Acting Secretary Eric Hargan
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW., Room 445–G,
Washington, DC 20201

RE: [CMS-9940-IFC/CMS-9925-IFC]

Dec. 5, 2017

Dear Acting Secretary Hargan,

Lift Louisiana is committed to ensuring all individuals have affordable coverage of birth control. We unequivocally oppose the Departments of Health and Human Services, Labor, and Treasury's (the Departments) efforts to undermine the Patient Protection and Affordable Care Act's (ACA) contraceptive coverage requirement through this Interim Final Rule (IFR). The ACA's women's preventive services requirement was designed to promote preventive medicine, reduce future medical costs, and improve the health, equality, and economic security of women[1] and families. Over 62 million women with private insurance, including nearly 800,000 in Louisiana, now have coverage of these vital health care services, such as breast and cervical cancer screening, breastfeeding services and supplies, and contraception and contraceptive counseling.[2]

By allowing virtually any employer and university to deprive women of contraceptive coverage, this IFR will harm women and their health and well-being. It discriminates against women in violation of multiple federal laws and the Constitution. The IFR also violates the Administrative Procedure Act. The IFR ignores Congress's explicit intent that the ACA require coverage of contraception. And the IFR is predicated upon a distorted picture of the science supporting contraception, and the federal programs supporting and state laws regarding contraception. The harm from this rule would be especially harmful for the women in Louisiana who reside in a state that is hostile to women's health and consequently have some of the worst health outcomes and least access to services and resources in the nation.

Making effective methods of contraception available to women who want them but could not otherwise afford to use them consistently and correctly prevents a substantial number of unintended pregnancies. That, in turn, reduces the incidence of the unplanned births, abortions, miscarriages and pregnancy-related deaths that would otherwise follow.

For all of these reasons Lift Louisiana calls on the Departments to rescind the IFR.

I. Louisiana Women Need Coverage

[1] This comment uses the term "women" because women are targeted by the IFRs. We recognize, however, that the denial of reproductive health care and insurance coverage for such care also affects people who do not identify as women, including some gender non-conforming people and some transgender men.
[2] at'l Women's L. Ctr., New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs (Sept. 2017), *available at* https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf. Figure includes non-elderly adult women ages 18-64.

Louisiana struggles with health care inequities in access and outcomes. These inequities are amplified for Louisiana women and become even more dire when one considers Louisiana's restrictions on reproductive rights and other systematic oppressions.

In 2016, Louisiana women had the one of the highest uninsured rates (12%) in the U.S.[3] 59 percent of Louisiana's women were covered under private health insurance, with 51 percent covered by employer-sponsored insurance and the remaining 8 percent covered by individual coverage.[4] Individuals who were uninsured were primarily low-income, in working families, and White non-Hispanic.[5] The majority of nonelderly, uninsured Louisianans in 2014 had income below 400% of the federal poverty level (FPL, 85%).[6] Almost half (49%) of nonelderly, uninsured Louisianans identified as White, over one-third (37%) identified as Black, and 15% identified as Hispanic.[7]

Louisiana ranks 47th for women's poverty & opportunity[8] and 49th for women's employment & earnings, equal pay, women's overall earning potential and labor force participation.[9] Studies have found Louisiana to be the worst state for women's equality (for example, Black women in Louisiana make $0.48 to the dollar compared to White men), as well as one of the worst states for women's health.[10] One out of every five working-age women has income below poverty. This include 49.3% of single mothers. Thirty-six percent of Black women in the state live in poverty. Nearly 30% of our children are living poverty.

Louisiana also suffers with poor access to reproductive health care access and funding. Louisiana ranks 46th for reproductive rights.[11]

Louisiana has only one OB/GYN physician per 13,136 women, ranking 43rd (of 48) in the nation with respect to the ratio of women per every OB/GYN physician.[12]

The state spends almost 2.4 times as much per pregnant woman as the national average.[13]

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[3] Kaiser Family Foundation, Health Insurance Coverage of Women 19-64 (2016) *available at* https://www.kff.org/other/state-indicator/nonelderly-adult-women

[4] *Id.*

[5] Kaiser Family Foundation,New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women (Oct 06, 2017), *available at* https://www.kff.org/womens-health-policy/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/

[6] *Id*.

[7] *Id.*

[8] Institute for Women's Policy Research, *The Status of Women in the States: 2015*, *available at* http://statusofwomendata.org/wp-content/uploads/2015/02/Status-of-Women-in-the-States-2015-Full-National-Report.pdf

[9] *Id.*

[10] Anna Chu & Charles Posner, Ctr. For Am. Progress, The State Of Women In America: A 50-state Analysis Of How Women Are Faring Across The Nation, 1, 35 (2013), *available at:* https://www.americanprogress.org/wp-content/uploads/2013/09/StateOfWomen-4.pdf.

