Case Nos. 14-2396
IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

WHEATON COLLEGE,
Plaintiff-Appellant,
v.
SYLVIA M. BURWELL, Secretary of the U.S. Department of Health and Human Services, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of Illinois

(No. 1:13-cv-08910 (Dow, J.))

MOTION FOR LEAVE TO FILE BRIEF OF THE NATIONAL HEALTH LAW PROGRAM, AMERICAN PUBLIC HEALTH ASSOCIATION, NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, NATIONAL WOMEN'S HEALTH NETWORK, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, **ASIAN AMERICANS ADVANCING JUSTICE | LOS ANGELES, IPAS, SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE U.S. (SIECUS), CHRISTIE'S PLACE, BLACK WOMEN'S HEALTH IMPERATIVE, 30 FOR 30 CAMPAIGN, NATIONAL WOMEN AND AIDS COLLECTIVE, CALIFORNIA WOMEN'S LAW CENTER, LEGAL VOICE, SOUTHWEST WOMEN'S LAW CENTER**, AND **WOMEN'S LAW PROJECT AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES**

Pursuant to Fed. R. App. P. 29, *amici curiae*, the National Health Law Program (NHeLP), American Public Health Association, National Family Planning & Reproductive Health Association, National Women's Health Network, Asian & Pacific Islander American Health Forum, National Asian Pacific American Women's Forum, Asian Americans Advancing Justice | Los Angeles, Ipas, Sexuality Information and Education Council of the U.S. (SIECUS), Black

Women's Health Imperative, Christie's Place, 30 for 30 Campaign, National Women and AIDS Collective, California Women's Law Center, Legal Voice, Southwest Women's Law Center, and Women's Law Project respectfully request leave of this Court to file the attached brief in support of Defendants-Appellees.

Founded in 1969, NHeLP protects and advances the health rights of low-income and underserved individuals. NHeLP advocates, educates, and litigates at the federal and state level and in court to further its mission of improving access and overcoming barriers to quality health care for individuals, including women's access to comprehensive health care services. Joining NHeLP in the filing of the attached brief are 16 additional national and state organizations. While each *amicus* has particular interests they collectively bring to the Court an in depth understanding of the impact of cost-sharing on health care service utilization, including on contraception, and existing federal laws that address coverage of and access to contraception. The information provided in the attached Brief bear upon the legality of the requirements for preventive health care services under § 2713(a)(4) of the Public Health Service Act, and its implementing regulations, at issue in this case.

Counsel for Defendants-Appellees consented to the filing of this brief. However, counsel for Plaintiff-Appellant would not consent to the filing of the attached brief, thereby necessitating the filing of this motion. *Amici* accordingly

respectfully request leave to file the attached brief of the National Health Law Program, et al. in Support of Defendants-Appellees.

Dated: May 18, 2015

Martha Jane Perkins
Counsel of Record
Dipti Singh
NATIONAL HEALTH LAW PROGRAM
101 East Weaver Street, Suite G-7
Carrboro, North Carolina 27510
Tel: (919) 968-6308 (x 101)
perkins@healthlaw.org

Counsel for Amici Curiae

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and Circuit Rule 26.1(a), the undersigned counsel certifies that the *amici curiae* National Health Law Program, American Public Health Association, National Family Planning & Reproductive Health Association, National Women's Health Network, Asian & Pacific Islander American Health Forum, National Asian Pacific American Women's Forum, Asian Americans Advancing Justice | Los Angeles, Ipas, Sexuality Information and Education Council of the U.S. (SIECUS), Black Women's Health Imperative, Christie's Place, 30 for 30 Campaign, National Women and AIDS Collective, California Women's Law Center, Legal Voice, Southwest Women's Law Center, and Women's Law Project are not subsidiaries of any other corporation and no publicly held corporation owns ten percent or more of any *amici curiae* organization's stock.

/s/ Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I hereby certify May 18, 2015, I electronically filed the foregoing Motion with the Clerk of this Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

Date: May 18, 2015

/s/Martha Jane Perkins
Martha Jane Perkins

Case Nos. 14-2396

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

WHEATON COLLEGE,

Plaintiff-Appellant,

v.

SYLVIA M. BURWELL, Secretary of the U.S. Department of Health & Human Services*, et al.*

Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of Illinois
(No. 1:13-cv-08910 (Dow, J.))

BRIEF OF THE NATIONAL HEALTH LAW PROGRAM, AMERICAN PUBLIC HEALTH ASSOCIATION, NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, NATIONAL WOMEN'S HEALTH NETWORK, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, ASIAN AMERICANS ADVANCING JUSTICE | LOS ANGELES, IPAS, SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE U.S. (SIECUS), CHRISTIE'S PLACE, BLACK WOMEN'S HEALTH IMPERATIVE, 30 FOR 30 CAMPAIGN, NATIONAL WOMEN AND AIDS COLLECTIVE, CALIFORNIA WOMEN'S LAW CENTER, LEGAL VOICE, SOUTHWEST WOMEN'S LAW CENTER, AND WOMEN'S LAW PROJECT AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES

