Nos. 19-431 & 19-454

In The Supreme Court of the United States

LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME,

Petitioner,

v.

COMMONWEALTH OF PENNSYLVANIA
AND STATE OF NEW JERSEY,

Respondents.

DONALD J. TRUMP, PRESIDENT
OF THE UNITED STATES, ET AL.,

Petitioners,

v.

COMMONWEALTH OF PENNSYLVANIA
AND STATE OF NEW JERSEY,

Respondents.

On Writs Of *Certiorari* To The United States Court Of Appeals For The Third Circuit

BRIEF OF *AMICUS CURIAE* THE GUTTMACHER INSTITUTE IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICUS CURIAE*[1]

Amicus is the Guttmacher Institute, a nonprofit, nonpartisan corporation and a leading research and policy organization dedicated to advancing sexual and reproductive health and rights in the United States and globally. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by promoting evidence-based policies and conducting research according to the highest standards of methodological rigor. 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 rights issues are widely cited by policymakers, the media, and advocates across the ideological spectrum. *Amicus* therefore has a strong interest in the issues presented in this appeal.

In *Burwell v. Hobby Lobby, Inc.*, 573 U.S. 682, 686 (2014), the Court assumed, without deciding, that "the interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA. . . ." *Amicus* writes to share the extensive empirical evidence regarding the usage of contraception by women in the United States, the positive impact of the Affordable Care Act's contraceptive coverage guarantee, and the harm that will result if the Final Rules at issue in this appeal become law.

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[1] Pursuant to Supreme Court Rule 37.6, no counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* or its counsel made a monetary contribution to this brief's preparation. All parties consented to the filing of this brief.

That empirical evidence shows that cost-free access to contraception is indeed a compelling governmental interest in the welfare of our Nation's residents.

SUMMARY OF ARGUMENT

The Affordable Care Act's (ACA) contraceptive coverage guarantee has had a significant impact in reducing barriers to the use of contraceptives and in making them more affordable for the women who depend on them. If the Final Rules become law, much of that positive impact could disappear. Allowing employers to exclude all or certain types of contraceptive methods would compromise women's ability to consistently use the methods that work best for them, thus putting them at heightened risk of unintended pregnancies and interfering with their ability to time and space wanted pregnancies. That, in turn, would increase the risk of detrimental health outcomes for both women and their children, and would have negative social and economic consequences by interfering with women's ability to achieve their educational, professional and family goals.

Many of the government's arguments are not fairly supported by the empirical evidence. For example, the government does not adequately consider the health benefit of contraception or the number of women at risk for unintended pregnancy who would be adversely affected by the Final Rules; and coverage through other government-funded programs cannot replace the gains in access made possible by the ACA's contraceptive care guarantee.

ARGUMENT

I. Contraception Is Widely Used

More than 99% of the women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method. That is true across populations with a variety of religious affiliations.[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] 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]

Women and couples rely on a wide range of contraceptive methods, including oral contraceptives; condoms; female or male sterilization; hormonal or copper intrauterine devices (IUDs); other hormonal methods

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[2] Kimberly Daniels, et al., *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.

[3] Megan L. Kavanaugh and Jenna Jerman, *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] Adam Sonfield, et al., *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

including the injectable, the ring, the patch and the implant; and behavioral methods, such as withdrawal and fertility awareness-based methods.[5] Most women rely on multiple methods over the course of their reproductive lives—for instance, as their relationships, life circumstances, and family goals evolve—with 86% having used three or more methods by their early 40s.[6]

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.

II. Women Need Access to the Full Range of Contraceptive Options

Using any method of contraception greatly reduces a woman's risk of unintended pregnancy. Sexually active couples using no method of contraception have a

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[5] Ayana Douglas-Hall, Kathryn Kost, and Megan L. Kavanaugh, *State-level estimates of contraceptive use in the United States*, 2017, https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.

