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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

No. 1:19-cv-03040-SAB

DECLARATION OF
TESSA MADDEN, M.D., M.P.H.,
IN SUPPORT OF NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION'S MOTION FOR A PRELIMINARY INJUNCTION

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Tessa Madden, M.D., M.P.H., states as follows:

1. I am a licensed physician and Associate Professor of Obstetrics and Gynecology at the Washington University School of Medicine in St. Louis. I am also the Director of the Family Planning Division in the Department of Obstetrics and Gynecology. I earned my M.D. degree from Washington University School of Medicine in St. Louis in 2001. After completing residency in Obstetrics and Gynecology at New York Presbyterian Hospital at Columbia University, I earned an M.P.H. at the Johns Hopkins University Bloomberg School of Public Health, where I also completed a fellowship in family planning. I have provided family planning care since 2005. I submit this declaration in support of Plaintiffs' motion for a preliminary injunction.

2. In addition to my faculty appointment, I serve as the Medical Director of the Washington University School of Medicine Contraceptive Choice Center ("C3"). C3 has received Title X funding for its family planning services since 2015, the first year of C3's operation. C3 is a subrecipient of the Title X project administered by the Missouri Family Health Council. Like Missouri Family Health Council and all of its subrecipients, C3 is a member of the National Family Planning & Reproductive Health Association ("NFPRHA").

3. I provide direct Title X patient care at C3 and also supervise our nurse practitioners, contraceptive counselors, and other staff with regard to their Title X

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family planning care and C3's clinical standards. Nurse practitioners provide the majority of patient Title X care at C3. Trained contraceptive counselors also deliver education and counseling. C3 provides more than 2,400 Title X patient visits per year.

4. In my capacity as a clinical researcher, I have conducted extensive studies on contraception, including studying contraceptive preferences, barriers to contraceptive care, and patient health outcomes related to contraceptive use. My research includes detailed empirical analyses of patients' choice of contraceptive methods when educational, financial, and systems barriers are eliminated. I have published numerous articles in peer-reviewed medical journals on these subjects. I was a co-investigator for the Contraceptive CHOICE Project, a longitudinal study of 9,256 women who received comprehensive counseling about all reversible methods of birth control and were provided their contraceptive method of choice at no out-of-pocket cost.

5. I am also well-versed in related scientific literature regarding Title X's role in reducing educational and financial barriers to family planning services, as well as the impact of contraceptive access on health outcomes. Likewise, I am familiar with literature on pregnancy counseling and medical ethics regarding reproductive health care. Finally, in my various professional roles, I interact with

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other Title X health care providers and family planning researchers around the country.

6. My curriculum vitae, which sets out my professional qualifications, experiences, and publications in greater detail, is attached hereto as Exhibit A.

7. It is my expert opinion that the new Title X rules ("New Rule") would cause serious harm for Title X patients and providers. I explain some of the most significant harms that the New Rule imposes below.

8. I am familiar with the key provisions of the New Rule. In my own Title X practice, if the New Rule were allowed to take effect, I could not abide by its terms and would have to withdraw from the Title X program. In addition, the New Rule would significantly interfere with, and likely shut down, all Title X family planning care at C3. Its effects in St. Louis and the surrounding area would be to make quality family planning care less accessible for low-income patients here, thereby creating new health risks and harms for them, just as it would impose similar harms nationwide.

The New Rule Boxes All Title X Providers into Only Harmful Options

9. The New Rule forces Title X providers to provide all pregnant patients with referrals for prenatal care regardless of the patients' wishes, while simultaneously barring referrals for abortion care when requested by the patient. 84 Fed. Reg. 7714; Section 59.14(b). The New Rule only allows doctors and

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1 advanced practice clinicians with a graduate level degree to provide nondirective
2 pregnancy counseling, *id.* at Section 59.14(b)(1)(i) , and requires those clinicians to
3 discuss carrying the pregnancy to term even if the patient is only interested in
4 discussing terminating the pregnancy, *id.* at 7747.
5
6 10. As discussed in more detail below, these new limitations on
7 pregnancy counseling would trigger immediate injuries to patients and significant
8 disruption of the Title X network as soon as the New Rule takes effect: It would
9 force all Title X providers (including individual clinicians like myself) to suddenly
10 choose between two harmful options. The first bad option is to stay in the program
11 and provide unethical care by having to engage in coercive, misleading
12 counseling—licensed clinicians such as myself must (1) provide prenatal referrals
13 in every instance, even where the patient does not wish such a referral, which may
14 be especially confusing and distressing to the patient that seeks only information
15 about and referral to abortion; (2) refuse patient requests for referrals to abortion
16 providers or for other information that might help them access abortion care; and
17 (3) conduct what should be neutral, nonjudgmental professional counseling in a
18 way that may further stigmatize the decision to proceed with an abortion. In
19 addition, this would violate principles of medical ethics and HHS's own national
20 standards of clinical care, which would lead to reputational and other professional
21 harms for providers that conform to the new rules. The second bad option is to
22
23