Martha Jane Perkins
Counsel of Record
Dipti Singh
NATIONAL HEALTH LAW PROGRAM
101 East Weaver Street, Suite G-7
Carrboro, North Carolina 27510
Tel: (919) 968-6308 (x101)
perkins@healthlaw.org
Counsel for Amici Curiae

CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No.: 14-2396

Short Caption: *Wheaton College v. Sylvia M. Burwell*, *et al.*

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

National Health Law Program, American Public Health Association, National Family Planning & Reproductive Health Association, National Women's Health Network, Asian & Pacific Islander American Health Forum, National Asian Pacific American Women's Forum, Asian Americans Advancing Justice | Los Angeles, Ipas, Sexuality Information and Education Council of the U.S. (SIECUS), Black Women's Health Imperative, Christie's Place, 30 for 30 Campaign, National Women and AIDS Collective, California Women's Law Center, Legal Voice, Southwest Women's Law Center, and Women's Law Project, as *amicus curiae*

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

N/A

(3) If the party or amicus is a corporation:

(i) Identify all its parent corporations, if any; and

N/A

(ii) List any publicly held company that owns 10% or more of the party's or amicus' stock:

N/A

Attorney's Signature: /s/ Martha J. Perkins **Date:** May 18, 2015

Attorney's Printed Name: Martha J. Perkins

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). Yes

Address: National Health Law Program
101 East Weaver Street, Suite 5-7
Carrboro, North Carolina 27510

Phone Number: (919) 968-6308 (x 101) **Fax Number:** (919) 968-8855

Email Address: perkins@healthlaw.org

TABLE OF CONTENTS

TABLE OF AUTHORITIES ... ii

INTEREST OF THE AMICI ... 1

SUMMARY OF ARGUMENT ... 2

ARGUMENT ... 3

I. Cost prevents individuals from using health care services ... 3

II. Cost prevents women from accessing contraception ... 7

III. By eliminating cost barriers, the ACA helps ensure access to contraception ... 10

IV. The ACA's contraceptive coverage provision is part of a larger government scheme to ensure access to necessary health care services ... 12

V. Safety net programs should not be conflated with the private insurance market ... 17

CONCLUSION ... 19

TABLE OF AUTHORITIES

Cases

Muratore v. U.S. Office of Pers. Mgmt., 222 F.3d 918 (11th Cir. 2000)...13

Federal Statutes

5 U.S.C. §§ 8901-8914..........13

10 U.S.C. § 1071..........14

10 U.S.C. § 1072..........15

10 U.S.C. § 1073..........15

10 U.S.C. § 1074..........15

10 U.S.C. § 1077..........15

25 U.S.C. § 1602..........15

25 U.S.C. § 1603..........15

25 U.S.C. § 1621b..........15

42 U.S.C. § 300a..........18, 19

42 U.S.C. § 300e..........12

42 U.S.C. § 300e-1..........12

42 U.S.C. § 300e-5..........12

42 U.S.C. § 300e-10..........12

42 U.S.C. § 300gg-3..........17

42 U.S.C. § 300gg-6..........17

42 U.S.C. § 1396d..........16

42 U.S.C. § 18022..........17

Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 1, 87 Stat. 914 (1973) (codified at 42 U.S.C. §§ 300e-300e-17)..................................12

Omnibus Consolidated & Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, 112 Stat. 268 (1998)...13

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, § 2713(a)(4), 124 Stat. 119 (2010) (codified at 42 U.S.C. § 300gg-13(a)(4))..2

Pub. L. No. 85-861, § 1(25)(B), 72 Stat. 1450 (1958), amended by Pub. L. No. 89-614, § 2(1), 80 Stat. 862 (1966) (codified at 10 U.S.C. §§ 1071-1110b)…...14

Federal Regulations

32 C.F.R. § 199.3...14

32 C.F.R. § 199.4... 15

32 C.F.R. § 199.17...14

32 C.F.R. § 199.21...15

42 C.F.R. § 59.5...18

45 C.F.R. § 147.131…………… …………..…….......………...............2

42 C.F.R. § 441.20...16

Other Authorities

Adam Sonfeld et al., *Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update*, xx CONTRACEPTION xxx (2014)...11

Amal N. Trivedi et al., *Effect of Cost-sharing on Screening Mammography in Medicare Health Plans*, 358(4) NEW ENG. J. MED. 375 (Jan. 24, 2008)...............6

Centers for Medicare & Medicaid Services, Dear State Medicaid Director

(July 2, 2010)..16

Centers for Medicare & Medicaid Services, State Medicaid Manual § 4270..16

Christina Fowler et al., *Title X Family Planning Annual Report: 2013 National Summary* (Nov. 2014), http://www.hhs.gov/opa/pdfs/fpar-2013-national-summary.pdf..18, 19

Cong. Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* 1 (2012), http://www.cbo.gov/sites/default/files/09-19-12-Indiv_Mandate_Penalty.pdf..19

Cong. Research Servs., Laws Affecting the Federal Employees Benefits Program (FEHBP) (Feb. 13, 2013), https://www.fas.org/sgp/crs/misc/R42741.pdf..13