[6] Daniels, *Contraceptive methods women have ever used: United States, 1982–2010*, *supra*.

[7] Megan L. Kavanaugh and Jenna Jerman, *Concurrent Multiple Methods of Contraception in the United States, poster presented at the North American Forum on Family Planning*, Atlanta, Oct. 14–16, 2017.

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]

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.

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.

There are many features that people say are important to them when choosing a contraceptive method, and the importance of each feature varies across individuals.[9] These include the effectiveness of

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[8] Apana Sundaram, 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; James Trussell and Abigail Aiken, *Contraceptive Efficacy*, pp: 829-928 in Robert A. Hatcher, et al., Contraceptive Technology, 21st Ed. New York, NY: Ayer Company Publishers, Inc., 2018.

[9] Lauren N. Lessard, et al., *Contraceptive features preferred by women at high risk of unintended pregnancy*, Perspectives on Sexual and Reproductive Health, 2012, 44(2):194–200; Andrea V. Jackson, et al., *Racial and ethnic differences in women's*

the method; ease and convenience of use; concerns about and past experience with 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.

Being able to select the methods that best fulfill one's own needs and priorities is an important way to ensure that individuals will be satisfied with their chosen methods, and 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.[10] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[11]

Consistent contraceptive use in turn 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

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preferences for features of contraceptive methods, Contraception, 2015, 93(5):406-11.

[10] Guttmacher Institute, Improving contraceptive use in the United States, 2008, https://www.guttmacher.org/report/improving-contraceptive-use-united-states.

[11] *Id.*

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.[12]

III. Eliminating Contraceptive Costs Leads to Improved Use and Reduced Risk of Unintended Pregnancy

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,[13] which have higher up-front costs.[14]

The most effective methods of contraception are long-acting reversible contraceptives (LARC), such as implants and IUDs. The total cost of initiating one of

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[12] Sonfield, *Moving Forward: Family Planning in the Era of Health Reform*, *supra*.

[13] Trussell, et al., *Contraceptive Efficacy*, *supra.*

[14] James Trussell, et al., *Cost Effectiveness of Contraceptives in the United States*, Contraception, 2009, 79(1):5–14.

these methods generally exceeds $1,000.[15] 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. These costs can be dissuasive for many women not covered by the contraceptive coverage guarantee.[16] Even oral contraceptives, which are twice as effective as condoms in practice, require a prescription and have monthly costs.

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.[17] This is not true. For example, a national study found that 45% of adults with insurance, and 72% of those with household incomes of less than $40,000 a year, would

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[15] Erin Armstrong, et al., Intrauterine Devices & Implants: A Guide to Reimbursement, 2016, https://larcprogram.ucsf.edu/; David Eisenberg, et al., *Cost as a Barrier to Long-acting Reversible Contraceptive (LARC) use in Adolescents*, Journal of Adolescent Health, 2013, 52(4):S59–S63.

[16] Aileen Gariepy, 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.

[17] The government includes IUDs as one of the methods that costs $50 per month. That is not accurate because an IUD cannot be paid month to month, but instead requires a high up-front cost. Perhaps the government has confused an IUD with another method that has recurring monthly costs, such as the patch or the ring.

be unable to immediately afford an unexpected $500 medical bill.[18]

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.[19] A study conducted after 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.[20]

Other studies have found that uninsured women are less likely to use the most expensive (but most

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[18] Luna Lopes, Audrey Kearney, Liz Hamel, and Mollyann Brodie, *Data note: public worries about and experience with surprise medical bills*, 2020, https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/.

[19] Jennifer Frost and Jacqueline Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use*, Perspectives on Sexual and Reproductive Health, 2008, 40(2):94–104.

