No. 19-10754

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

RICHARD W. DEOTTE; on behalf of himself and others similarly situated; YVETTE DEOTTE; JOHN KELLEY; ALISON KELLEY; HOTZE HEALTH & WELLNESS CENTER; BRAIDWOOD MANAGEMET, INCORPORATED, on behalf of itself and others similarly situated,

Plaintiffs-Appellees,

v.

Defendants
STATE OF NEVADA,

Movant-Appellant.

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

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BRIEF FOR AMICUS CURIAE OF 15 COUNTIES, CITIES, AND TOWNS IN SUPPORT OF MOVANT-APPELLANT

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STATEMENT OF COMPLIANCE WITH RULE 29

This brief is submitted pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure with consent of all parties. No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money to fund the preparation or submission of this brief; and no other person except amici curiae and their counsel contributed money to fund the preparation or submission of this brief.

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INTERESTS OF AMICI

Amici are local governments from across the United States that provide critical healthcare services to their residents to protect local health, safety, and wellbeing. Amici directly benefit from the increased and more effective use of contraceptive methods made available by the contraceptive mandate of the Affordable Care Act (ACA), which, as implemented, requires most health plans to cover contraceptive care. Essential healthcare services provided or subsidized by amici include contraception, pregnancy-related services, and prenatal and postnatal care. Many services are provided without regard to ability to pay and are central to effective and efficient health promotion.

Amici support the State of Nevada's participation in this litigation and its appeal from the district court's rulings, which depart from this Court's guidance and Congress's intent by finding that the contraceptive mandate violates the Religious Freedom Restoration Act (RFRA). If left in place, the injunction issued by the district court will allow employers throughout the country to opt out of providing contraceptive coverage, without notice to employees or a mechanism to fill the resulting coverage gap. It will fall on state and local governments to address many of the resulting health, economic, and social costs and consequences. By undermining contraceptive coverage and increasing the rate of unintended pregnancy, the district court's erroneous rulings and its nationwide injunction will

impose significant public health and financial costs on state and local governments and, in turn, impair their exercise of key governmental functions and roll back public health gains achieved since the ACA's passage.

Amici also share a common objective of protecting free exercise of religion among their richly diverse communities. But, as this Court has recognized, the contraceptive mandate's exemption for religious employers and accommodation for other objecting religious entities meet federal requirements under RFRA and do not substantially burden religious exercise. *See E. Texas Baptist Univ. v. Burwell*, 793 F.3d 449, 452-54, 463 (5th Cir. 2015), *vacated and remanded sub nom. Zubik v. Burwell*, 136 S. Ct. 1557 (2016). Further, Congress already considered and rejected a statutory amendment paralleling the relief sought here. *See Pennsylvania v. Trump*, 930 F.3d 543, 571 (3d Cir. 2019), *cert. petitions pending*, Nos 19-431, 19-454 (citing 158 Cong. Rec. S1162, 1173-74 (2012)). The substantial risk of harm to Nevada and its residents from the district court's erroneous rulings mirrors harms that will reverberate throughout the country, and supports Nevada's intervention in the district court litigation and its Article III standing to ensure that these interests are adequately represented in an adversarial legal proceeding.

ARGUMENT

I. State and Local Governments Will Bear the Direct Costs of Decreased Contraceptive Access and Increased Unplanned Pregnancies Resulting from the Injunction.

The district court's grant of summary judgment to plaintiffs and issuance of a nationwide injunction are intended to, and will, cause a substantial number of women across the United States to lose employer-sponsored contraceptive coverage—often with no notice from employers. State and local governments will bear the costs of this loss of health coverage for contraceptive care, through the increased direct costs of providing subsidized contraception and the broader costs of unplanned pregnancies.[1]

State and local governments across the country provide a wide range of safety-net healthcare services.[2] In 23 states, counties are required to provide

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[1] *See, e.g.*, Jennifer J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 667, 685-91 (2014).

[2] *See* Nat'l Ass'n of Ctys., *Counties' Role in Health Care Delivery and Financing*, 3 (July 2007), http://www.naco.org/sites/default/files/documents/Counties'%20Role%20in%20Healthcare%20Delivery%20and%20Financing.pdf; Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, Nat'l Health Pol'y F. 9-10 (Aug. 18, 2010), https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf ("Twenty-nine states . . . have established a decentralized organizational model for public health in which local public health agencies are organizationally independent of the state agency and are primarily governed by local authorities. . . . Of the 2,794 local health departments in the United States, most (60 percent) serve counties; some (18 percent) serve a

medical services to their low-income and chronically ill residents.[3] Federal and state requirements also impose obligations on local governments to provide some forms of safety-net care.[4] In Texas, for example, counties must provide medical services to eligible residents without other sources of care.[5] In California, all 58 counties are required to provide safety-net health services. Cal. Welf. & Inst. Code § 17000. And in Tennessee, local and regional health departments provide a range of healthcare services, including primary care, child health, and family planning.[6]

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city, town, or township; some (11 percent) serve a joint city/county jurisdiction; and some (9 percent) serve a multicounty region.").