Dahlia K. Remler & Jessica Greene, *Cost-Sharing: A Blunt Instrument*, 30 ANNUAL REV. PUB. HEALTH 293 (2009)..3, 4, 7

David Machledt & Jane Perkins, National Health Law Program, *Medicaid Premiums & Cost-Sharing* (Mar. 26, 2014), http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#..3, 6

Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348(26) NEW ENG. J. OF MED. 2635 (2003).......................3, 5

Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRAC. MGMT 317 (1992), http://www.rand.org/pubs/reprints/RP1114.html...4, 5

Geetesh Solanki et al., *The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services*, 34(6) HEALTH SVCS. RESEARCH 1331 (Feb. 2000)..6

IMS Institute for Healthcare Informatics, *Medicine Use and Shifting Costs of Healthcare: A review of the use of medicines in the United States in 2013* (Apr. 2014)..11

Inst. of Med. of the Nat'l Acads., *Clinical Preventive Services for Women: Closing the Gaps* (2011)……………………………………………………………4, 8, 9

Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120(6) OBSTETRICS & GYNECOLOGY 1291 (Dec. 2012)……………………………………………………………………………9, 10

Julia Paradise, Kaiser Family Found., *Issue Brief: Medicaid Moving Forward* (Mar. 9, 2015)……………………………………………………………………16

Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L. J. 7 (1994)........5

Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90 (2006)……………………………………………………7

Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 CONTRACEPTION 478 (2011)……………………………………………………………………………………8

Kathleen N. Lohr et al., RAND Corp., *Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial* (1986), http://www.rand.org/content/dam/rand/pubs/reports/2006/R3469.pdf....................5

Katherine Swartz, Robert Wood Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes* (2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1……………………………………………………………………6

Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1) (2011)……………………………………………9

Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45 (2012)...6

Niteesh Choudhry et al., *Full Coverage for Preventive Medications after Myocardial Infarction*, 365 NEW ENG. J. MED. 2088 (2011)....................................6

Niteesh Choudhry et al., *At Pitney Bowes, Value-Based Insurance Design Cut Copayments and Increased Drug Adherence*, 29 HEALTH AFF. 1995 (2010)....6

Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (2006), http://www.rand.org/pubs/research_briefs/RB9174.html....................................5, 6

Robert Wood Johnson Found., *Preventive Care: A National Profile on Use, Disparities, and Health Benefits* (2007), http://www.rwjf.org/content/dam/farm/reports/reports/2007/rwjf13325..................5

Sheila D. Rustgi et al., The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (2009), http://www.commonwealthfund.org/~/media/Files/Publications/Issue20Brief/2009/May/Women20at20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf 7, 8

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 (June 2010)...8

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines/...2

U.S. Dep't of Health and Human Servs., Indian Health Serv., Indian Health Manual § 3-13.12B(1), http://www.ihs.gov/ihm/index.cfm 16

U.S. Dep't of Health & Human Servs., Office of Population Affairs, *Title X Funding History*, http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/title-x-funding-history/...18, 19

U.S. Office of Personnel Management, FEHB Program Carrier Letter re: Federal Employees Health Benefits Program Call Letter, Letter No. 2012-09 at 2

(Mar. 29, 2012), http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-09.pdf...13

U.S. Office of Personnel Management, *The Fact Book, Federal Civilian Workforce Statistics* 82 (2007), http://www.opm.gov/feddata/factbook...13

U.S. Office of Personnel Management, Benefits Admin. Ltr. No. 98-418 (Nov. 6, 1998)...13

U.S. Office of Personnel Management, Federal Employees Health Benefits Program Patients' Bill of Rights and the Federal Employees Health Benefits Program, http://www.opm.gov/insure/archive/health/billrights.asp#Choice.....................14

INTEREST OF THE AMICI[1]

The *amici curiae* are the National Health Law Program, American Public Health Association, National Family Planning & Reproductive Health Association, National Women's Health Network, Asian & Pacific Islander American Health Forum, National Asian Pacific American Women's Forum, Asian Americans Advancing Justice | Los Angeles, Ipas, Sexuality Information and Education Council of the U.S. (SIECUS), Black Women's Health Imperative, Christie's Place, 30 for 30 Campaign, National Women and AIDS Collective, California Women's Law Center, Legal Voice, Southwest Women's Law Center, and Women's Law Project. While each *amicus* has particular interests, they collectively bring to the Court an in depth understanding of the impact of cost-sharing on health care service utilization, including on contraception, and existing federal laws that address coverage of and access to contraception. The *amici* want to bring accurate information on these topics to the Court as it considers the legality of the requirements for preventive health care services under § 2713(a)(4)

[1] Counsel for Defendants-Appellees consented to the filing of this brief. Counsel for Plaintiff-Appellant would not consent to the filing of this brief. Thus, in accordance with Circuit Rule 29(b), *amici* have concurrently filed a motion requesting leave to file this brief. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici* and *amici*'s counsel, contributed money intended to fund preparation or submission of this brief.

of the Public Health Service Act, added by the Patient Protection and Affordable Care Act (ACA).