[20] Jonathan Bearak and Rachel Jones, *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.

effective) contraceptive methods, such as IUDs, implants, and oral contraceptives,[21] and are more likely than insured women to report using no contraceptive method at all.[22] A 2017 study found that even after controlling for demographic characteristics, individuals with health insurance coverage have increased odds of using a most or moderately effective contraceptive method—the methods that are most expensive and require the most contact with health care providers—which underscores the importance of health insurance in aiding access to these methods.[23]

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.[24] 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

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[21] Kelly Culwell and Joe Feinglass, *The Association of Health Insurance with use of Prescription Contraceptives*, Perspectives on Sexual and Reproductive Health, 2007, 39(4):226–230.

[22] *Id.*; Kelly Culwell and Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995–2002: the Effect of Insurance Coverage*, Obstetrics & Gynecology, 2007, 110(6):1371–1378.

[23] Megan L. Kavanaugh, Ayana Douglas-Hall and Sean Finn, *Health insurance coverage and contraceptive use at the state level: findings from the 2017 Behavioral Risk Factor Surveillance System*, Contraception, 2019, https://doi.org/10.1016/j.conx.2019.100014.

[24] Guttmacher Institute, *Insurance Coverage of Contraceptives (as of June 2012)*, 2012.

demonstrates that having insurance coverage matters.[25] 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 women living in states with no such requirement, even after accounting for differences including education and income.[26]

Although these state policies reduced women's upfront costs, other actions to eliminate out-of-pocket costs entirely—which is what the federal contraceptive

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[25] The government argues in the IFRs 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 relies on for this assertion was published in a law review rather than in a peer-reviewed scientific journal. *See* Michael J. New, *Analyzing the impact of state level contraception mandates on public health outcomes*, Ave Maria Law Review, 13(2):345–369 (2015). 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. *See* Adam 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.

[26] Brianna Magnusson, et al., *Contraceptive Insurance Mandates and Consistent Contraceptive use Among Privately Insured Women*, Medical Care, 2012, 50(7):562–568.

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.[27] 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.[28] 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.[29]

Government-funded programs to help low-income people afford family planning services provide further evidence that reducing or eliminating cost barriers to

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[27] Debbie Postlethwaite, et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, Contraception, 2007, 76(5): 360–365.

[28] Jeffrey Peipert, et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, Contraception, 2012, 120(6):1291–1297.

[29] Sue Rickets, et al., *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.

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.[30] It is estimated that without publicly 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.[31]

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

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

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[30] Jennifer J. Frost, et al., *Publicly supported family services in the United States, 2016: methodological appendix*, Guttmacher Institute, October 2019, https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2016-method-appendix.pdf.

[31] *Id*.

contraceptives, the vaginal ring, and the IUD.[32] 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.[33] Another study showed a similar trend of increasing $0 out-of-pocket costs for oral contraceptives among insured women for the same time period.[34]

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, and that before the ACA, contraceptives accounted for between 30–44% of out-of-pocket health care spending for women.[35] Another study found that for privately insured women, out-of-pocket costs for sterilization and reversible prescription contraceptives decreased about

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

[33] Laurie Sobel, et al., *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/.

[34] Nam Hyo Kim and Kevin A. Look, *Effects of the Affordable Care Act's contraceptive coverage requirement on the utilization and out-of-pocket costs of prescribed oral contraceptives*, Research in Social and Administrative Pharmacy, 2018, 14(5):479–487.

[35] Nora Becker and Daniel Polsky, *Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives after ACA Mandate Removed Cost Sharing*, Health Affairs, 2015, 34(7):1204–1211.

70% immediately after the implementation of the ACA.[36]

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 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 themselves.[37]

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

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[36] Amy W. Law, et al., *Are women benefiting from the Affordable Care Act? A real-world evaluation of the impact of the Affordable Care Act on out-of-pocket costs for contraceptives*, Contraception, 2016, 93(5):392–397.

[37] Bearak, et al., *Did Contraceptive Use Patterns Change after the Affordable Care Act?, supra*.

had an impact on contraceptive use, among those benefiting from the provision.