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leave the Title X program, forego its funding, and cease providing free or low-cost care to patients with limited economic means who critically need it—not just pregnancy testing and counseling, but the full range of family planning care.

11. If it takes effect, the New Rule would destroy the integrity of nondirective pregnancy counseling throughout the Title X program and at all of its remaining sites and impose an ever-widening group of harms to the Title X network and its patients, as described below.

12. Moreover, if the New Rule is allowed to take effect, it would also impose: untenable physical, staff, and systems separation requirements that separate Title X work from the other health care provided by the institution and that dismantle the current, effective provision of Title X care, *see* Section 59.15; new counseling and recordkeeping mandates that threaten confidentiality and waste resources, *see* Section 59.17; and other new policies that would force many grantees, sub-recipients, and health centers to decide to leave the Title X program, *see* Sections 59.15-.19.

13. As explained below, C3 cannot comply with the New Rule's separation requirements, among other new burdens; these constraints would exclude C3 from the program. Other committed Title X health centers would likewise be forced to decide whether they can comply with these strict separation requirements, and if they cannot, they would also have to leave the Title X

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program, which may cause serious harm to their patients who rely on them to provide quality family planning care.

14. The resulting disruptions to the Title X network would decrease patient access to family planning care and interfere with patients' ability to make decisions about if and when to have children by decreasing their access to all reversible contraception, including the most effective forms. Less access to effective contraception and other family planning care, including sexually transmitted infections (STI) and cancer screening, would then mean additional individual, family, and public health harms.

The New Rule Would Harm Pregnant Patients Seeking Counseling about Their Options

15. Patients would suffer immediate harm if the New Rule takes effect because of its numerous restrictions on pregnancy counseling, including the prohibition on any meaningful abortion referral and the Rule's mandatory, coercive prenatal referral. *See* Sections 59.5, 59.14.

16. Patients who come to Title X clinics like C3 for pregnancy testing arrive with a wide range of emotions: They may be hoping for, dreading, or ambivalent about a positive result.

17. Patients who are excited to learn that they are pregnant want to talk about next steps in continuing their pregnancy, including possible referrals for prenatal care.

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18. But when patients are told about unplanned pregnancies, they may not immediately know what they want to do. In those cases, the central purpose of pregnancy counseling is to allow a space for patients to talk through the new knowledge that they are pregnant, to ask questions and gather factual information, and to weigh their options.

19. Because of the highly personal nature of the decision they are weighing, as a medical professional, I understand that it is essential for clinicians to provide full, unbiased information.

20. To that end, ethical rules adopted by the American Medical Association and the American College of Obstetricians and Gynecologists, together with standards of care published by the Centers for Disease Control and Prevention ("CDC") and the HHS Office of Population Affairs in "Providing Quality Family Planning Services" ("QFP"), require that pregnancy counseling be nondirective, offer complete information, and be voluntary.[i] Appropriate counseling must take its cue from the patient's inquiries and reactions to a positive pregnancy test, and make available full medical and referral facts, if desired by the patient.

21. Nondirective counseling that includes information about and referral for all types of pregnancy care, including abortion, is especially important for Title X patients, who are disproportionately low-income individuals, adolescents and

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young people, individuals with limited English-language abilities, populations with limited experience in clinical settings, and other especially vulnerable groups.[ii] These patients sometimes do not know that abortion is available or even legal. Even if they understand those basic facts that it might be available somewhere, they may know very little of the medical information about abortion or have no idea how to access it.

22. Under the New Rule, however, Title X providers may not mention any referral information regarding abortion—even in response to patient questions. *See* 84 Fed. Reg at 7761; Section 59.5(a)(5). This disrupts the clinician-patient relationship and erodes the trust that is necessary for effective medical care. It also violates medical ethics and standards of care.[iii]

23. Title X clinicians' inability to direct patients to where they can find out more about or receive an abortion and provide specific referral information, would mean confusion and delay for many patients who might want that care. The delay in even gathering information would, for some, delay those patients' access to their chosen care—abortion. Though abortions are generally very safe, each week of delay increases the medical risks associated with the procedure,[iv] and, if prolonged, may force the woman past the point when abortion is legally available.