SUMMARY OF ARGUMENT

The ACA recognizes that preventive health services are critical to individual and community health and that cost is a barrier to access. The ACA seeks to build upon existing federal laws and increase access to preventive health care services by requiring most group health plans and health insurance issuers to cover, without cost-sharing, women's preventive health care services identified in guidelines issued by the Health Resources and Services Administration (HRSA).[2] Regulations implementing this provision provide an accommodation for the group health plans of certain religiously affiliated non-profit organizations.[3] By doing so, these laws seek to accommodate sincerely held religious beliefs while also recognizing that women have unique reproductive and gender-specific health needs and that cost is often a barrier to meeting those needs. Of critical importance, these rules ensure that all women, regardless of where they work, have access to all Food and Drug Administration-approved methods of contraception without cost-sharing.

---

[2] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, § 2713(a)(4), 124 Stat. 119, 131 (codified at 42 U.S.C. § 300gg-13(a)(4)); U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines (last visited May 15, 2015).

[3] 45 C.F.R. § 147.131(b) (defining "eligible organization").

ARGUMENT

I. Cost prevents individuals from using health care services.

Americans do not receive recommended health care services.[4] Cost often is a barrier to individuals obtaining medically necessary health care services, particularly preventive services. Health insurance can help individuals obtain necessary health care services by removing some of the financial barriers to access.

Health insurance offers two primary values.[5] One is financial protection: health insurance pays for the cost of medical care so a person does not have to pay for all of the out-of-pocket expenses related to that care.[6] The second is health protection: "[h]ealth insurance provides access to health care, usefully increasing the care one receives."[7] Individuals pay for this health insurance through premiums and cost-sharing.[8] Cost-sharing is the portion of health care expenses not covered

---

[4] Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635, 2636, 2643 (June 26, 2003) (2003 study of adults living in 12 metropolitan areas in United States).

[5] Dahlia K. Remler & Jessica Greene, *Cost-Sharing: A Blunt Instrument*, 30 ANNUAL REV. PUB. HEALTH 293, 295 (2009); *see also* Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1876-79 (2011).

[6] Remler & Greene, *supra* note 5, at 295.

[7] *Id.*

[8] David Machledt & Jane Perkins, *Medicaid Premiums & Cost-Sharing* 1 (Mar. 26, 2014), http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.

by the insurer that the patient must pay out-of pocket.[9] Cost-sharing includes copayments and coinsurance that health plan enrollees must pay out-of-pocket when they use a service or purchase a product (*e.g.*, for a doctor visit or prescription drug), as well as deductibles, which are the amounts a person must pay out-of-pocket before the insurer will cover any expenses during a given benefit period.[10] The imposition of cost-sharing at the point of service is generally justified as a means of discouraging the use of non-essential services and reducing costs, though its efficacy at achieving these goals is far from clear.[11]

The Institute of Medicine of the National Academies (IOM) noted that "[s]tudies have . . . shown that even moderate copayments for preventive services . . . deter patients from receiving those services."[12] The RAND Health Insurance Experiment (HIE), conducted from 1971 to 1986, remains the longest-term randomized experiment studying the impact of cost-sharing on medical service utilization and health outcomes.[13] The HIE found that although higher cost-sharing reduced overall use of services and total health care expenditures, it also reduced

---

[9] Remler & Greene, *supra* note 5, at 294.
[10] *Id.*
[11] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRAC. MGMT 317, 318-19 (1992), http://www.rand.org/pubs/reprints/RP1114.html.
[12] Inst. of Med. (IOM) of the Nat'l Acads., *Clinical Preventive Services for Women: Closing the Gaps* 19 (2011).
[13] Emmett B. Keeler, *supra* note 11, at 320.

use of essential health care services and produced some negative health outcomes.[14] In particular, cost-sharing is a proven barrier to accessing preventive care.[15] The reductions in utilization found by the HIE impacted the use of preventive care more than they affected chronic care.[16]

Before the ACA went into effect, individuals in the United States used preventive services at about half the recommended rate.[17] Low-income individuals and people of color used fewer preventive care services than non-Hispanic whites.[18] A 2001 to 2004 study of 366,745 patients enrolled in 174 Medicare managed care plans found that the imposition of cost-sharing reduced

---

[14] Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* 2 (2006), http://www.rand.org/pubs/research_briefs/RB9174.html; *see also* Keeler, *supra* note 11, at 319.

[15] Robert Wood Johnson Found., *Preventive Care: A National Profile on Use, Disparities, and Health Benefits* (2007), http://www.rwjf.org/content/dam/farm/reports/reports/2007/rwjf13325; Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L. J. 7, 22 (1994).

[16] Kathleen N. Lohr et al., RAND Corp., *Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial*, 29 (1986), http://www.rand.org/content/dam/rand/pubs/reports/2006/R3469.pdf.

[17] Robert Wood Johnson Found., *supra* note 15, at 8 ("Among the 12 preventive services examined in this report, 7 are being used by about half or less of the people who should be using them. Racial and ethnic minorities are getting even less preventive care than the general U.S. population."); *see also* E. A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348(26) NEW ENG. J. OF MED. 2635, 2641 (2003).