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.[38] Similarly, a study using claims from millions of privately insured women found a small but statistically significant increase in LARC use after the ACA provision took effect.[39] 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).[40]

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[38] Caroline Carlin, et al., *Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women with Employer Coverage*, Health Affairs, 2016, 35(9):1608–1615.

[39] Ashley H. Snyder, et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women*, Women's Health Issues, 2018, 28(3):219–223.

[40] Lydia Pace, et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, Health Affairs, 2016, 35(9):1616–1624.

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 women at risk of unintended pregnancy before and after the guarantee's implementation.[41] 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.[42] 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.[43]

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

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[41] Bearak, et al., *Did Contraceptive use Patterns change after the Affordable Care Act?, supra*; Kavanaugh, et al., *Contraceptive Method use in the United States: Trends and Characteristics Between 2008, 2012 and 2014, supra*.

[42] *Id.*

[43] Bearak, et al., *Did Contraceptive use Patterns Change after the Affordable Care Act?*, *supra*.

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%.[44] Study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[45] Similarly, when access to both contraception and abortion increased in Iowa, the abortion rates actually declined.[46] Starting in 2006, the state expanded 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%.[47]

V. Expanding Exemptions Would Harm Women

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

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[44] Peipert, et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, *supra*.

[45] *Id.*

[46] M. Antonia Biggs, *Did Increasing use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?* Contraception, 2015, 91(2):167–173.

[47] *Id.*

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.

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.[48]

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,

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[48] *See Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 761-62 (2014).

rather than methods that are best suited to their needs and that they are therefore most likely to use consistently and effectively.

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 when women had not wanted to become pregnant either at that time or ever, 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.[49] Contraceptive use can also prevent preexisting health conditions from worsening and new health problems from occurring, because pregnancy can exacerbate existing health conditions such as diabetes, hypertension, and heart

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[49] Amanda Wendt, et al., *Impact of increasing inter-pregnancy interval on maternal and infant health*, Paediatric and Perinatal Epidemiology, 2012, 26(Suppl. 1):239–258; Agustin Conde-Agudelo, Anyeli Rosas-Bermúdez and Ana Cecilia Kafury-Goeta, *Birth spacing and risk of adverse perinatal outcomes: a meta-analysis*, Journal of the American Medical Association, 2006, 295(15): 1809–1823; Kathryn Kost and Laura Lindberg, *Pregnancy intentions, maternal behaviors and infant health: Investigating relationships with new measures and propensity score analysis Demography*, 2015, 52(1):83-111, PMID: 25573169.

disease.[50] Unintended pregnancy also affects women's mental health; notably, it is a risk factor for depression in adults.[51] 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.[52]

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 IFRs, 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

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[50] Hal Lawrence, 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.

[51] Pamela Herd, et al., *The Implications of Unintended Pregnancies for Mental Health in Later Life*, American Journal of Public Health, 2016, 106(3):421–429; *Screening for Depression in Adults: Recommendation Statement*, American Family Physician, 2016, 94(4):340A–340D, http://www.aafp.org/afp/2016/0815/od1.html.

[52] *Achievements in public health, 1900–1999: family planning*, CDC, Morbidity and Mortality Weekly Report, 1999, 48(47): 1073–1080.

clinicians and patients identify potential contraindications and decide which specific contraceptive methods are most appropriate for each patient's needs and health circumstances.[53] 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.[54]

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.[55] Economic analyses have found positive

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

[54] 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.

[55] Adam Sonfield, et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, Guttmacher Institute, 2013, https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children; Martha J. Bailey, *Fifty Years of Family Planning: New Evidence on the Long-Run Effects of*

associations between women's ability to obtain and use oral contraceptives and their education, labor force participation, average earnings and chance of living above the poverty level, as well as a narrowing of the gender-based wage gap and a positive economic impact for their children.[56] 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%).[57]

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

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Increasing Access to Contraception https://www.nber.org/papers/w19493.pdf; Anna Bernstein and Kelly M. Jones, *The Economic Effects of Contraceptive Access: A Review of the Evidence*, Institute for Women's Policy Research, 2019 https://iwpr.org/wp-content/uploads/2019/09/B381_Contraception-Access_Final.pdf.