24. Patients may also infer abortion-related stigma from providers' unwillingness to discuss the procedure in the same fashion that other options are

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discussed. This inference, in turn, risks further damaging the essential trust at the heart of the patient-clinician relationship.

25. In response to pregnant patients' requests for referrals to abortion providers, the New Rule directs that the "response would be to say it does not refer for abortions, and then to offer her, if she desires, a list of comprehensive primary health care providers (including providers of prenatal care); that list could include (but not identify) such providers that also perform abortions." 84 Fed. Reg. at 7761. This provider list, particularly in response to questions that seek abortion information, may mislead patients to erroneously conclude that abortion is not available to or appropriate for them. It may also further delay abortion care by routing patients to inappropriate follow-up care and to practitioners that cannot help with the information or care that the patients desire. This non-responsive approach and refusal to provide usable referral information violates medical ethics and national standards of care, and in turn, may cause patients to distrust their Title X providers.[v]

26. The New Rule also forbids providers from linking patients with even indirect referrals to abortion providers. Thus, Title X clinicians are apparently supposed to ensure that any "emergency medical or other referrals" to which they might send pregnant patients also would not offer them a referral to abortion care. 84 Fed. Reg. at 7763.

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27. Even where a patient's medical history or condition indicates that continued pregnancy would be high risk—though not pose a medical emergency—Title X clinicians are prevented under the New Rule from referring such high-risk patients directly to abortion care when patients want to explore or seek that option. *See* Section 59.14.

28. The New Rule further mandates that Title X providers engage in coercive counseling, which, again, is expressly prohibited by medical ethics and the standards of care.[vi]

29. Specifically, the New Rule directs that providers give a referral for prenatal care (and/or other options, like adoption, that each continue the pregnancy) for every pregnant patient. *See* Section 59.14(b)(1). This required referral, regardless of patients' wishes, may be severely upsetting to patients whose pregnancies are unplanned and who may be considering or have decided on abortion care. The referral must be undertaken under the New Rule regardless of consent. Such action violates the dignity and autonomy of pregnant patients who do not desire this assistance.

30. The kind of care mandated by the New Rule would damage the patient-provider relationship, including by forbidding clinicians from providing referrals and stigmatizing the patient and her consideration of abortion. In those respects, the New Rule would also cause ensuing reputational harm to Title X

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providers that decide to attempt to stay in the Title X program, despite these professional compromises, because of its important role in offering access to low-income patients.

31. C3 feedback surveys reflect that our patients—many of whom repeatedly return to C3 for family planning services—have a high degree of trust in our counselors and clinicians. C3 patients report that they return because they trust the staff to provide complete, not misleading, information about their options. Even for new patients, trust develops quickly from our clinicians' expertise, responsiveness, and unbiased efforts to help patients assess their options and obtain full information about their medical situation.

32. The New Rule would destroy this kind of essential trust between clinician and patient for many patients faced with an unplanned pregnancy and interfere with Title X providers' ability to give quality and consistent care to all patients in the family planning program.

33. This effect would be especially dramatic with adolescents. Both my experience and medical literature demonstrate that young people may communicate less with health care providers or forego health care altogether if they do not trust the provider.[vii]

34. The New Rule, ironically, permits Title X staff members who could not provide nondirective pregnancy counseling (*i.e.*, personnel who do not have a

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graduate level degree) to provide "medically necessary information" about abortion in the context of contraceptive counseling. Specifically, the New Rule allows the provision of such information "to assess the risks and benefits of different methods of contraception in the course of selecting a method[.]" *See* Section 59.14(d). Once a patient is pregnant, however, that same staff member must withhold abortion-related information.

35. As an OB/GYN specializing in family planning care, the New Rule's mandated, coercive prenatal referral coupled with its ban on abortion referral is antithetical to my training, medical ethics, and the standard of care I believe I owe my patients. I therefore could not continue to participate in the Title X program, providing compromised care to patients who need and deserve better.

The New Rule Would Disrupt the Title X Network and Prevent Patient Access

36. The New Rule would also significantly disrupt the Title X network because existing provider organizations would be unable to comply professionally, logistically, and financially with a number of the new regulatory requirements.