[18] Robert Wood Johnson Found., *supra* note 15, at 7.

mammography screening.[19] The study concluded that "[f]or effective preventive services such as mammography, exempting elderly adults from cost-sharing may be warranted."[20] Another study of 11,000 employees with employer-sponsored coverage found that cost-sharing reduced use of pap smears, preventive counseling, and mammography.[21] The large body of literature demonstrates that cost-sharing reduces use of medically necessary, valuable services, as opposed to merely discouraging overuse of unnecessary services.[22]

---

[19] Amal N. Trivedi et al., *Effect of Cost-sharing on Screening Mammography in Medicare Health Plans*, 358(4) NEW ENG. J. MED. 375, 381-82 (Jan. 24, 2008).
[20] *Id.*
[21] Geetesh Solanki et al., *The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services*, 34(6) HEALTH SVCS. RESEARCH 1331, 1342-43 (Feb. 2000); *see also* Machledt & Perkins, *supra* note 8, at 2-3.
[22] Katherine Swartz, Robert Wood Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes* (2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1; Solanki et al., *supra* note 21, at 320; Brook et al., *supra* note 14, at 3. For example, studies have shown increased adherence to key preventive medications, like hypertensives, when cost-sharing was reduced or eliminated. *See* Niteesh Choudhry et al., *Full Coverage for Preventive Medications after Myocardial Infarction*, 365 NEW ENG. J. MED. 2088 (2011); Niteesh Choudhry et al., *At Pitney Bowes, Value-Based Insurance Design Cut Copayments and Increased Drug Adherence*, 29 HEALTH AFF. 1995, 1995 (2010).
Such medications are among the most cost effective treatments available, and better adherence has been consistently associated with improved health outcomes. Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45, 47 (2012). *See* Niteesh Choudhry et al., *Full Coverage for Preventive Medications after Myocardial Infarction*, 365 NEW ENG. J. MED. 2088 (2011); Niteesh Choudhry et al., *At Pitney Bowes, Value-Based Insurance Design Cut Copayments and*

II. Cost prevents women from accessing contraception.

Cost prevents women from accessing necessary health care services, including contraception. As compared to men, women are "more likely to forgo needed care because of cost and to have problems paying their medical bills, accrue medical debt, or both."[23] The "[d]ifferences between men and women reporting problems accessing needed care because of cost persists across all income groups, but is widest among adults with moderate incomes," according to a 2009 study.[24] That study, which analyzed 2007 survey data, found that sixty-five percent of women with incomes between $20,000 and $39,999 experienced problems accessing health care services because of cost.[25]

In light of the established impact of cost on access to health care services, such as contraception, it is not surprising that lower-income women's inability to select the most effective methods of contraception has contributed to their having higher rates of unintended pregnancy as compared to higher-income women.[26]

Increased Drug Adherence, 29 HEALTH AFF. 1995 (2010).

[23] Sheila D. Rustgi et al, The Commonwealth Fund, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* 1-2 (May 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; *see also* Remler & Greene, *supra* note 5, at 304.

[24] Rustgi et al., *supra* note 23, at 4.

[25] *Id.*

[26] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended*

Lower-income women are the least likely to have the resources to obtain reliable methods of family planning, and yet, they are the most likely to be impacted negatively by unintended pregnancy.[27] The inability to afford the most reliable contraceptive methods has resulted in their having higher rates of unplanned pregnancies.[28]

High out-of-pocket costs are also one of the major barriers to consistent contraceptive use for women.[29] A 2010 study found that privately insured women with prescription drug coverage paid on average $14 per oral contraceptive pill pack or approximately half of the cost of the pills.[30] Moreover, studies consistently show that "[e]ven small increments in cost sharing have been shown to reduce the use of preventive services."[31] The IOM has accordingly recognized that the

---

Pregnancy in the United States, 1994 and 2001, 38 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 90, 92-94 (2006).

[27] *See* Rustgi et al., *supra* note 23, at 4-5 (explaining that women's lower incomes and higher demands for health care, as compared to men, put them at increased risk for accruing medical debt and increased the likelihood of putting off care).

[28] Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 CONTRACEPTION 478, 480 (2011).

[29] 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 (June 2010); *see also* IOM, *supra* note 12, at 109.

[30] Liang et al., *supra* note 29, at 530-31.

[31] IOM, *supra* note 12, at 94.