[56] *Id.*

[57] Jennifer Frost and Laura Duberstein Lindberg, *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.

unintended pregnancy,[58] and millions of these women rely on private insurance coverage—particularly following implementation of the ACA. In fact, from 2013 to 2018, 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.[59] In addition, the ACA specifically expanded 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.

VI. Medicaid, Title X, and State Laws Are No Substitute for the Federal Guarantee

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 IFRs, the government claimed that "[i]ndividuals who are unable to obtain contraception coverage through their

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[58] Lawrence B. Finer and Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, New England Journal of Medicine, 2016, 374:843-852.

[59] Adam Sonfield, *U.S. insurance coverage, 2018: The Affordable Care Act is still under threat and still vital for reproductive-age women*, Guttmacher Institute, Jan. 27, 2020, https://www.guttmacher.org/article/2020/01/us-insurance-coverage-2018-affordable-care-act-still-under-threat-and-still-vital.

employer-sponsored health plans because of the exemptions created in these interim final rules . . . have other avenues for obtaining contraception. . . ."[60]

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 ($12,760 for a single person in 2020),[61] 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.

Funding for Title X has not increased sufficiently for the program even to keep up with the increasing number of women who likely need public support for contraceptive services and supplies;[62] therefore, Title X

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[60] 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.

[61] Office of the Assistant Secretary for Planning and Evaluation, U.S. Federal Poverty Guidelines used to Determine Financial Eligibility for Certain Federal Programs, 2020, https://aspe.hhs.gov/poverty-guidelines.

[62] Jennifer Frost, et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, Guttmacher Institute, 2019, https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016.

cannot sustain additional beneficiaries as a result of the Final Rules. From 2010 to 2016, even as the number of women likely in need of public support for contraceptive services and supplies rose 8%, representing an additional 1.5 million women in need,[63] Congress cut funding for Title X by 10% (not even accounting for inflation).[64] With its current resources, Title X is able to serve only 17% of the nationwide likely need for public support for contraceptive services.[65] 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, an action that would inevitably hurt patients who rely on publicly funded services.

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 17% of the

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[63] *Id.*

[64] Department of Health and Human Services, Office of Population Affairs, *Funding History*, 2020, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html.

[65] Frost, et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016, supra*.

federal poverty level in Texas.[66] 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.[67] 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.[68]

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. The Department of Health and Human Services promulgated sweeping changes to Title X regulations[69] that

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[66] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2020, 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.

[67] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of February 2020)*, 2020, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[68] *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

[69] Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, March 4, 2019; Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 14312,

have led to nearly 1,000 clinic sites leaving the Title X provider network, reducing the network's capacity to serve female contraceptive patients by at least 46% and potentially affecting 1.6 million patients.[70] In addition, the changes to Title X make it even more unsuitable as a substitute for contraceptive coverage under the ACA by removing the requirement that the contraceptive methods offered by a Title X provider be "medically approved" and by encouraging participation in Title X by entities that prioritize their own religious or moral beliefs over patient-centered care and by entities that offer only a single contraceptive method (such as fertility awareness-based methods).[71]

Similarly, the government has taken multiple steps to undermine Medicaid's capacity. Its recent budget proposals have sought to exclude Planned Parenthood Federation of America and its affiliates

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April 10, 2019, https://www.federalregister.gov/documents/2019/04/10/2019-06971/compliance-with-statutory-program-integrity-requirements.

[70] Mia Zolna, Sean Finn and Jennifer J. Frost, *Estimating the impact of changes in the Title X network on patient capacity*, memorandum, Feb. 5, 2020, https://www.guttmacher.org/article/2020/02/estimating-impact-changes-title-x-network-patient-capacity.