37. The New Rule mandates, for example, that any Title X project establish physical and administrative separation from any entity that discusses, refers for, or provides abortion care. *See* Section 59.15. This required separation of systems, staff, and facilities is impossible, or prohibitively expensive, for many Title X projects. While C3, like other Title X providers, already keeps detailed

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financial records and maintains its Title X funds separately, these new separation rules go far beyond the current, already stringent financial separation rules and federal funding compliance requirements and oversight. Because of the ways in which modern medical practices are organized and operated, a number of current Title X providers would be unable to comply.

38. C3, for example, is part of Washington University School of Medicine's clinical practice. The School of Medicine's healthcare system comprises more than 1,500 faculty physicians in more than 76 specialties and subspecialties. Some practitioners in this large network discuss, refer for, and/or provide abortion care.

39. As is standard in today's practice of medicine, the entire Washington University healthcare network is fully integrated. All providers, including C3, operate on a single electronic health records system. The network adopted a single electronic medical record system because it improves the quality of patient care, helps to avoid mistakes or inconsistencies in patient health records, and allows more effective, fully informed medical care. Similarly, all faculty physicians use the same email system, rely on the same billing, payment, and accounting personnel, and appear on shared websites. Again, this infrastructure helps both clinicians and patients.

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40. C3's practice is located in a building that also houses other outpatient practices, including those of physicians who in the ordinary course of their practice might respond to questions about and discuss abortion with their patients. Those conversations could take place in the offices or examination rooms on the same floor or on another floor, at any time. C3 shares a common waiting room and front desk staff with multiple other OB/GYN providers. All of the practices in this multispecialty outpatient center use the same building entrances and exits, are supported by shared building staff, and utilize a shared laboratory.

41. As a result of all of this integration, C3 would not be able to comply with the New Rule's separation requirements. Nor could its university affiliation, staffing, and finances somehow be transformed to re-establish the practice somewhere totally separate from the university's outpatient facility and systems; C3 simply does not have the resources to exist on its own. C3 would be forced to leave the Title X program for all the reasons discussed in this declaration, if the New Rule takes effect.

42. This rapid departure by C3 and other specialized, highly effective clinics would reduce the number of Title X providers, at least for many months and likely longer. Some care for the displaced patient populations may shift to federally qualified health centers ("FQHCs") and remaining Title X providers, but those reduced number of providers lack capacity to see all of the patients who

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1 currently depend on the Title X network.[viii] Nationally, FQHC sites providing
2 contraceptive care would have to increase their contraceptive care by more than
3 two and a half times to meet patients currently served by Title X.[ix] In my
4 experience, it can be very difficult for patients in St. Louis to get an appointment at
5 one of the FQHCs, especially in a timely manner. With provider departures
6 dotting the country, some areas would remain unserved by Title X until (and if) a
7 replacement grantee or sub-recipient can be found, but the changes discussed here
8 would discourage new providers as well as driving away current ones.
9
10 43. This provider shortage would result in diminished access to quality
11 family planning care for many low-income patients. As discussed below,
12 diminished access results in an increased risk of unintended pregnancy and
13 resulting low birthweight and other negative health consequences, as well as
14 increased instances of abortion.[x]
15
16 **The New Rule Would Compromise Access to the Most Effective Contraceptive Methods**
17
18 44. The literature demonstrates that Title X is critical to reducing
19 educational and financial barriers that low-income women face in seeking
20 reproductive and family planning care.[xi]
21
22 45. This is because Title X offers free access to care for low-income
23 women and its standards of care, as established by the QFP, advise that providers
should offer a full range of medically approved contraceptive methods, together

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1 with counseling that highlights methods' effectiveness.[xii] This counseling equips
2 patients with the knowledge they need to make and follow through on decisions
3 about their contraceptive use.[xiii]
4
5 46. The QFP also stresses that delivery of desired contraceptive methods
6 should be as seamless and efficient as possible to eliminate access, logistical, and
7 financial barriers.[xiv] Contraceptives should be available on-site, and provision
8 should, where possible, occur in the same visit as the contraceptive counseling.[xv]
9 47. I was an investigator for a longitudinal study, the Contraceptive
10 CHOICE Project, which sought to determine whether high and stagnant rates of
11 unintended pregnancy could be reduced with increased use of long-acting
12 reversible contraception ("LARC")—facilitated by reducing the most common
13 barriers: cost, patient knowledge, and access.[xvi]
14
15 48. This study, consistent with the broader literature, demonstrates that
16 the same kind of barrier-reduction achieved by Title X providers enables patients
17 to choose, and continue to use, the most effective contraceptive methods: LARC,
18 which includes intrauterine devices ("IUDs"), and hormonal implant methods.[xvii]
19 Health centers that receive funding through Title X are more likely to offer a wider
20 range of contraceptive methods, have protocols to facilitate initiation and
21 continuation of methods, and provide same-day insertion of IUDs and implants
22 compared to health centers that do not receive Title X funds.[xviii]
23

