,000 women were in need of publicly funded family planning in Connecticut, and the state's family planning network was able to only meet 38% of this need.[120]

68. Another indicator of the existing unmet need for contraception in Connecticut is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 32,000 unintended pregnancies occurred among Connecticut residents, a rate of 46 per 1,000 women aged 15–44.[121]

[120] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[121] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

69. Of those unintended pregnancies that ended in birth, 61% were paid for by Medicaid and other public insurance programs.[122] Unintended pregnancies cost the state approximately $80 million and the federal government approximately $128 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

70. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Connecticut or its residents.

Delaware

71. In Delaware, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

72. For example, in Delaware, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[123] (Delaware has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

73. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

[122] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[123] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

74. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

75. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 50,000 women were in need of publicly funded family planning in Delaware, and the state's family planning network was able to only meet 30% of this need.[124]

76. Another indicator of the existing unmet need for contraception in Delaware is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 11,000 unintended pregnancies occurred among Delaware residents, a rate of 62 per 1,000 women aged 15–44.[125]

77. Of those unintended pregnancies that ended in birth, 71% were paid for by Medicaid and other public insurance programs.[126] Unintended pregnancies cost the state approximately $36 million and the federal government approximately $58 million in 2010. The Final Rules are likely

[124] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[125] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[126] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

78. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Delaware or its residents.

District of Columbia

79. In the District of Columbia, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

80. For example, in the District of Columbia, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 215% or 221%, respectively, of the federal poverty level.[127] (The District of Columbia has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

81. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

82. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would

[127] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

83. The increase in the number of women relying on publicly funded services would increase the strain on the district's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 45,000 women were in need of publicly funded family planning in the District of Columbia, and the district's family planning network was able to only meet 84% of this need.[128]

84. Another indicator of the existing unmet need for contraception in the District of Columbia is that substantial numbers of residents experience unintended pregnancy each year. In 2010, 10,000 unintended pregnancies occurred among District of Columbia residents, a rate of 58 per 1,000 women aged 15–44.[129]

85. Of those unintended pregnancies that ended in birth, 85% were paid for by Medicaid and other public insurance programs.[130] Unintended pregnancies cost the district approximately $13 million and the federal government approximately $51 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by district residents, and thus to increase state and federal expenditures.

86. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of the District of Columbia or its residents.

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[128] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[129] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[130] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

Hawaii

87. In Hawaii, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

88. For example, in Hawaii, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[131] (Hawaii has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

89. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

90. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

91. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 73,000 women were in need of

[131] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

publicly funded family planning in Hawaii, and the state's family planning network was able to only meet 25% of this need.[132]

92. Another indicator of the existing unmet need for contraception in Hawaii is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 16,000 unintended pregnancies occurred among Hawaii residents, a rate of 61 per 1,000 women aged 15–44.[133]

93. Of those unintended pregnancies that ended in birth, 50% were paid for by Medicaid and other public insurance programs.[134] Unintended pregnancies cost the state approximately $38 million and the federal government approximately $77 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

94. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Hawaii or its residents.

Illinois

95. In Illinois, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

[132] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[133] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[134] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

96. For example, in Illinois, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[135] (Illinois has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

97. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

98. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

99. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 773,000 women were in need of publicly funded family planning in Illinois, and the state's family planning network was able to only meet 20% of this need.[136]

[135] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[136] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

100. Another indicator of the existing unmet need for contraception in Illinois is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 128,000 unintended pregnancies occurred among Illinois residents, a rate of 49 per 1,000 women aged 15–44.[137]

101. Of those unintended pregnancies that ended in birth, 78% were paid for by Medicaid and other public insurance programs.[138] Unintended pregnancies cost the state approximately $352 million and the federal government approximately $572 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

102. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Illinois or its residents.

Maryland

103. In Maryland, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

104. For example, in Maryland, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[139] and

[137] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[138] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[139] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

individuals are eligible for coverage of family planning services specifically up to 200% of poverty.[140] This means that affected women who lose coverage as a result of the rules may not be eligible.

105. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

106. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

107. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 298,000 women were in need of publicly funded family planning in Maryland, and the state's family planning network was able to only meet 25% of this need.[141]

108. Another indicator of the existing unmet need for contraception in Maryland is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[140] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[141] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

71,000 unintended pregnancies occurred among Maryland residents, a rate of 60 per 1,000 women aged 15–44.[142]

109. Of those unintended pregnancies that ended in birth, 58% were paid for by Medicaid and other public insurance programs.[143] Unintended pregnancies cost the state approximately $181 million and the federal government approximately $285 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

110. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Maryland or its residents.

Minnesota

111. In Minnesota, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

112. For example, in Minnesota, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[144] and individuals are eligible for coverage of family planning services specifically up to 200% of

[142] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[143] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[144] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

poverty.[145] This means that affected women who lose coverage as a result of the rules may not be eligible.

113. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

114. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

115. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 295,000 women were in need of publicly funded family planning in Minnesota, and the state's family planning network was able to only meet 29% of this need.[146]

116. Another indicator of the existing unmet need for contraception in Minnesota is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[145] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[146] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

38,000 unintended pregnancies occurred among Minnesota residents, a rate of 36 per 1,000 women aged 15–44.[147]

117. Of those unintended pregnancies that ended in birth, 67% were paid for by Medicaid and other public insurance programs.[148] Unintended pregnancies cost the state approximately $129 million and the federal government approximately $204 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

118. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Minnesota or its residents.

New York

119. In New York, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

120. For example, in New York, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[149] and individuals are eligible for coverage of family planning services specifically up to 223% of

[147] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[148] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[149] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

poverty.[150] This means that affected women who lose coverage as a result of the rules may not be eligible.

121. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

122. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

123. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 1.2 million women were in need of publicly funded family planning in New York, and the state's family planning network was able to only meet 32% of this need.[151]

124. Another indicator of the existing unmet need for contraception in New York is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[150] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[151] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

246,000 unintended pregnancies occurred among New York residents, a rate of 61 per 1,000 women aged 15–44.[152]

125. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs.[153] Unintended pregnancies cost the state approximately $601 million and the federal government approximately $938 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

126. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of New York or its residents.

North Carolina

127. In North Carolina, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

128. For example, in North Carolina, parents are eligible for full-benefit Medicaid only if they have incomes at or below 43% of the federal poverty level, and childless adults are ineligible for full-benefit Medicaid at any income.[154] Individuals are eligible for coverage of family

[152] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[153] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[154] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

planning services specifically up to 200% of poverty.[155] This means that affected women who lose coverage as a result of the rules may not be eligible.

129. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

130. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

131. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 668,000 women were in need of publicly funded family planning in North Carolina, and the state's family planning network was able to only meet 20% of this need.[156]

132. Another indicator of the existing unmet need for contraception in North Carolina is that substantial numbers of state residents experience unintended pregnancy each year. In 2010,

[155] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.
[156] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

95,000 unintended pregnancies occurred among North Carolina residents, a rate of 49 per 1,000 women aged 15–44.[157]

133. Of those unintended pregnancies that ended in birth, 75% were paid for by Medicaid and other public insurance programs.[158] Unintended pregnancies cost the state approximately $215 million and the federal government approximately $644 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

134. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of North Carolina or its residents.

Rhode Island

135. In Rhode Island, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

136. For example, in Rhode Island, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[159] (Rhode Island has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

[157] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[158] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[159] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

137. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

138. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

139. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 71,000 women were in need of publicly funded family planning in Rhode Island, and the state's family planning network was able to only meet 35% of this need.[160]

140. Another indicator of the existing unmet need for contraception in Rhode Island is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 9,000 unintended pregnancies occurred among Rhode Island residents, a rate of 43 per 1,000 women aged 15–44.[161]

[160] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[161] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002,* New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

141. Of those unintended pregnancies that ended in birth, 70% were paid for by Medicaid and other public insurance programs.[162] Unintended pregnancies cost the state approximately $28 million and the federal government approximately $49 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

142. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Rhode Island or its residents.