[71] Kinsey Hasstedt, *What the Trump Administration's Final Regulatory Changes Mean for Title X*, Health Affairs Blog, March 4, 2019, https://www.guttmacher.org/article/2019/03/what-trump-administrations-final-regulatory-changes-mean-title-x.

from Medicaid and other federal programs,[72] and have called for massive cuts to Medicaid, by proposing unprecedented caps on federal Medicaid spending.[73] The government has also 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.[74] The administration has strongly backed similar congressional proposals for cutting and limiting access to Medicaid.

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.[75] For example, many states have blocked reproductive

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[72] Kinsey Hasstedt, *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.

[73] Adam Sonfield and Leah H. Keller, Proposed Medicaid block grants and spending caps threaten enrollees' sexual and reproductive health and rights, 2019, https://www.guttmacher.org/gpr/2019/12/proposed-medicaid-block-grants-and-spending-caps-threaten-enrollees-sexual-and.

[74] Leah H. Keller and Adam Sonfield, The evidence and the courts agree: work requirements threaten Medicaid enrollees' health and well-being, Guttmacher Policy Analysis, 2019, https://www.guttmacher.org/article/2019/08/evidence-and-courts-agree-work-requirements-threaten-medicaid-enrollees-health-and.

[75] Rachel Benson Gold and Kinsey Hasstedt, *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.

health-focused providers or providers with ties to abortion from receiving state-controlled family planning funding and other public health funding, thereby limiting access to care for patients.[76]

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-two states have no such laws at all.[77] Of the 28 states and the District of Columbia that do have contraceptive coverage requirements, only 16 bar copayments and deductibles for contraception. 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).[78] Few of the state laws include similar protections. Similarly, most of the state requirements do not specifically require coverage of all the distinct

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[76] Guttmacher Institute, State family planning funding restrictions, *State Laws and Policies (as of March 2020)*, 2020, https://www.guttmacher.org/state-policy/explore/state-family-planning-funding-restrictions.

[77] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of March 2020)*, 2020, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[78] 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.

methods that the federal requirement encompasses. For example, only 14 states 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).[79] Finally, state laws cannot regulate self-insured employers at all, and those employers account for 61% of all workers with employer-sponsored health coverage.[80]

VII. State-Specific Impacts

If implemented, the Final Rules would have public health and fiscal consequences in Pennsylvania, New Jersey and other states across the country. 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. For example, in Pennsylvania and New Jersey, childless adults and parents are only eligible for full-benefit Medicaid if they have incomes at or below 138% of the federal

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[79] Guttmacher Institute, Insurance coverage of contraceptives, *State Laws and Policies (as of March 2020)*, 2020, http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

[80] Gary Claxton, et al., *Employer Health Benefits: 2019 Annual Survey*, San Francisco: Kaiser Family Foundation, 2019, https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.

poverty level,[81] and individuals are eligible for coverage of family planning services specifically up to 220% of poverty in Pennsylvania and 205% in New Jersey.[82] This means that affected women who lose coverage as a result of the rules may not be eligible for Medicaid. 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 forego contraception use entirely.

Other women would be eligible for and rely on publicly funded family planning services through programs such as Medicaid and Title X. The increase in the number of women relying on publicly funded services would increase the strain on the states' family planning programs and providers, making it more difficult for them to meet the existing need for publicly funded care. In 2016, 735,000 women in Pennsylvania and 431,000 in New Jersey likely needed public support for contraceptive services and supplies, and the

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[81] Kaiser Family Foundation, Medicaid income eligibility limits for adults as a percent of the federal poverty level, 2019, 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.