[11] "The Status of Women in the States: 2015", Institute for Women's Policy Research, available at http://statusofwomendata.org/wp-content/uploads/2015/02/Status-of-Women-in-the-States-2015-Full-National-Report.pdf

[12] *Id.*

[13] LDH-OPH, MCH Program, Louisiana Pregnancy-associated Mortality Review: 2008 Report 1 (2012), *available at* http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/maternal/2008PAMRreport.pdf

Maternal mortality rates in Louisiana are higher than the national average. The Louisiana Pregnancy Mortality Surveillance System (LPMSS) reported the 2001-2005 pregnancy associated mortality ratios to be between 86.3 and 89.4 maternal deaths per 100,000 live births.[14]

For these reasons, Louisiana women are in need of comprehensive contraceptive services.

II. Birth Control Is Critical to Women's Health

Women face a unique set of healthcare challenges because they use more health services than men yet earn less on average than men.[15] As a result, women face a high level of health care insecurity which leads many women to forgo necessary care because of prohibitive patient cost-sharing. Before the ACA, one in seven women with private health insurance and nearly one-third of women covered by Medicaid either postponed or went without needed services in the prior year because they could not afford it.[16] Women were spending between 30% and 44% of their total out-of-pocket health costs just on birth control.[17] One national study estimates that for uninsured women, the average cost of these pills over a year ($370) is 68 percent of their annual out-of-pocket expenditures for health care services.[18] The average cost of a year's supply of birth control pills is the equivalent of 51 hours of work for a woman making minimum wage of $7.25 an hour, two-thirds of which are women in Louisiana.[19] Out-of-pocket costs prevented many women, not just low-income women, from accessing preventive services, including contraception.[20]

The gap between men and women who struggled to access needed care was in fact widest among adults with moderate incomes.[21] Nationally, 13.0% of women reported not receiving health care at some point in the last 12 months due to cost in 2016; in Louisiana, 19.6% of women reported not receiving care due

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[14] TRI TRAN ET AL., LDH-OPH, MCH Program, 2001-2005 Maternal & Child Health Data Book 28 (2009), *available at:* http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/maternal/MCHdatabook0105.pdf

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

[16] Kaiser Family Foundation. Women's Health Care Chartbook. 2011.

[17] *Id*.

[18] Sonfield, A., Tapales, A., Jones, R. K., & Finer, L. B. (2015). Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update,. Contraception, 91(1), 44–48. http://doi.org/10.1016/j.contraception.2014.09.006

[19] Brief of the National Women's Law Center and 68 Other Organizations as Amici Curiae Supporting Respondents, *Zubik v. Burwell*, 136 S.Ct. 1557 (May 16, 2016).

[20] Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills between 1996 and 2006*, 83 CONTRACEPTION 491, 531 (2010); *see also* Inst. of Med. of the Nat'l Acads., *Clinical Preventive Services for Women: Closing the Gaps* 19 (2011), https://www.nap.edu/read/13181/chapter/1. Another study of 11,000 employees with employer-sponsored coverage found that cost-sharing reduced use of pap smears, preventive counseling, and mammography. Geetesh Solanki et al., *The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services*, 34 HEALTH SERVS. RESEARCH 1331, 1342-43 (2000); 1342-43; *see also* David Machledt & Jane Perkins, *Medicaid Premiums & Cost-Sharing* 2-3 (2014), http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.WgCFehNSzeQ.

[21] Sheila D. Rustgi et al., The Commonwealth Fund, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* 4 (2009), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf. Finding that sixty-five percent of women with incomes between $20,000 and $39,999 experienced problems accessing health care services because of cost.

to cost.[22] By contrast, eliminating cost barriers has helped increase access to contraception for women with employer-sponsored coverage.[23] Because of the birth control benefit, women saved more than $1.4 billion in out-of-pocket costs on birth control pills in 2013 alone.[24]

The goal of preventive health care is to help people control, track, and better manage their life-long health, and the health of their families. Similarly, the goal of prevention of unintended pregnancy is to help women time and space their pregnancies, or prevent pregnancy altogether, in accordance with their own desires and to improve maternal, child, and family health.[25] Contraception enables women to prevent unintended pregnancy and control the timing of a desired pregnancy. In addition, access to birth control is particularly critical for women with underlying physical and psychological conditions or chronic conditions which can be exacerbated by pregnancy itself. These women may need to take particular care in planning their pregnancies to ensure that their health can support carrying a pregnancy to term.[26]

Unintended pregnancies are associated with higher rates of long-term health complications for mother and infant. Women with unplanned pregnancies are more likely to delay prenatal care, leaving their health complications unaddressed and increasing risk of infant mortality, birth defects, low birth weight, and preterm birth.[27] Other long term health harms of unintended pregnancy include the impact on health behaviors such as breastfeeding and negative physical and mental effects on children. Women with unintended pregnancies are also at higher risk for maternal morbidity and mortality, maternal depression, or experiencing physical violence during pregnancy.[28] Unintended pregnancy rates are higher in the United States than in most other developed countries, with approximately 45% of pregnancies unintended.[29] In 2010, 60% of all pregnancies (53,000) in Louisiana were unintended; much higher than the national rate.[30] Unintended pregnancies are also costly to the federal and state governments, resulting in $21.0 billion in public expenditures in 2010.[31]

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[22] NWLC calculations of Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Behavioral Risk Factor Surveillance System Prevalence and Trends Data, 2016 Annual Survey.