Vermont

143. In Vermont, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

144. For example, in Vermont, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level.[163] (Vermont has not expanded Medicaid eligibility specifically for family planning services.) This means that affected women who lose coverage as a result of the rules may not be eligible.

145. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

[162] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

[163] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

146. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

147. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 36,000 women were in need of publicly funded family planning in Vermont, and the state's family planning network was able to only meet 59% of this need.[164]

148. Another indicator of the existing unmet need for contraception in Vermont is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 4,000 unintended pregnancies occurred among Vermont residents, a rate of 36 per 1,000 women aged 15–44.[165]

149. Of those unintended pregnancies that ended in birth, 74% were paid for by Medicaid and other public insurance programs.[166] Unintended pregnancies cost the state approximately $10 million and the federal government approximately $22 million in 2010. The Final Rules are likely

[164] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[165] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[166] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

150. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Vermont or its residents.

Virginia

151. In Virginia, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs. Virginia women may be particularly likely to be impacted by the Final Rules because the state does not have its own policy requiring some level of contraceptive coverage among private insurance plans.

152. For example, in Virginia, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level (starting in January 2019),[167] and individuals are only eligible for coverage of family planning services specifically up to 205% of poverty.[168] This means that affected women who lose coverage as a result of the rules may not be eligible.

153. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

154. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to

[167] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[168] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

155. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 448,000 women were in need of publicly funded family planning in Virginia, and the state's family planning network was able to only meet 17% of this need.[169]

156. Another indicator of the existing unmet need for contraception in Virginia is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 84,000 unintended pregnancies occurred among Virginia residents, a rate of 51 per 1,000 women aged 15–44.[170]

157. Of those unintended pregnancies that ended in birth, 45% were paid for by Medicaid and other public insurance programs.[171] Unintended pregnancies cost the state approximately $195 million and the federal government approximately $312 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

[169] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[170] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[171] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

158. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Virginia or its residents.

Washington State

159. In Washington State, some women impacted by the Final Rules would not qualify for Medicaid or Title X because they would not meet the income eligibility requirements for coverage or subsidized care under these programs.

160. For example, in Washington, childless adults and parents are eligible for full-benefit Medicaid only if they have incomes at or below 138% of the federal poverty level,[172] and individuals are eligible for coverage of family planning services specifically up to 260% of poverty.[173] This means that affected women who lose coverage as a result of the rules may not be eligible.

161. As a result, some women would be at increased risk of unintended pregnancy, either because they are not able to afford the methods that work best for them, or because cost would force them to forgo contraception use entirely.

162. Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. Those women could be denied the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care, increasing the time, effort and expense involved in getting needed contraception. In addition, isolating contraceptive coverage in this way would

[172] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2018, State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

[173] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of December 2018),* 2018, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

interfere with the ability of health care providers to manage all of a woman's health conditions and needs at the same time.

163. The increase in the number of women relying on publicly funded services would increase the strain on the state's family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2014, 429,000 women were in need of publicly funded family planning in Washington, and the state's family planning network was able to only meet 26% of this need.[174]

164. Another indicator of the existing unmet need for contraception in Washington is that substantial numbers of state residents experience unintended pregnancy each year. In 2010, 61,000 unintended pregnancies occurred among Washington residents, a rate of 45 per 1,000 women aged 15–44.[175]

165. Of those unintended pregnancies that ended in birth, 63% were paid for by Medicaid and other public insurance programs.[176] Unintended pregnancies cost the state approximately $177 million and the federal government approximately $291 million in 2010. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

166. In conclusion, adding to the number of women at risk of unintended pregnancy by expanding the exemption is not in the public health or economic interest of Washington or its residents.

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[174] Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2014 Update*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[175] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002.