"elimination of cost-sharing for contraception . . . could greatly increase its use, including use of the more effective and longer-acting methods." [32]

In this regard, the California Kaiser Foundation Health Plan's experience is informative. The California Kaiser Foundation Health Plan eliminated copayments for the most effective contraceptive methods in 2002.[33] Prior to the change, users paid up to $300 for a five-year contraceptive method; after elimination of the copayment, use of these methods increased by 137%.[34]

Similarly, the Contraceptive CHOICE Project—a large prospective cohort study of nearly 10,000 adolescents and women in the St. Louis, Missouri area—provided participants a choice of no-cost contraception and followed them for two to three years. [35] The study concluded that providing no-cost contraception significantly reduced abortion rates and teenage birth rates.[36] Specifically, between 2008 and 2010, the abortion rate of study participants ranged from 4.4 to 7.5 per 1,000 teens compared to the national average of 19.6 per 1,000 teens. [37] The study

---

[32] *Id.* at 109.
[33] Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011).
[34] *Id.*
[35] Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120(6) OBSTETRICS & GYNECOLOGY 1291, 1291-92 (Dec. 2012).
[36] *Id.* at 1295-96.
[37] *Id.* at 1294.

participant teen birth rate was 6.3 per 1,000 teens compared to the national average of 34.1 per 1,000 teens.[38] The researchers concluded that providing access to no-cost contraception greatly increased the ability of adolescents and women in the St. Louis region to select the most effective methods of contraception, thereby allowing them to reduce unintended pregnancies.[39] Based on their findings, the researchers estimated that providing no-cost contraception to all women would reduce unintended pregnancy and prevent as many as forty-one to seventy-one percent of abortions in the United States annually.[40]

III. By eliminating cost barriers, the ACA helps ensure access to contraception.

Reflecting the body of research discussed above, the ACA has increased access to contraception and its use by eliminating cost-sharing. The ACA seeks to remove cost barriers to contraception, and increase a woman's ability to access such services by requiring health plans to cover contraception without cost-sharing. And, the ACA is working in this regard. In the Guttmacher Institute's Continuity and Change in Contraceptive Use study, researchers surveyed women aged eighteen to thirty-nine years about their contraceptive use before the ACA

[38] *Id.* The researchers "evaluated teenage birth . . . as a proxy for unintended pregnancy because up to 80% of these births are unintended." *Id.*
[39] *Id.* at 1295-96.
[40] *Id.* at 1291-97.

contraceptive coverage requirement went into wide-scale effect in 2012 and after it went into effect in 2013.[41] The results show that the proportion of privately insured women with no out-of-pocket cost for their oral contraceptives increased from fifteen percent to sixty-seven percent; for injectable contraception, from twenty-four percent to fifty-seven percent; for the vaginal ring, from twenty percent to seventy-four percent; and for the intrauterine device, from forty-five percent to sixty-two percent.[42] As rates of contraceptive coverage without cost-sharing increased, so did contraceptive use.[43] A report from the Institute for Healthcare Informatics found that 24.4 million more prescriptions for oral contraceptives with no copayment were filled in 2013 than in 2012.[44] According to that report, oral contraceptives accounted for the largest increases in prescriptions dispensed without a copayment.[45] Reducing the cost barrier to contraception is resulting in greater access to contraception, just as the ACA intended.

---

[41] Adam Sonfeld et al., *Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update*, xx CONTRACEPTION xxx-xxx, 1 (2014). The federal government phased in the contraceptive coverage requirement starting in August 2012 and it went into wide-scale effect in January 2013. *Id.* at 3.

[42] *Id.* at 3.

[43] *See* IMS Institute for Healthcare Informatics, *Medicine Use and Shifting Costs of Healthcare: A review of the use of medicines in the United States in 2013* (Apr. 2014).

[44] *Id.* at 16.

[45] *Id.* at 13.

IV. The ACA's contraceptive coverage provision is part of a larger government scheme to ensure access to necessary health care services.

The ACA's coverage provisions reflect a long history of federal legislation which requires coverage of preventive contraceptive counseling, services, and supplies. In 1973, Congress enacted the Health Maintenance Organization (HMO) Act to encourage the delivery of health care through the HMO model.[46] The Act applies to private health plans that apply for federal qualification, a designation that enables HMOs to, among other things, avoid state laws more restrictive than the HMO Act.[47] The HMO Act identifies basic health services that HMOs must provide.[48] "Basic health services" include "family planning services."[49]

The Federal Employees Health Benefits (FEHB) program also covers family planning services without cost-sharing. The FEHB program provides employee health benefits to civilian government employees and annuitants of the United

---

[46] Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 1, 87 Stat. 914, 914 (1973) (codified at 42 U.S.C. §§ 300e-300e-17); *see also* S. Rep. No. 93-129, at 3037-41 (1973) (stating purpose of Act to "provide assistance and encouragement for the establishment and expansion of health maintenance organizations").

[47] 42 U.S.C. §§ 300e (defining HMO as a "public or private entity"), 300e-5 (application requirements), 300e-10 (stating that restrictive state laws do not apply to federally qualified HMOs).

[48] 42 U.S.C. § 300e-1.

[49] 42 U.S.C. §§ 300e-1(1)(H)(iv) (defining "basic health service"), 300e (requiring HMO to cover "basic and supplemental health services").

States government.[50] The United States Office of Personnel Management contracts with qualified private insurance carriers to offer health care plans through the FEHB program.[51] As part of the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, Congress approved a "contraceptive equity provision" requiring most FEHB plans to cover contraception.[52] Today, the United States Office of Personnel Management requires FEHB plans to cover the full range of FDA-approved contraceptive drugs and devices without cost-sharing.[53] As amended in 1998, the FEHB program provides that specifically enumerated religious health plans do not have to cover contraception and allows for the potential that future other plans objecting to contraceptive coverage "on the basis of religious beliefs will be included."[54] However, the decision of whether to

---

[50] *See* 5 U.S.C. §§ 8901-8914 (health insurance for government employees), 8905(a)-(b) (defining eligible persons).