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

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

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

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

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

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

[29] 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,

[30] Guttmacher Institute, State Facts About Unintended Pregnancy: Louisiana (2017), *available.at:* https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-louisiana

[31] *Id.*

And, Louisiana has one of the highest maternal mortality rates in the U.S. which has the highest rate of maternal mortality in the developed world.[32] Contraceptive efficacy in preventing unintended pregnancy is well established and supported in evidence.[33] And contraception is considered a major factor in reducing rates of maternal mortality and morbidity.

Most women who use birth control do so for both contraceptive and noncontraceptive purposes.[34] Beyond the well-established evidence that contraceptives are effective in the prevention of unintended pregnancy, non-contraceptive health benefits of contraception are recognized in evidence, including decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including endometriosis, myoma, pelvic inflammatory disease, and a decreased risk of endometrial and ovarian cancer.[35] Non-contraceptive health benefits also include treatment for non-gynecologic conditions.[36, 37]

Insurance coverage of contraception is critical to ensuring women can use it. Unintended pregnancy rates are highest among those least able to afford contraception, particularly those who face additional barriers to accessing health care services including economic instability and/or discrimination based on race, ethnicity, gender identity, or sexual orientation.

Birth control is also vital in furthering equal opportunity for women, enabling women to be equal participants in the social, political, and economic life of the nation. By enabling women to decide if and when to become parents, birth control allows women to access more professional and educational opportunities. Only 25% of working mothers in Louisiana are able to take exclusively paid parental leave, with 61% taking exclusively unpaid leave, and 7% taking no leave at all. Of women employed during their pregnancies, 44% do not have jobs that offer paid leave, 35% cannot financially afford to take leave, and 16% are afraid of losing their jobs.[38] Preventing pregnancy can have serious economic consequences for Louisiana women and their families.

Studies show that access to contraception has increased women's wages and lifetime earnings.[39] In fact, the availability of the oral contraceptive pill alone is associated with roughly one-third of the total wage

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[32] Murray, J.L., Wang, H., Kassebaum, N., "Sharp Decline in Maternal and Child Deaths Globally, New Data Show." Institute for Health Metrics and Evaluation. University of Washington. 2016.
[33] Trussell J. Contraceptive failure in the United States. Contraception. 2011;83(5):397-404.
[34] Jones RK. Beyond birth control: The overlooked benefits of oral contraceptive pills. New York: Guttmacher Institute, 2011.
[35] Schindler AE. Non-contraceptive benefits of oral hormonal contraceptives. Int J Endocrinol Metab. 2013;11(1):41-7, and Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:250–5.
[36] *Id*.
[37] Cortessis VK, Barrett M, Brown W, et. Al. Intrauterine Device Use and Cervical Cancer Risk; A Systematic Review and Meta-analysis Obstet Gynecol. 2017
[38] LDH-OPH, LA. Pregnancy Risk Assessment Monitoring System (PRAMS), Maternity Leave In Louisiana. 2015, *available at* http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/maternal/LouisianaPRAMS/PRAMS_Maternity_Leave_Fact_Sheet.pdf.

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

gains for women born from the mid-l940s to early 1950s.[40] Access to oral contraceptives may also account for up to one-third of the increase in college enrollment by women in the 1970s,[41] which was followed by large increases in women's presence in law, medicine, and other professions.[42] The Departments have previously acknowledged these significant benefits, noting that prior to the ACA's passage, disparities in health care coverage "place[d] women in the workforce at a disadvantage compared to their male co-workers," and that the contraceptive coverage benefit "furthers the goal of eliminating this disparity by allowing women to achieve equal status as healthy and productive members of the job force."[43]

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

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

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

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

A. Congress Intended the ACA to Require Contraceptive Coverage

When Congress passed the Women's Health Amendment, it meant "to ensure that recommended preventive services for women are covered adequately by non-grandfathered group health plans and group health insurance coverage, recogniz[ing] that women have unique health care needs and burdens."[44] Allowing more entities to deprive women of contraceptive coverage, as the IFR does, strikes at the very purpose of the contraceptive coverage requirement.

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

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

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

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

[44] *Id*. at 8,727.

Indeed, Congress intended the Women's Health Amendment, which includes the contraceptive coverage requirement, to help alleviate the "punitive practices of insurance companies that charge women more and give [them] less in a benefit" and to "end the punitive practices of the private insurance companies in their gender discrimination."[45] In enacting the Amendment, Congress recognized that the failure to cover women's preventive health services meant that women paid more in out-of-pocket costs than men for necessary preventive care and in some instances were unable to obtain this care at all because of cost barriers:

> Women must shoulder the worst of the health care crisis, including *outrageous discriminatory practices in care and coverage*. . . . In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost. *This fundamental inequity in the current system is dangerous and discriminatory and we must act*.[46]

In considering the Amendment, Congress expressed its expectation that the preventive services covered would include family planning services. For example, Senator Gillibrand stated, "With Senator Mikulski's amendment, even more preventive screening will be covered, including for…family planning."[47] And Senator Franken also said in regards to the Women's Health Amendment, "[A]ffordable family planning services must be accessible to all women in our reformed health care system."[48] That contraception would be covered was clear.[49]