[3] *See* Nat'l Ass'n of Ctys., *supra* note 7 at 3.

[4] *See, e.g.*, Public Health Services Act, Section 330, 42 U.S.C. § 254b (requiring federally-qualified health centers to serve all residents of their communities regardless of their ability to pay); Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, P.L. No. 101-381, 104 Stat. 576 (1990) (requiring providers to offer HIV/AIDS medications and health care services to poor patients who need these medications and services but cannot otherwise access them).

[5] Tex. Health & Safety Code § 61.022; *see* Tex. Health & Hum. Servs., *Texas Hospital Uncompensated Care Report* (Jan. 16, 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider-10-hospital-uncompensated-care-report-dec-2018.pdf ("The Texas Constitution states that care for the uninsured is a local government responsibility. The Texas Department of State Health Services oversees this law in the form of The County Indigent Health Care Program. Counties must provide select medical care to all of their residents who are [eligible].").

[6] Tenn. Dep't of Health, *Services Offered by Local Health Departments* (last visited Dec. 26, 2019), https://www.tn.gov/health/health-program-areas/localdepartments/lrhd/local-services.html.

Many localities fund or support safety-net health centers that provide free or reduced-fee services to patients, often including contraception, pregnancy, sexually transmitted disease testing, and other maternal and child health services.[7] In fact, from 2006 to 2010, one in four women who obtained contraceptive services did so at a publicly funded center.[8] In 2015, 82% of U.S. counties had at least one safety-net health center providing family planning services.[9] State governments provide significant funding for many of these local services, as well as for services provided at the state level.[10]

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[7] *See generally Fact Sheet: Publicly Funded Family Planning Services in the United States*, Guttmacher Inst. (Oct. 2019), https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states; Salinsky, *supra* note 3.

[8] *See* Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995-2010* 16 (2013), https://www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf.

[9] *See Fact Sheet: Publicly Funded Family Planning Services in the United States*, *supra* note 8.

[10] *See, e.g.*, Nat'l Ass'n of Ctys., *supra* note 7 at 4-15; Centers for Disease Control and Prevention, *Evidence Summary: Prevent Unintended Pregnancy*, 2 (2015), https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-pregnancy.pdf ("In seven states, the costs for births from unintended pregnancies exceeded a half-billion dollars."); Adam Sonfield & Kathryn Frost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy Related Care: National and State Estimates for 2010*, 8 (2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf (estimating state-by-state expenditures).

While the availability of public contraceptive coverage differs by jurisdiction, it is certain that some portion of the women who will lose contraceptive care coverage under the injunction will qualify for state or locally subsidized care to fill the gap left by private insurers. The ACA's coverage expansions dramatically decreased the proportion of women relying on publicly funded family planning services.[11] If the number of women without full contraception coverage rises, state and local governments will once again be forced to fill the resulting coverage gaps and bear the costs of more unplanned pregnancies.

[11] *See* Jennifer J. Frost et al., *Contraceptive Needs and Services, 2014 Update* 15 (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf ("Between 2013 and 2014, millions of Americans gained health insurance through provisions of the ACA—either as newly eligible Medicaid enrollees or by purchasing health insurance through the ACA's health insurance marketplaces. Among poor and low-income women in need of contraceptive services, the change in insurance status was dramatic. Over this one-year period, the number of women in need of publicly funded contraceptive care who had neither public nor private health insurance fell by nearly 20%, from 5.6 million to 4.5 million."); Kinsey Hasstedt, *Through ACA Implementation, Safety-Net Family Planning Providers Still Critical for Uninsured—and Insured—Clients* (Aug. 18, 2016), https://www.guttmacher.org/article/2016/08/through-aca-implementation-safety-net-family-planning-providers-still-critical (Small-scale investigation of 28 safety-net family planning centers found that proportion of family planning visits not covered by insurance went down after the ACA. "Most notably, the proportion of visits paid for by private insurance at the 28 sites rose from 14% in the last three quarters of 2013 to 22% in in the same period of 2015.").

State and local government safety-net providers will bear a direct financial burden if the district court's injunction is upheld. For example, California's Family PACT Program offers comprehensive family planning services at no cost to families below 200% of the federal poverty level with no other source of family planning coverage.[12] As women with private health insurance lose contraceptive coverage, more low-income women will need services through Family PACT or other local government programs, at a direct cost to local governments, which already operate their public health systems at significant deficits.[13]

Nor can local governments avoid cost increases by opting out of subsidizing contraceptive care. Without contraceptive access, governments incur greater costs providing pregnancy, delivery, and early childhood care.[14] In 2010, every $1.00 invested in publicly funded family planning services saved $7.09 in Medicaid expenditures that would otherwise have been needed to pay the medical costs of pregnancy, delivery, and early childhood care.[15] Such costly outcomes associated

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[12] *See, e.g.*, *Welcome to Family PACT* (June 28, 2017), http://www.familypact.org/Home/home-page (describing California's program programs providing comprehensive family planning services to eligible residents).