[51] *Id.* § 8902; *Muratore v. U.S. Office of Pers. Mgmt.*, 222 F.3d 918, 920 (11th Cir. 2000) ("Congress enacted the FEHBA . . . to create a comprehensive program of subsidized health care benefits for federal employees and retirees."); U.S. Office of Pers. Mgmt., *The Fact Book, Federal Civilian Workforce Statistics* 82 (2007), http://www.opm.gov/feddata/factbook/ (last visited May 15, 2015).

[52] Omnibus Consolidated & Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, § 656(a), 112 Stat. 268, 530 (1998).

[53] U.S. Office of Pers. Mgmt. (OPM), Benefits Admin. Ltr. No. 98-418 (Nov. 6, 1998); OPM, FEHB Program Carrier Letter re: Federal Employees Health Benefits Program Call Letter, Letter No. 2012-09 at 2 (Mar. 29, 2012), http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-09.pdf (last visited May 15, 2015).

[54] Pub. L. No. 105-277, § 656(b), 112 Stat. 268, *supra* note 73; *see also* Cong.

take up contraceptive coverage is left to the employee, who can choose from up to 300 plans, most of which cover contraception.[55]

Federal legislation regulating health services available to military personnel and their families also requires coverage of preventive contraceptive services. Congress established a military health system "to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents."[56] Pursuant to congressionally delegated authority, the Department of Defense established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1967 (now known as TRICARE).[57] In 1995, the Department of Defense established TRICARE as a "comprehensive managed health care program for the delivery and financing of health care services in the Military Health System."[58] TRICARE provides health

---

Research Servs., *Laws Affecting the Federal Employees Benefits Program (FEHBP)* (Feb. 13, 2013), https://www.fas.org/sgp/crs/misc/R42741.pdf (last visited May 15, 2015).

[55] U.S. Office of Pers. Mgmt., *Federal Employees Health Benefits Program Patients' Bill of Rights and the Federal Employees Health Benefits Program*, http://www.opm.gov/insure/archive/health/billrights.asp#Choice (last visited May 15, 2015).

[56] 10 U.S.C. § 1071.

[57] Pub. L. No. 85-861, § 1(25)(B), 72 Stat. 1450 (1958), amended by Pub. L. No. 89-614, § 2(1), 80 Stat. 862 (1966) (codified at 10 U.S.C. §§ 1071-1110b).

[58] 32 C.F.R. §§ 199.17(a), 199.3; 10 U.S.C. § 1073(2).

care benefits to active-duty service members, retirees and their families, and other beneficiaries from any of the seven services.[59] TRICARE offers all beneficiaries a range of FDA-approved methods of contraception, including intrauterine devices, diaphragms, prescription contraceptives, and surgical sterilization.[60] Service women on active duty have coverage of contraception without cost-sharing.[61]

Congress' declaration of a national policy of "ensur[ing] the highest possible health status for Indians and urban Indians" also includes the requirement that health plans cover family planning services and supplies.[62] Among other things, Congress authorized the Secretary of HHS, acting through the Indian Health Service (IHS), "to provide health promotion and disease prevention services to Indians . . . ."[63] Congress' definition of "health promotion" includes programs for "reproductive health and family planning."[64] According to the Indian Health Manual, IHS "provide[s] comprehensive family planning services to all eligible

---

[59] *See* 10 U.S.C. §§ 1072 (defining TRICARE), 1074 (providing for medical and dental care for members and certain former members of armed forces), 1077 (providing for medical and dental care for dependents).
[60] 32 C.F.R. § 199.4(e)(3); 10 U.S.C. § 1077 (preventive health care services for women includes pregnancy prevention).
[61] *See* 32 C.F.R. § 199.21(i)(2).
[62] 25 U.S.C. § 1602(1)-(2).
[63] 25 U.S.C. § 1621b(a).
[64] 25 U.S.C. § 1603(11)(G)(xix).

American Indian and Alaska Native men and women."[65] This includes, "[a]ll available Food and Drug Administration (FDA) approved types of contraceptive (mechanical, chemical and natural) methods," with the individual deciding the appropriate choice of method.[66]

Coverage of family planning services and supplies is also a requirement of Medicaid—the country's largest public health insurance program covering nearly seventy million low-income people.[67] States participating in Medicaid receive significant federal funding in return for providing specified health coverage to specified population groups (with a state option to cover additional groups and services). The Medicaid Act requires participating states to cover family planning services and supplies without cost-sharing for all categorically needy beneficiaries.[68]

Through the ACA, the federal government sought to transform the country's health care system. One way it did so was by increasing the quality and

---

[65] HHS, Indian Health Serv., *Indian Health Manual* § 3-13.12B(1), http://www.ihs.gov/ihm/index.cfm (last visited May 15, 2015).