To meet the Amendment's objectives, the Department of Health and Human Services commissioned the Institute of Medicine ("IOM") "to convene a diverse committee of experts in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines to review existing guidelines, identify existing coverage gaps, and recommend services and screenings for [the Department of Health and Human Services] to consider in order to fill those gaps."[50] After conducting its analysis, the IOM panel recommended eight preventive services for women, including contraceptive coverage.[51] On August 1, 2011, HRSA adopted the recommendations set forth in the IOM Report.[52] These were

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[45] 155 Cong. Rec. S12,021, S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski); *see also id.* at S12,030 (statement of Sen. Dodd) ("I support the effort by Senator Mikulski on her efforts to see to it that women are treated equally, and particularly in preventive care[.]").

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

[47] 155 Cong. Rec. S12,021, S12,027 (daily ed. Dec. 1, 2009).

[48] 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 1, 2009). *See also,* 155 Cong. Rec. S12,106, S12,114 (daily ed. Dec. 2, 2009) (statement of Sen. Feinstein) ("[The Amendment] will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include . . . family planning . . .").

[49] *See also* 155 Cong. Rec. S12025 (Dec. 1, 2009) (Sen. Boxer) (preventative care "include[s] . . . family planning services"); 155 Cong. Rec. S12114 (Dec. 2, 2009) (Sen. Feinstein) ("The amendment . . . will require insurance plans to cover at no cost basic preventive services" including "family planning."); id. at 12277 (Sen. Nelson) ("I strongly support the underlying goal of furthering preventive care for women, including . . . family planning."); 155 Cong. Rec. S12671 (Dec. 8, 2009) (Sen. Durbin) (under the ACA "millions more women will have access to affordable birth control and other contraceptive services").

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

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

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

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

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

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

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

II. The IFR Violates Other Statutory and Constitutional Protections

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

Religious arguments have long been used in attempts to thwart women's equality, just as they have been used to thwart racial equality.[53] But those efforts have time and again been rejected. For example, in passing Title VII of the Civil Rights Act of 1964, Congress barred workplace discrimination based on a variety of factors including race and sex, over objections based on religion.[54] And as society has evolved beyond a religiously imbued vision of women as mothers and wives, courts have rejected efforts to allow religious exemptions to undermine civil rights protections for women.[55]

Like Title VII and other civil rights laws, the birth control benefit was intended to address longstanding discrimination and ensure women equal access to the preventive services that allow them to be full participants in society. In interfering with that access, the IFR targets women for adverse treatment, resulting in health insurance that covers preventive care that men need, but not care that women need. It interferes with the right to contraception encompassed by the fundamental constitutional right to liberty. As a result, the IFR discriminates against women on the basis of sex, in violation of the Due Process

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[53] *See*, e.g., at 21 https://www.aclu.org/sites/default/files/field_document/02.17.16_amicus_brief_in_support_of_respondents-_aclu_et_al.pdf
[54] *Id.* at 19.
[55] *See*, e.g., at 24-27 https://www.aclu.org/sites/default/files/field_document/02.17.16_amicus_brief_in_support_of_respondents-_aclu_et_al.pdf

Clause of the Fifth Amendment, which guarantees people equal protection of the laws. And it violates Section 1557 of the ACA, which prohibits discrimination on the basis of sex in "any health program or activity, any part of which is receiving Federal financial assistance . . . or under any program or activity that is administered by an Executive Agency."[56]

Finally, the Constitution bars the Departments from crafting an exemption like this because it harms women. Freedom of religion and belief is a fundamental right, protected by our Constitution and federal law. It guarantees us all the right to believe (or not) as we see fit. But it doesn't give anyone the right to use religious or moral beliefs as an excuse to harm others. The Constitution commands that a religious or moral accommodation must be "measured so that it does not override other significant interests" or "impose unjustified burdens on other[s]." [57] In fact, in *Hobby Lobby* under the Religious Freedom Restoration Act, the Court described that the impact of the accommodation on third parties would be "precisely zero." [58] Prior to this IFR, HHS met this requirement by ensuring employees continued to receive no-cost contraception coverage, even if their employer objected to providing coverage. The IFR fails the constitutional do-no-harm test.

III. The IFR Violates the Administrative Procedure Act

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

The APA requires an agency to follow notice and comment procedures which provide "interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation"[59] unless the agency can establish good cause to skip that process. Good cause is narrowly construed, and exists only where public comment is "impracticable, unnecessary, or contrary to the public interest." The APA further requires that a rule be published 30 days prior to its effective date.[60] Good cause plainly does not exist here.

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

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[56] 2 U.S.C. § 18116.
[57] E.g., Cutter v. Wilkinson, 544 U.S. 709, 722, 726 (2005).
[58] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2760 (2014). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that the burdens on third parties must be considered. *See id* at 2781 n.37.; *id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n.8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting).
[59] 5 U.S.C. § 553(b), (c).
[60] 5 U.S.C. § 553(d).