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49. Use of LARC, in turn, has been shown to decrease instances of unplanned pregnancy, low birthweight, and other negative health consequences, as well as instances of abortion.[xix]

50. Based on these well-documented phenomena, disruptions to the Title X network would increase informational and financial barriers for people seeking contraceptive care and other family planning services. Adolescents, women of color, and low income women would likely be disproportionately affected.[xx]

51. For patients at or below the federal poverty line, those increased out-of-pocket costs, together with additional logistical burdens, may be enough of a barrier to prevent access to contraceptive services altogether.[xxi] Reduced access to the most effective methods of contraception would cause increased instances of unplanned pregnancy, negative health consequences, as well as increased instances of abortion.[xxii]

52. Studies examining disruptions to family planning care for low-income patients in Texas illustrate what we might expect if the new rules take effect. The Texas data demonstrate that a decrease in the number of family planning providers for low-income individuals reduces access to reproductive care, especially access to the most effective methods.[xxiii] These studies also show that such interruptions produce increased instances of unplanned pregnancy.[xxiv]

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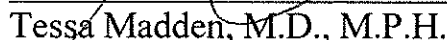
53. Additionally, the New Rule would allow a Title X-funded entity to offer only a single family planning method or a limited number of methods. *See* Section 59.5(a)(1). This would harm patients who seek full contraceptive counseling but only have one option (or limited options) presented to them, while the provider withholds information about other, more effective methods. The patient may not know there are other options available, and based on my research, that patient would often choose the more effective method if given the information and access. The New Rule would allow providers to leave those informational and financial barriers in place and prevent Title X patients from learning about and accessing the contraceptive method of their choosing.

54. For all of these reasons, the New Rule would cause significant harm to the patients Title X aims to serve, to Title X physicians and other clinicians, and to Title X health centers. At C3, the combination of the harmful pregnancy counseling restrictions, the expansive separation requirements, and the other new constraints imposed by the New Rule would force me and the entire C3 entity from the Title X program.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on 3/21/19 in St. Louis, Missouri.



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[i] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* ("QFP"), 63 Recommendations & Reports 4, 14 (2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; American College of Obstetricians & Gynecologists ("ACOG"), *College Statement of Policy* (2014), https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf; ACOG, *Guidelines for Women's Health Care: A Resource Manual* 719-20 (4th ed. 2014); American Medical Association ("AMA") Code of Medical Ethics §§ 2.1.1(a), 2.1.3.

[ii] *See, e.g.*, L.M. Dobkin et al., *Pregnancy Options Counseling for Adolescents: Overcoming Barriers to Care and Preserving Preference*, 43 Current Problems in Pediatric & Adolescent Health Care 96 (2013) (reflecting on particular access hurdles faced by adolescents and noting that "[c]ounseling that neglects to account for these hurdles," by, inter alia, providing information about how to obtain an abortion, "may not only contribute to the risk of abortion denial but also subsequent delays in prenatal care"); V.A. French et al., *What Women Want from Their Health Care Providers about Pregnancy Options Counseling: A Qualitative Study*, 27 Women's Health Issues 715 (2017) (showing that most patients want to receive information about all options during pregnancy counseling, regardless of whether they choose abortion care or prenatal care).

[iii] *See, e.g.*, AMA Code of Medical Ethics Opinion 1.1.3 (explaining that patients have the right "to receive information from their physicians and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives").

[iv] U.D. Upadhyay, et al. *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175-83 (2015).

[v] *See* AMA Code of Medical Ethics § 1.2.3 ("Physicians' fiduciary obligation to promote patients' best interests and welfare can include . . . referring patients to other professionals to provide care."); *id.* § 2.1.1(a); *see also* World Medical Ass'n, *International Code of Medical Ethics* (2018) ("Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability."), https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/; ACOG, *Informed Consent,* Committee Opinion No. 439, 114 Obstetrics & Gynecology 401–408 (2009), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent; Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), *AWHONN Position Statement: Health Care Decision Making for Reproductive Care*, 45 Journal of Obstetric, Gynecologic & Neonatal Nursing 718 (2016), http://www.jognn.org/article/S0884-2175(16)30229-5/fulltext; *Consultations and/or Policies on Referrals*, American Academy of Family Physicians (2017), https://www.aafp.org/about/policies/all/consultations-mandatory.html.