[66] *Id.* at §§ 3-13.12F(2), 3-13.12B(1); *see also* 42 U.S.C. § 18071(d)(1)-(2).

[67] *See* 42 U.S.C. § 1396d(a)(4)(C) (addressing family planning services and supplies); Julia Paradise, Kaiser Family Found., *Issue Brief: Medicaid Moving Forward* 1 (Mar. 9, 2015).

[68] 42 U.S.C. § 1396d(a)(4)(c); 42 C.F.R. § 441.20; *see* Ctrs. for Medicare & Medicaid Srvs. (CMS), *State Medicaid Manual* § 4270; CMS, *Dear State Medicaid Director* (July 2, 2010) (discussing family planning related services in context of new eligibility option under ACA § 2303).

affordability of health insurance through a number of mechanisms, including the establishment of a minimum level of "essential health benefits" in health insurance coverage.[69] Congress also added § 2713(a)(4) of the Public Health Service Act to ensure that women receiving coverage through private insurance—a "group health plan" or from "a health insurance issuer offering group or individual health insurance coverage"—have a minimum level of coverage of preventive health services necessary to preserve and maintain women's health without cost-sharing.[70] By doing so, the ACA builds upon the existing body of federal law already working to ensure access to necessary reproductive health services in other arenas.

V. Safety net programs should not be conflated with the private health insurance market.

The contraceptive coverage requirement focuses on the private health insurance market. Title X is the nation's only dedicated source of federal funding for safety net family planning services, serving as a wraparound and infrastructure program designed to help ensure that low-income and vulnerable populations are

---

[69] *See, e.g.*, 42 U.S.C. § 300gg-6(a) (requiring individual or small group market health plans to cover a package of "essential health benefits"); 42 U.S.C. § 18022(b)(1) (listing ten categories of "essential health benefits").
[70] 42 U.S.C. § 300gg-3(a)(4).

able to access affordable family planning services.[71] Indeed, while Title X health centers can provide care to all patients, federal law requires them to give priority to "persons from low-income families."[72] In addition to being low-income, Title X patients are also disproportionately people of color. In 2013, of the approximately 4.6 million Title X family planning users, thirty percent self-identified as black or African American, Asian, Native Hawaiian or other Pacific Islander, or American Indian or Alaska Native, or more than one race, and thirty percent self-identified as Hispanic or Latino.[73]

Safety net programs like Title X are not designed to absorb the unmet needs of higher-income, insured individuals. Furthermore, Title X is designed to subsidize a program of care, not pay all of the cost of any service or activity; the Title X statute and regulations direct Title X-funded agencies to seek payment from third party payers.[74] Moreover, Title X is already underfunded and

---

[71] *See* 42 U.S.C. §§ 300-300a-8; HHS, Office of Population Affairs, *Title X Funding History*, http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/title-x-funding-history/ (last visited May 15, 2015).
[72] 42 C.F.R. § 59.5(a)(6)-(9).
[73] Christina Fowler et al., *Title X Family Planning Annual Report: 2013 National Summary* (Nov. 2014) http://www.hhs.gov/opa/pdfs/fpar-2013-national-summary.pdf (last visited May 15, 2015).
[74] *See, e.g.*, 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 C.F.R. § 59.5(a)(7), (9).

overburdened. Between the 2010 and 2013 fiscal years, Title X funding decreased by approximately thirty-nine million dollars, or 12.3%.[75] This time period also corresponds with the largest decrease in the number of patients served in Title X sites in more than a decade—a loss of more than 667,000 patients.[76]

Title X and similar programs seek to ensure preventive services for primarily low-income and uninsured individuals who rely on publicly funded safety net programs for access to services. Even with the ACA's expansion of health insurance coverage, the U.S. Congressional Budget Office estimates that approximately 30 million nonelderly individuals will remain uninsured in 2016.[77] Congress designed safety net programs such as Title X to provide access to care for underserved populations. They should not be conflated with private health insurance coverage.

CONCLUSION

Section 2713(a)(4) of the Public Health Service Act makes access to contraception possible by ensuring that health plans in the individual and small group market adequately cover contraception without cost-sharing—cost-sharing

[75] *See* HHS, Office of Population Affairs, *supra* note 71.
[76] Christina Fowler et al., *supra* note 73, at ES-1.
[77] Cong. Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* 1 (2012), http://www.cbo.gov/sites/default/files/09-19-12-Indiv_Mandate_Penalty.pdf (last visited May 15, 2015).

that would otherwise reduce use of this necessary service. This Court should find for the Government and uphold the contraceptive coverage provision.

Date: May 18, 2015

Respectfully submitted,
/s/Martha Jane Perkins
Martha Jane Perkins
National Health Law Program, Inc.
101 East Weaver St., Suite G-7
Carrboro, NC 27510
(919) 968-6308
perkins@healthlaw.org

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(7)(B) and 29(d), and that the total number of words in this brief is 4,576 words, according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

Date: May 18, 2015

/s/Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2015, I electronically filed the foregoing brief with the Clerk of the Court by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

Date: May 18, 2015

/s/Martha Jane Perkins
Martha Jane Perkins