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

Further, the Departments' action in issuing this interim final rule constitutes arbitrary and capricious behavior. In unilaterally broadening the existing exemption and making the accommodation optional, the Departments jettisoned the careful balance that they had previously struck—with input from hundreds of thousands of commenters and numerous courts—between women's need for a critical preventive service and certain institutions' religious beliefs, and they did so without any statutory authority or even a reasoned explanation. The rule is therefore unlawful under the APA.[61]

Specifically, the rule is in excess of statutory authority. The rule is contrary to Section 1557 of the ACA, 42 U.S.C. 18116, which prohibits sex discrimination in certain health programs and activities, because it sanctions sex discrimination by allowing employers and universities to direct health insurance companies to prevent their employees and students from receiving contraceptive coverage. The rule is also contrary to Section 1554 of the ACA, which prohibits the Secretary of Health and Human Services from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[62] As discussed throughout this comment, some women have historically been unable to obtain contraception because of cost barriers. By permitting objecting institutions to deny no-cost contraceptive coverage, the rule erects unreasonable barriers to medical care and impedes timely access to contraception. The rule is therefore invalid in violation of 5 U.S.C. § 706(2) because they are supported by no valid justification, contradict the ACA and the U.S. Constitution, and exceed Defendants' statutory jurisdiction, authority, or limitations.[63]

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

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

As the nation's health policy center, the Department of Health and Human Services (HHS) policies and activities must be firmly based on scientifically valid and appropriate terms and evidence. The IFR does not meet the high standard of scientific evidence used by the IOM and WPSI, instead prioritizing the religious beliefs of individuals over evidence-based medical recommendations. The Departments make several false and misleading statements in this Rule to undermine the contraceptive benefit. Lift Louisiana unequivocally opposes the Departments' effort to undermine the contraceptive coverage requirement based not on science and medicine, but on individual's beliefs.

A. Contraceptives Do Not Interfere with an Existing Pregnancy

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[61] 5 U.S.C. § 706.

[62] 42 U.S.C. § 18114(1).

[63] Under the APA, a reviewing court shall "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), "contrary to a constitutional right," id. § 706(2)(B), or "in excess of statutory jurisdiction," id. § 706(2)(C).

Policies that restrict women's access to preventive health care should not be based on falsehoods that are not supported by science, regardless of who "believes" them. The Rule takes issue with the IOM recommended coverage of the full range of U.S. Food and Drug Administration (FDA)-approved contraceptive methods because it includes "certain drugs and devices… that many persons and organizations believe are abortifacient—that is, as causing early abortion."[64] FDA-approved contraceptive methods are not abortifacients. Every FDA-approved contraceptive acts before implantation, does not interfere with a pregnancy, and is not effective after a fertilized egg has implanted successfully in the uterus, which is when pregnancy begins.[65]

If policies are being based upon American sentiment, it should also be considered that, according to The National Campaign to Prevent Teen and Unplanned Pregnancy, 94% of adults agree that everyone should have the power to decide if, when, and under what circumstances to get pregnant, 87% of adults agree that everyone deserves the power to access the full range of birth control methods, no matter who they are, where they live, and what their economic status is.[66]

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

The Rule raises concerns about the "negative health effects" of contraception.[67] As with any medication, certain types of contraception may be contraindicated for patients with certain medical conditions, including high blood pressure, lupus, or a history of breast cancer.[68, 69] Specifically, the Rule suggests an increased risk of venous thromboembolism (VTE). In fact, VTE among oral contraceptive users is very low and is much lower than the risk of VTE during pregnancy or in the immediate postpartum period.[70] Moreover, other medications covered by insurance under the ACA, such as prescription medication for erectile dysfunction, pose a risk of VTE but are not under attack.[71] The Rule also suggests contraception increases the risk of breast cancer, but there is no proven increased risk of breast cancer among contraceptive users, particularly those under 40.[72]

C. Contraceptives Do Not Increase Sexual Activity Among Adolescents

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[64] 82 Fed. Reg. 47,792, 47,749 (Oct. 13, 2017).
[65] Brief for Physicians for Reproductive Health, American College of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Respondents, Sebelius v. Hobby Lobby, 573 U.S. XXX (2014) (No. 13-354). *Available at:* acog.org/~/media/Departments/Government%20Relations%20and%20Outreach/20131021AmicusHobby.pdf?. Moreover, the Department of Health and Human Services defines pregnancy as beginning at implantation. 45 C.F.R. § 46.202(f) (2017).
[66] The National Campaign to Prevent Teen and Unplanned Pregnancy, "Survey Says", *available at:* https://thenationalcampaign.org/sites/default/files/resource-primary-download/774_37_surverysays_birthcontrol_v3_letter.pdf
[67] 82 Fed. Reg. 47,792, 47,804 (Oct. 13, 2017).
[68] Progestin-only hormonal birth control: pill and injection. FAQ No. 86. American College of Obstetricians and Gynecologists. July 2014.
[69] Combined hormonal birth control: pill, patch, and ring. FAQ No. 185. American College of Obstetricians and Gynecologists. July 2014.
[70] Risk of venous thromboembolism among users of drospirenone-containing oral contraceptive pills. Committee Opinion No. 540. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:1239–42.
[71] The Telegraph, "Study links Viagra to increased stroke risk", *available at* http://www.telegraph.co.uk/news/uknews/1418453/Study-links-Viagra-to-increased-stroke-risk.html.
[72] Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.