[176] Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy.

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Ample evidence demonstrates that the Final Rules would interfere with women's ability to identify and consistently use the contraceptive methods that would work best for them, thus putting them at heightened risk of unintended pregnancy and the health, social and economic harms that would result.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on the 18th day of December, 2018, in New York, New York.

Kathryn Kost
Acting Vice President for Domestic Research
The Guttmacher Institute

EXHIBIT A

Kathryn Kost

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EDUCATION

Princeton University, Princeton, New Jersey
Ph.D., Sociology, 1990; Area of Specialization: Demography

Reed College, Portland, Oregon
Bachelor of Arts, Sociology, 1982

PROFESSIONAL EXPERIENCE

The Guttmacher Institute, New York, New York
Acting Vice President of Domestic Research 2018 - present
Director of Domestic Research 2016-2018
Principal Research Scientist 2015-2016
Senior Research Associate, 1989-1998, 2009-2014
Consultant, 2004-2009

Gynuity Health Projects, New York, New York
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Princeton University, Princeton, New Jersey
Teaching Assistant, Introductory Statistics (graduate-level), Woodrow Wilson School, 1986-1987

East-West Population Institute, Population Research Division, University of Hawaii, Honolulu, HI
Research Intern, 1987

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National Academy of Sciences, Institute of Medicine, Washington, D.C.
Research Intern, Committee on Contraceptive Development, 1986

Princeton University, Princeton, New Jersey
NICHD Trainee, Office of Population Research, 1985-1989

American Health Foundation, New York, New York
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AREAS OF SPECIALIZATION

Sexual and Reproductive Health; Unintended Pregnancy and Childbearing; Pregnancy Surveillance and Statistics; Contraceptive Effectiveness.

PEER-REVIEWED PUBLICATIONS

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HONORS, AWARDS AND FELLOWSHIPS

East-West Center, University of Hawaii, Summer Fellowship (1987)

PROFESSIONAL ASSOCIATIONS

Population Association of America
American Sociological Association
PRAMS Steering Committee, New York City Department of Health & Mental Hygiene
Editorial Board, International Journal of Population Research
Full Fellow, Society of Family Planning
Member, Social Science and Population Studies Review Panel, National Institutes of Health (2012-2015)