[13] *See, e.g.*, U.S. Gov't Printing Office, Public Papers of the Presidents of the United States: Barack Obama 2009 at 127 (2010) (describing how "spiraling health care costs are … straining budgets across government"), https://www.govinfo.gov/content/pkg/PPP-2009-book1/pdf/PPP-2009-book1.pdf .

[14] *See, e.g.*, Frost et al., *supra* note 2.

[15] *Id.*

with unplanned births are well established.[16] As safety-net healthcare funders and providers, local jurisdictions will have to fund many of the medical services associated with unintended pregnancies for their eligible residents.

The limited remaining Title X providers offer little in the way of a backstop. Recent federal restrictions to Title X, the federal government's only dedicated family planning funding program, have dramatically reduced the number of Title X providers,[17] putting a twofold strain on state and local resources. First, local health departments now have to increase their patient capacity just to continue to serve all existing Title X patients.[18] This need for increased capacity will only grow if women denied insurance coverage for contraception turn to Title X programs, with states and localities bearing those additional costs. Second, in states that offer contraceptive services through private providers, providers are often paid with a

[16] *See, e.g.*, Mary Tschann & Reni Soon, *Contraceptive Coverage and the Affordable Care Act*, 42 Obstetrics & Gynecology Clinics N. Am. 605, 606 (2015).

[17] Laurie Sobel et al., *New Title X Regulations: Implications for Women and Family Planning Providers*, Kaiser Family Found. (Mar. 8, 2019), https://www.kff.org/womens-health-policy/issue-brief/new-title-x-regulations-implications-for-women-and-family-planning-providers/.

[18]Nakisa B. Sadeghi & Leana S. Wen, *After Title X Regulation Changes: Difficult Questions for Policymakers and Providers*, HealthAffairs (Sept. 24, 2019), *available at* https://www.healthaffairs.org/do/10.1377/hblog20190923.813004/full/.

combination of Title X, state, and local resources.[19] In these states, governments not only have to provide more services through their health departments, they must make up the Title X funding that was used to pay private providers. This puts an even greater incremental strain on state and local resources.

Further, decades of research confirms that individuals use contraception most effectively absent upfront financial and logistical barriers.[20] Some of the most highly effective forms of contraception are also those with the greatest upfront costs, making them more difficult to access without health coverage. Before the ACA's passage, insurers could refuse to cover these contraceptives, decline to cover contraceptive-related medical appointments, or impose impractically large copayments. The district court's injunction would usher in a partial return to this regime.

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[19] Adam Sonfield et al., *Assessing the Gap Between the Cost of Care for Title X Family Planning Providers and Reimbursement from Medicaid and Private Insurance* (Jan. 2016), https://www.guttmacher.org/sites/default/files/pubs/Title-X-reimbursement-gaps.pdf.

[20] Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 Persp. on Sexual & Reprod. Health 226, 226 (2007); Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost Sharing*, 14 Guttmacher Pol'y Rev. 7, 10 (2011) (citing Lydia E. Pace et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 Health Aff. 1616 (2016)).

The ACA's contraceptive mandate ensures a woman can choose appropriate contraception without regard to upfront costs or other insurance considerations that might result in less effective or less consistent use of family planning. Three of the most commonly used methods of contraception—oral contraception (the "pill"), female sterilization, and intrauterine devices ("IUDs")[21]—are also among the most effective.[22] While these methods are ultimately cost-effective, they entail high up-front costs. Absent "the contraceptive coverage guarantee, many women would need to pay more than $1,000 to start using one of these methods"—nearly a month's salary for a woman working full-time at federal minimum wage.[23] Even oral contraceptives, twice as effective as condoms in practice,[24] require a prescription and can cost $60 per month without insurance.[25]

State and local governments are also likely to be harmed by the decrease in tax revenues when women with unexpected pregnancies lose economic

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[21] *See* Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14, 16 (2017).

[22] U.S. Food & Drug Admin., *Birth Control Guide* (last visited Apr. 19, 2019), https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf.

[23] Adam Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee?*, 20 Guttmacher Pol'y Rev. 8, 9 (2017).

[24] *Birth Control Guide*, *supra* note 25.