The Rule suggests the contraceptive coverage benefit could "affect risky sexual behavior in a negative way."[73] Increased access to contraception is not associated with increased unsafe sexual behavior or increased sexual activity.[74,75] In fact, research has shown school-based health centers that provide access to contraceptives are proven to increase use of contraceptives by already sexually active students, not to increase onset of sexual activity.[76,77] On the other hand, young females who did not use birth control at first sexual intercourse were twice as likely to become teen mothers.[78]
Louisiana has the 6th highest teen birth rates in the nation.[79] In 2010, the state's teen pregnancy rate remained well above national levels (69 vs. 57 pregnancies per 1,000).[80] As a result, the state spends tens of millions annually on teen childbearing.[81] As minors, teens are necessarily dependent on health insurance coverage obtained by their parents or guardians and are not likely going to be able to afford out-of-pocket expenditures for essential health benefits they may be using, such as contraception.

Overall, increased access to and use of contraception has contributed to a dramatic decline in rates of adolescent pregnancy.[82] More females are using contraception the first time they have sex.[83]

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

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

The Departments assert that existing government-sponsored programs, such as Medicaid and Title X, and state coverage requirements can serve as alternatives for individuals who will lose access to contraceptive coverage without cost sharing as a result of this IFR.[84] This assertion fails to recognize that Medicaid and Title X are not designed to absorb the needs of higher income, privately insured individuals and do not have the capacity to meet the needs of current enrollees *and* those seeking care at Title X health centers. Further, the existence of the programs is threatened by legislative and

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[73] 82 Fed. Reg. 47,792, 47,805 (Oct. 13, 2017).
[74] Kirby D. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. 2009.
[75] Meyer JL, Gold MA, Haggerty CL. Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature. J Pediatr Adolesc Gynecol. 2011;24(1):2–9).
[76] Minguez M, Santelli JS, Gibson E, Orr M, & Samant, S. Reproductive health impact of a school health center. Journal of Adolescent health, 2015;56(3), 338-344.
[77] Knopf JA, Finnie RKC, Peng Y, et al. Community Preventive Services Task Force. School-based health centers to advance health equity: a Community Guide systematic review. American Journal of Preventive Medicine 2016;51(1):114–26.
[78] *Id*.
[79] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Teen Birth Rate Comparison, 2015 Among Girls Age 15-19*, *available at* https://thenationalcampaign.org/data/compare/1701
[80] Kaiser Family Foundation, *The Louisiana Health Care Landscape*, *available at* https://www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/
[81] The National Campaign to Prevent Teen and Unplanned Pregnancy, Louisiana Data, available at: https://thenationalcampaign.org/data/state/louisiana
[82] Lindberg L, Santelli J, Desai S. Understanding the Decline in Adolescent Fertility in the United States, 2007–2012. J Adolesc health. 2016;59(5):577-583. DOI: 10.1016/j.jadohealth.2016.06.024.
[83] *Id*.
[84] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47803 (Oct. 13, 2017) (to be codified at 45 C.F.R. 147, pt. 147).

administrative proposals. With respect to the state laws, the Departments' claim misconstrues the scope and protections of state contraceptive coverage laws which cannot fill in the coverage gaps caused by this IFR.

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

Safety net programs like the Title X family planning program and Medicaid are not designed to absorb the unmet needs of higher-income, insured individuals. Title X is the nation's only dedicated source of federal funding for family planning services, and federal law requires Title X-funded health centers to give priority to "persons from low-income families."[85] Low-income individuals receive services at these health centers at low or no cost depending on their family income.[86] Furthermore, Congress did not design Title X as a substitute for employer-sponsored coverage. The Title X statute and regulations contemplate how Title X and third-party payers, including employer-sponsored coverage, will work together to pay for care, directing Title X-funded agencies to seek payment from such third-party payers.[87]

Further, the IFR argues that Title X-funded health centers could fill the gap in contraceptive coverage it creates, and provide care to more patients than are currently served by the program. However, with current funding and resources, the Title X provider network cannot meet the existing need for publicly funded family planning, let alone absorb the increase in demand that would result from the Department's rules.