[vi] *See* AMA Code of Medical Ethics, § 2.1.1(a); ACOG, *College Statement of Policy*; ACOG, *Informed consent*.

[vii] *See* C.A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care*, 278 J. of the Am. Medical Ass'n 1029 (1997).

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[viii] *See* Kinsey Hasstedt, *Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net*, 20 Guttmacher Pol'y Rev. (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf.

[ix] *See* Frost JJ and Zolna MR, Response to inquiry concerning the availability of publicly funded contraceptive care to U.S. women, memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, May 3, 2017, https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

[x] *See, e.g.*, Gina M. Secura et al, *The Contraceptive CHOICE Project*, 203 Am. J. of Obstetrics & Gynecology e1 (2010) (reducing access and information barriers increases LARC usage and decreases unintended pregnancies); Paul D. Blumenthal et al, *Strategies to Prevent Unintended Pregnancy*, 17 Human Reproduction Update 121 (2011) (unintended pregnancy increases risks of, *inter alia*, low birthweight babies, adverse behaviors, and physical violence by partners); M. Antonia Biggs et al, *Did Increasing Use of Highly Effective Contraception Contributing to Declining Abortions in Iowa?* 91 Contraception 167 (2015) (abortion rate decline).

[xi] *See* Lisa Romero et al, *Vital Signs*, 64 Morbidity & Mortality Weekly Report 363 (2015) (study using Title X data); Jennifer J. Frost et al, *Specialized Family Planning Clinics in the United States*, 22 Women's Health Issues e519 (2012) (41% of patients rely on family planning clinic as only recent source for health care).

[xii] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* ("QFP"), 63 Recommendations & Reports 1, 7, 9 (2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

[xiii] *Id.*

[xiv] *Id.* at 7, 11.

[xv] *Id.* at 11.

[xvi] *See* Natalia E. Birgisson et al, *Preventing Unintended Pregnancy*, 24 J. of Women's Health 349 (2015).

[xvii] *See, e.g.*, Romero et al (Title X data shows improved access to LARC, increases LARC use); Natalia E. Birgisson et al, *Preventing Unintended Pregnancy*, 24 J. of Women's Health 349 (2015) (removing barriers of cost, information, and access to LARC methods increases patient choice of LARCs, decreasing unintended and teen pregnancy rates); Justin T. Diedrich et al, *Three-Year Continuation of Reversible Contraception*, 213 Am. J. of Obstetrics & Gynecology e1 (2015) (with reduced cost barriers and increased education, high LARC continuation rates as compared to other contraceptive methods); David L. Eisenberg et al, *Knowledge of Contraceptive Effectiveness*, 206 Am. J. of Obstetrics & Gynecology e1 (2012) (patients with full range of options are more likely to choose LARC, which is connected with lower unintended pregnancy rate); Secura et al (reducing access and information barriers increases LARC usage and decreases unintended pregnancies).

[xviii] Zolna MR and Frost JJ, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, New York: Guttmacher Institute, 2016, http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

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[xix] *See, e.g.*, Secura et al; Biggs et al; Blumenthal et al.

[xx] *See* Melody Goodman et al*, Reducing Health Disparities by Removing Cost, Access, and Knowledge Barriers*, 216 Am. J. of Obstetrics & Gynecology 382 e1 (2017) (racial disparities in pregnancy rates among teens mitigated by removing cost, access, and educational barriers to contraceptive access).

[xxi] *See* Yao Lu & David J.G. Slusky, *The Impact of Women's Health Clinic Closures on Preventive* Care, 8 Am. Economic J.: Applied Economics 100 (2016) (detrimental impact on all facets of reproductive health, especially for low-income women who may forgo care all together).

[xxii] *See supra* n.19.

[xxiii] *See* Amanda J. Stevenson et al, *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N.E. J. of Medicine 853 (2016) (reduced claims for LARC after exclusion of Planned Parenthood).

[xxiv] *See* Kristine Hopkins et al, *Women's Experiences Seeking Publicly Funded Family Planning Services in Texas*, 47 Perspectives on Sexual & Reproductive Health 63 (2015) (women had to pay more, use less effective contraceptive methods, or forgo care, resulting in an uptick of unplanned pregnancies).

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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED, this 22nd of March, 2019, at Seattle, Washington.

/s/ *Emily Chiang*
Emily Chiang, WSBA No. 50517