[82] Guttmacher Institute, Medicaid family planning eligibility expansions, *State Laws and Policies (as of March 2020)*, 2020, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

family planning network was able to only meet 32% of this need in Pennsylvania and 27% in New Jersey.[83]

Another indicator of the existing unmet need for contraception is that substantial numbers of state residents experience pregnancies each year that are wanted later or not wanted at all (often collectively referred to as unintended). In 2014, 82,000 pregnancies wanted later or unwanted occurred among Pennsylvania residents, a rate of 34 per 1,000 women aged 15–44, and 79,000 such pregnancies occurred among New Jersey residents, a rate of 46 per 1,000.[84]

Of those unintended pregnancies that ended in birth, 54% in Pennsylvania and 52% in New Jersey were paid for by Medicaid and other public insurance programs in 2010 (the last year for which data are available).[85] Unintended pregnancies to residents of Pennsylvania cost the state approximately $248 million and the federal government $479 million in 2010; those to residents of New Jersey cost the state $186

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[83] Frost, et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, supra*.

[84] Kathryn Kost, Isaac Maddow-Zimet and Shivani Kochhar, *Pregnancy Desires and Pregnancies at the State Level: Estimates for 2014*, New York: Guttmacher Institute, 2018, https://www.guttmacher.org/report/pregnancy-desires-and-pregnancies-state-level-estimates-2014.

[85] Adam Sonfield and Kathryn Kost, *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.

million and the federal government $291 million. The Final Rules are likely to increase the number of unintended pregnancies experienced by state residents, and thus to increase state and federal expenditures.

Data for all 50 states and the District of Columbia are included in a table as Exhibit A.

CONCLUSION

For the reasons set forth above, the decisions of the Court of Appeals for the Third Circuit should be affirmed.

Respectfully submitted,

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Exhibit A: State-Specific Data on Impact

	Medicaid eligibility, as % of federal poverty level			Women who likely need public support for contraceptive services and supplies, 2016		Pregnancies wanted later or unwanted, 2014		% of unplanned births paid for by public insurance programs, 2010	Public costs for unintended pregnancies, 2010	
	Childless adults (Jan. 2019)	Parents (Jan. 2019)	Family planning specific (Mar. 2020)	Number	% of likely need met by publicly supported clinics	Number	Rate per 1,000 women aged 15–44		State (in millions)	Federal (in millions)
Alabama	—	18%	146%	351,220	28%	34,770	36	61.6%	$72.6	$250.5
Alaska	138%	138%	—	39,770	54%	5,280	36	64.3%	42.9	70.8
Arizona	138%	138%	—	465,750	19%	45,930	35	64.6%	161.5	509.4
Arkansas	138%	138%	—	223,810	23%	17,880	31	72.3%	61.9	266.8
California	138%	138%	200%	2,526,010	64%	306,070	38	64.3%	689.3	1,062.1
Colorado	138%	138%	—	334,150	35%	31,460	29	63.8%	91.1	146.1
Connecticut	138%	155%	263%	180,670	38%	23,460	34	60.8%	80.1	128.4
Delaware	138%	138%	—	54,050	30%	7,860	44	71.3%	36.0	58.2
District of Columbia	215%	221%	—	49,390	88%	7,450	42	84.6%	13.3	50.9
Florida	—	32%	—	1,329,300	16%	162,700	44	70.6%	427.1	892.8
Georgia	—	35%	200%	741,940	26%	77,330	37	80.5%	229.7	687.7
Hawaii	138%	138%	—	66,120	21%	9,670	36	49.9%	37.8	76.7
Idaho	138%	138%	—	116,180	18%	9,060	29	60.4%	18.5	70.2
Illinois	138%	138%	—	779,490	24%	94,010	36	78.3%	352.2	571.5
Indiana	139%	139%	146%	457,150	17%	41,100	32	64.6%	91.4	284.6
Iowa	138%	138%	—	195,480	27%	16,750	29	61.5%	48.3	127.6
Kansas	—	38%	—	186,150	18%	17,020	30	47.2%	50.4	115.7
Kentucky	138%	138%	—	307,010	23%	25,970	30	66.8%	75.0	302.8
Louisiana	138%	138%	138%	345,760	21%	39,720	42	78.7%	120.6	530.4
Maine	138%	138%	214%	74,070	34%	6,660	29	74.7%	14.6	43.6
Maryland	138%	138%	259%	308,590	32%	52,190	44	58.2%	180.9	285.4
Massachusetts	138%	138%	—	359,770	25%	40,660	30	56.4%	138.3	219.6
Michigan	138%	138%	—	649,310	16%	71,530	38	71.9%	177.0	485.1
Minnesota	138%	138%	200%	300,810	25%	28,300	27	66.7%	128.7	203.9
Mississippi	—	26%	199%	233,270	23%	24,090	40	81.9%	40.4	226.7