Publicly supported family planning centers in Louisiana served 49,570 female contraceptive clients in 2014. They met 15% of Louisiana women's need for contraceptive services and supplies.[88]

Reductions in funding for Title X already limit the number of patients Title X-funded providers are able to serve.[89] Since 2010, the reported annual number of clients served at Title X sites has dropped from approximately 5.2 million patients to just over 4 million.[90] This decline corresponds to over $30 million in cuts to Title X's annual appropriated amount over the same period.[91] Requiring otherwise

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[85] *See* Fam. Plan. Servs. & Population Res. Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504, and 42 CFR § 59.5 (a)(6-9).
[86] 42 U.S.C. § 300a-4(c)(2); 42 C.F.R. § 59.5(a)(7)-(8).
[87] 42 U.S.C. § 300a-4(c)(2) (prohibiting charging persons from a "low-income family" for family planning services "except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge"); 42 CFR § 59.5(a)(7), (9).
[88] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2014 Update, New York: Guttmacher Institute, 2016, *available at https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.*
[89] August, Euna M. et al., "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (2016), available at http://doi.org/10.2105/AJPH.2015.302928. Congress would have to increase federal funding for Title X by over $450 million to adequately address the existing need for publicly funded contraception.
[90] *See* Fowler, CI, Lloyd, SW, Gable, J, Wang, J, and Krieger, K, *Family Planning Annual Report: 2010 National Summary*, RTI International (Sept. 2011), *available at* https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf; Fowler, C.I, Gable, J., Wang, J., & Lasater, B, *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), *available at* https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[91] U.S. Dept. of Health and Human Servs., Funding History HHS.Gov (2017), *available at* https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html (last visited Nov 3, 2017).

higher-income, privately insured individuals to use Title X-funded health centers would deplete resources from an already overburdened and underfunded program.

Similarly, Medicaid is a source of coverage designed to meet the unique health care needs of individuals who are low-income. However, unlike Title X, which requires the health centers it funds to take all patients, Medicaid has income and other eligibility requirements for individuals to participate.[92] Many individuals enrolled in Medicaid have extremely low incomes and minimal savings at hand. These individuals also face severe health problems and lack any resources to address these issues on their own, unlike individuals with higher incomes and employer-sponsored coverage.

Medicaid enrollees have robust access to health care, including family planning services and supplies, and Medicaid already operates as a very lean program. In spite of this, provider shortages have persisted. The majority (two-thirds) of state Medicaid programs face challenges to securing an adequate number of providers to furnish services to patients.[93] This is particularly true with respect to specialty providers, including OB/GYNs.[94] There is unmet need for health care providers in Louisiana. 62 of 64 parishes in the state contain a Health Professional Shortage Area (HPSA).[95] Given this provider shortage and Medicaid's eligibility requirements discussed above, Medicaid does not have capacity to serve individuals who lose coverage as a result of this IFR.

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

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

Within the last year, as part of the numerous, failed attempts to repeal the ACA, policymakers have sought to radically alter the financial structure of Medicaid.[96] Policymakers continue to try to impose

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

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

[94] A recent report from the HHS Office of Inspector General found that many Medicaid managed care plans had provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments to new patients. U.S. Department of Health and Human Services, supra at note 7.

[95] Louisiana Department Of Health, Office Of Public Health- Bureau Of Family Health, Reproductive Health Needs Assessment, 2017.

[96] The most recent legislative proposal sponsored by Senators Lindsey Graham and Bill Cassidy would have decimated the Medicaid program by cutting over one trillion dollars to the program over the next ten years. Cong. Budget Office, Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants, 6, (Sept. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf. The proposal would have repealed Medicaid expansion, converted Medicaid's financing structure to a per capita cap, and would have permitted states to block grant their Medicaid programs for certain communities, resulting in drastic cuts to coverage and services that

steep cuts to the Medicaid program through the budget process and to undermine the program through regulatory measures. The Department of Health and Human Services has made clear its intent to approve "innovations" to the Medicaid program.[97] These "innovations" may very well include provisions that undermine the ability of individuals qualified to enroll in Medicaid to receive the coverage and health care they need. Finally, Congress and the Trump Administration have blatantly threatened women's health by attempting to block Planned Parenthood from participating in Medicaid despite the outsized role that Planned Parenthood plays in delivering family planning care to people with Medicaid coverage. The state of Louisiana has joined this effort, by passing a law prohibiting any organization that performs abortions, or contracts with an entity or organization that from receiving public funding. This was a direct effort to remove Planned Parenthood from being eligible to receive public funding which they receive from Medicaid reimbursements and Title X funding for family planning services. Planned Parenthood Gulf Coast's two clinics provide care to over 5200 Medicaid beneficiaries, who comprise more than half of the patients they serve in Louisiana.[98] Efforts in other states to prohibit Planned Parenthood from serving Medicaid recipients have been blocked by federal courts who have held, a state may not exclude a provider simply based on the scope of the services it provides.[99]

Unfortunately, Medicaid is not the only health care program that has faced administrative and congressional attacks despite playing a critical role in the health care safety net; Title X has also been targeted. In fact, Title X-funded health centers play a particularly important role in serving communities of color.[100] The number of women in need of publicly funded family planning is trending upwards nationally, and in Louisiana, an estimated 321,480 adolescents and low income women are in need of publicly funded services and supplies.[101]

Further, Federally Qualified Health Centers (FQHCs) are not able to fill gaps in services because the scope and quality of these services vary greatly. While 99.8% of FQHCs in Louisiana provide one or more contraceptive methods, only 87% provide "typical" family planning, defined as STI testing and treatment; oral contraceptives; and one other contraceptive method. Only 51% of FQHCs provide

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individuals enrolled in Medicaid need and deserve. Mara Youdelman & Kim Lewis, Nat'l Health Law Program, Top 10 Changes to Medicaid Under the Graham-Cassidy Bill, (Sept. 14, 2017), http://www.healthlaw.org/publications/browse-all-publications/top-10-changes-to-medicaid-under-graham-cassidy-bill#.Wft9mmhSzIV.