EXHIBIT B

Exhibit B: State-Specific Data on Impact

	Medicaid eligibility, as % of federal poverty level (as of January 2018)			Women needing publicly supported contraceptive services and supplies, 2014		Unintended pregnancies, 2010		% of unplanned births paid for by public insurance programs, 2010	Public costs for unintended pregnancies, 2010	
	Childless adults	Parents	Family planning specific	Number	% of need met by publicly supported providers	Number	Rate per 1,000 women 15–44		State (in millions)	Federal (in millions)
Alabama	—	18%	146%	332,750	31%	46,000	48	61.6%	$72.6	$250.5
Alaska	138%	139%	—	41,200	63%	8,000	54	64.3%	42.9	70.8
Arizona	138%	138%	—	465,450	15%	61,000	49	64.6%	161.5	509.4
Arkansas	138%	138%	—	204,850	29%	29,000	50	72.3%	61.9	266.8
California	138%	138%	200%	2,643,580	50%	393,000	50	64.3%	689.3	1,062.1
Colorado	138%	138%	—	326,490	38%	43,000	42	63.8%	91.1	146.1
Connecticut	138%	138%	263%	183,070	38%	32,000	46	60.8%	80.1	128.4
Delaware	138%	138%	—	50,100	30%	11,000	62	71.3%	36.0	58.2
District of Columbia	215%	221%	—	44,910	84%	10,000	58	84.6%	13.3	50.9
Florida	—	33%	—	1,216,520	17%	207,000	58	70.6%	427.1	892.8
Georgia	—	36%	200%	695,120	16%	119,000	57	80.5%	229.7	687.7
Hawaii	138%	138%	—	73,090	25%	16,000	61	49.9%	37.8	76.7
Idaho	—	26%	—	113,020	21%	12,000	38	60.4%	18.5	70.2
Illinois	138%	138%	—	772,510	20%	128,000	49	78.3%	352.2	571.5
Indiana	139%	139%	146%	446,230	19%	55,000	43	64.6%	91.4	284.6
Iowa	138%	138%	—	190,270	29%	23,000	39	61.5%	48.3	127.6
Kansas	—	38%	—	188,100	17%	24,000	43	47.2%	50.4	115.7
Kentucky	138%	138%	—	284,530	24%	34,000	40	66.8%	75.0	302.8
Louisiana	138%	138%	138%	321,480	15%	53,000	57	78.7%	120.6	530.4
Maine	—	105%	214%	78,880	33%	9,000	37	74.7%	14.6	43.6
Maryland	138%	138%	200%	298,190	25%	71,000	60	58.2%	180.9	285.4
Massachusetts	138%	138%	—	373,060	25%	54,000	40	56.4%	138.3	219.6
Michigan	138%	138%	—	635,660	16%	93,000	49	71.9%	177.0	485.1
Minnesota	138%	138%	200%	294,680	29%	38,000	36	66.7%	128.7	203.9
Mississippi	—	27%	199%	213,930	28%	35,000	57	81.9%	40.4	226.7
Missouri	—	22%	—	391,510	18%	54,000	46	72.2%	132.6	385.9
Montana	138%	138%	216%	66,380	41%	7,000	42	47.8%	9.1	31.7
Nebraska	—	63%	—	118,170	20%	14,000	41	63.1%	41.7	91.9
Nevada	138%	138%	—	194,430	10%	29,000	54	60.0%	37.1	65.8
New Hampshire	138%	138%	201%	65,530	29%	8,000	32	52.7%	10.3	16.5
New Jersey	138%	138%	—	455,260	22%	97,000	56	52.4%	186.1	291.0
New Mexico	138%	138%	255%	151,950	28%	22,000	56	77.1%	47.9	191.2
New York	138%	138%	223%	1,227,170	32%	246,000	61	70.2%	601.1	937.7
North Carolina	—	43%	200%	667,910	20%	95,000	49	74.8%	214.7	643.5
North Dakota	138%	138%	—	44,180	26%	5,000	41	36.8%	7.7	17.9
Ohio	138%	138%	—	730,110	14%	109,000	49	68.7%	218.8	605.8
Oklahoma	—	45%	138%	256,880	31%	36,000	49	80.7%	77.0	254.0
Oregon	138%	138%	250%	270,990	39%	31,000	41	69.9%	47.2	122.7
Pennsylvania	138%	138%	220%	745,550	29%	115,000	47	53.5%	248.2	478.6
Rhode Island	138%	138%	—	71,320	35%	9,000	43	70.1%	27.5	48.7
South Carolina	—	67%	199%	323,140	31%	42,000	46	78.6%	84.0	327.3
South Dakota	—	50%	—	52,610	27%	7,000	46	46.2%	14.4	35.0
Tennessee	—	98%	—	434,440	26%	62,000	49	73.7%	130.7	400.0
Texas	—	18%	—	1,795,160	10%	298,000	56	73.7%	842.6	2,056.8
Utah	—	60%	—	207,350	22%	24,000	40	53.3%	30.4	127.6
Vermont	138%	138%	—	35,810	59%	4,000	36	73.5%	9.6	21.8
Virginia	—	38%	205%	447,970	17%	84,000	51	45.4%	194.6	312.0
Washington	138%	138%	260%	429,300	26%	61,000	45	63.1%	177.1	290.7
West Virginia	138%	138%	—	110,910	47%	15,000	43	76.0%	24.9	120.5
Wisconsin	100%	100%	306%	353,620	22%	42,000	38	62.0%	92.1	221.4
Wyoming	—	55%	—	34,630	30%	4,000	42	67.4%	21.3	34.1

Sources: References 113–117.