	Medicaid eligibility, as % of federal poverty level			Women who likely need public support for contraceptive services and supplies, 2016		Pregnancies wanted later or unwanted, 2014		% of unplanned births paid for by public insurance programs, 2010	Public costs for unintended pregnancies, 2010	
	Childless adults (Jan. 2019)	Parents (Jan. 2019)	Family planning specific (Mar. 2020)	Number	% of likely need met by publicly supported clinics	Number	Rate per 1,000 women aged 15–44		State (in millions)	Federal (in millions)
Missouri	—	21%	—	403,790	21%	36,710	31	72.2%	132.6	385.9
Montana	138%	138%	216%	66,600	36%	5,910	32	47.8%	9.1	31.7
Nebraska	—	63%	—	123,070	24%	10,970	30	63.1%	41.7	91.9
Nevada	138%	138%	—	193,020	14%	22,610	40	60.0%	37.1	65.8
New Hampshire	138%	138%	201%	64,970	29%	6,720	28	52.7%	10.3	16.5
New Jersey	138%	138%	205%	431,170	27%	79,030	46	52.4%	186.1	291.0
New Mexico	138%	138%	255%	151,130	35%	13,310	33	77.1%	47.9	191.2
New York	138%	138%	223%	1,179,070	37%	193,590	48	70.2%	601.1	937.7
North Carolina	—	42%	200%	720,450	16%	73,040	37	74.8%	214.7	643.5
North Dakota	138%	138%	—	47,140	23%	4,760	33	36.8%	7.7	17.9
Ohio	138%	138%	—	751,340	20%	83,150	38	68.7%	218.8	605.8
Oklahoma	—	42%	138%	278,850	30%	26,580	35	80.7%	77.0	254.0
Oregon	138%	138%	250%	270,540	40%	22,720	29	69.9%	47.2	122.7
Pennsylvania	138%	138%	220%	735,170	32%	82,200	34	53.5%	248.2	478.6
Rhode Island	138%	138%	—	65,990	41%	6,490	31	70.1%	27.5	48.7
South Carolina	—	67%	199%	351,550	26%	36,260	38	78.6%	84.0	327.3
South Dakota	—	49%	—	53,510	21%	5,360	34	46.2%	14.4	35.0
Tennessee	—	95%	—	466,350	22%	49,840	39	73.7%	130.7	400.0
Texas	—	17%	—	1,950,990	21%	223,100	39	73.7%	842.6	2,056.8
Utah	138%	138%	—	213,270	18%	16,660	26	53.3%	30.4	127.6
Vermont	138%	138%	—	35,650	55%	2,990	26	73.5%	9.6	21.8
Virginia	138%	138%	205%	480,930	16%	57,170	34	45.4%	194.6	312.0
Washington	138%	138%	260%	432,940	31%	42,770	31	63.1%	177.1	290.7
West Virginia	138%	138%	—	117,990	66%	9,930	30	76.0%	24.9	120.5
Wisconsin	100%	100%	306%	351,580	24%	26,390	24	62.0%	92.1	221.4
Wyoming	—	54%	—	34,960	26%	3,540	32	67.4%	21.3	34.1

Sources: *supra* notes 81-85