[97] Letter from Secretary Tom E. Price and CMS Administrator, Seema Verma, to Governors (on file with NHeLP-DC), https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf and Paige Winfield Cunningham, *States Will Be Allowed to Impose Medicaid Work Requirements, Top Federal Official Says*, WASH. POST (Nov. 7, 2017), *available at:* https://www.washingtonpost.com/news/powerpost/wp/2017/11/07/states-will-be-allowed-to-impose-medicaid-work-requirements-top-federal-official-says/?utm_term=.0513a6c28c8e.

[98] *Planned Parenthood Of Gulf Coast v. Rebekah Gee, Secretary, Louisiana Department of Health and Hospitals*, Opinion of the United States Court of Appeals Fifth Circuit, Case: 15-30987, June 29, 2017.

[99] *Id.*

[100] In 2016, 21 percent of Title X clients identified as Black or African American, 3 percent identified as Asian, and 1 percent identified as either Native Hawaiian, Pacific Islander, American Indian or Alaska Native. Also, 32 percent of Title X patients identified as Hispanic or Latina/o. Fowler, C. I., Gable, J., Wang, J., & Lasater, B., *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), *available at* https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[101] Louisiana Department Of Health, Office Of Public Health- Bureau Of Family Health, Reproductive Health Needs Assessment, 2017.

"typical" family planning services plus one other contraceptive method, in addition to IUDs and/or hormonal implants.[102]

In Louisiana in 2010, the federal and state governments spent $651.0 million on unintended pregnancies; of this, $530.4 million (72%) was paid by the federal government and $120.6 million was paid by the state.[103] Yet the Louisiana spends less on family planning ($39 million) than unintended pregnancies ($100 million).[104]

In addition to severe cuts to Title X's budget since 2011, political opponents of reproductive health have repeatedly sought to defund or interfere with patients' access to care under the program.[105] The administration has not only signaled its support for these efforts, but has also put forth its own proposals to restrict access to publicly funded family planning under Title X.[106] Publicly funded family planning centers in Louisiana helped avert 12,000 unintended pregnancies in 2014, which would have resulted in 5,800 unplanned births and 4,300 abortions.[107]

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

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[102] Wood, S. (2016). Scope of Family Planning Services Available in Federally Qualified Health Centers. Contraception, 89, 85–90.

[103] 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, *available at:* https://www.guttmacher.org/report/publiccosts-unintended-pregnancies-and-role-public-insurance-programspaying-pregnancy .

[104] Sonfield A and Gold RB, Public Funding for Family Planning Sterilization and Abortion Services, FY 1980–2010, New York: Guttmacher Institute, 2012, *available at:* https://www.guttmacher.org/report/publicfunding-family-planning-sterilization-and-abortion-services-fy-1980-2010.

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

[106] The White House, Statement Of Administration Policy: H.R. 3354 — Make America Secure and Prosperous Appropriations Act, 2018 (Rep. Frelinghuysen, R-NJ) (Sept. 5, 2017), *available at* https://www.whitehouse.gov/the-press-office/2017/09/05/hr-3354-make-america-secure-and-prosperous-appropriations-act-2018. For instance, the President's FY 2018 budget plan proposed blocking low-income and uninsured patients from obtaining federally-funded health care services, including Title X-funded care, at Planned Parenthood health centers, even though Planned Parenthood health centers currently serve 41 percent of patients that access contraception through Title X nationwide. Kinsey Hasstedt, Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X, *Guttmacher Policy Review,* (Aug. 2017), *available at* https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x, and White House, Office of Management and Budget, The President's Fiscal Year 2018 Budget: Overview (May 2017), *available at* https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/fact_sheets/2018%20Budget%20Fact%20Sheet_Budget%20Overview.pdf (last visited Nov 3, 2017).

[107] Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2014 Update, New York: Guttmacher Institute, 2016, *available at:* https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

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

Similarly, the IFRs suggest that the existence of state-level contraceptive coverage requirements somehow diminish the need for a federal requirement. This suggestion ignores the fact that twenty-two states, including Louisiana, do not have contraceptive coverage laws at all.[108] In fact, efforts over the last two decades in Louisiana to ensure health insurance coverage of contraceptives failed in the state legislature, leaving Louisiana's women without coverage.

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

VI. The Department's Proposed Changes to the Rule Do Not Fix the Above Problems

The Department's request comment on several ways the IFR could be changed to expand exemptions to the birth control benefit. Each of the questions presented by the Department is based on an assumption that the IFR is legally sound, and in some instances, that it should be expanded. As described in detail above, this assumption is incorrect. Other than completely striking it, there is nothing the Departments could do to make this better, and any expansion would only further violate the law. The IFR should be struck in its entirety.

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

If you have any questions, please contact me at (504) 484-9636.

Sincerely,

Michelle Erenberg
Executive Director
Lift Louisiana

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