[25] Adam Sonfield, *supra* note 21 at 9.

opportunities. When women are able to plan their pregnancies, they are better able to invest in their educations and careers, enabling them to contribute more meaningfully to their local economies.[26] One study indicates that gender equity and women's participation in the economy promotes overall economic development;[27] between 1980 and 2010, every 10% increase in female labor force participation rate in metropolitan areas was associated with an increase in real wages of nearly 5%.[28] Such growth is significant for state and local governments relying on their tax base to fund public services. Nationally, unplanned pregnancies can cost taxpayers as much as $11 billion annually.[29] Should the district court's injunction be left in place, state and local governments nationwide would likely face irreparable harm as more women lose economic opportunities due to unplanned pregnancies.

The longer the district court's injunction is left in place, the greater the burden on state and local governments and the more difficult it will be to unravel

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[26] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730 (2002); *see also* Claudia Goldin & Lawrence F. Katz, *Career and Marriage in the Age of the Pill*, 90 Am. Econ. Rev. 461 (2000).

[27] Amanda L. Weinstein, *Working Women in the City and Urban Wage Growth in the United States*, 57 J. Regional Sci. 591 (2017).

[28] *Id.*

[29] Emily Monea & Adam Thomas, *Unintended Pregnancy and Taxpayer Spending*, 43 Perspect. Sexual & Reprod. Health 88 (2011).

the long-term effects. Localities will be forced to plan without certainty, to cover more contraception and pregnancy care, and to otherwise reorganize their healthcare delivery systems to care for their populations. Factors such as the time required for group health plans and health insurance issuers to take coverage "changes into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits," 75 Fed. Reg. 41,726 (July 19, 2010); the cyclical start dates for health insurance plan years, *see* 76 Fed. Reg. 46,621 (Aug. 3, 2011); and lag times between open enrollment periods, *see* 42 U.S.C. § 18031(c)(6) (2010), all contribute to the impact. Similarly, as a practical matter, local governments cannot restore their contraceptive, prenatal, or postnatal programs without significant disruption and costs and considerable time. Local government operations involve substantial commitments—in physical infrastructure, budgets, human capital, research, services, outreach, public education, electronic systems, and much more. These cannot be undone without tremendous expense, gaps, and harm.

II. This Court Should Recognize Nevada's Right to Intervene and Standing to Appeal to Afford Concrete, Adversarial Testing of the Challenged Rulings.

The harms to Nevada, which reflect those that will be felt across the country, support its right to intervene in the district court and its Article III standing to seek review of the district court's rulings. This case calls out for the sharpened,

adversarial testing contemplated by Article III, with careful consideration of the real-world consequences of the sweeping relief ordered below. The district court imposed nationwide relief based on a ruling that, it acknowledged, runs contrary to a prior ruling by this Court that the contraceptive mandate complied with RFRA. *See DeOtte v. Azar*, 393 F. Supp. 3d 490, 502 (N.D. Tex. 2019) (*citing E. Texas Baptist*, 793 F.3d at 463)). This ruling also runs contrary to the position that the relevant federal agencies—the Departments of Treasury, Labor, and Health and Human Services (the Departments)—previously took in courts all over the country, contending that the mandate's existing exemption and accommodation structure fully complied with RFRA. *See* Brief of Amici Curiae States, ECF No. 515245760, at 22 (collecting cases); Brief for Respondents at 29-88, *Zubik* (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), 136 S. Ct. 1557.

The central issue confronting the district court had, moreover, resulted in a stalemate in the United States Supreme Court and is currently being litigated in multiple other circuits in challenges brought by various of the amici states to subsequent federal rulemaking. *See* App. Br. at 5-10 (summarizing the litigation history).[30] With the benefit of adversarial testing by several amici states, a sister

[30] Reflecting their strong interest in this issue, local governments submitted comments as part of the federal rulemaking process. *See, e.g.*, Comments of the County of Santa Clara, California on Religious Exemptions and Accommodations for Coverage of Certain Preventative Services Under the Affordable Care Act, 82 Fed. Reg. 47792 (Oct. 13, 2017).

Circuit had already rejected the federal government's contention that RFRA requires expansion of the exemption from the mandate. *See Pennsylvania v. Trump*, 930 F.3d 543, 573 (3d Cir. 2019), *cert. petitions pending*, Nos 19-431, 19-454.

Nevada should be permitted to intervene as of right under Rule 24(a) before the district court resolves this pivotal legal question regarding the interplay between RFRA and the ACA, especially in light of the consequences for state and local governments and their residents. Courts construe Rule 24 liberally, to allow intervention when no one would be hurt and the greater justice could be attained. *See Wal–Mart Stores, Inc. v. Texas Alcoholic Beverage Comm'n*, 834 F.3d 562, 565 (5th Cir. 2016). A district court's denial of intervention as of right is reviewed *de novo*. *See id.*

Nevada sought intervention to protect interests closely analogous to those recognized by three other circuits as a basis for other states' Article III standing to challenge expansion of the exemption by federal rulemaking. *See Pennsylvania*, 930 F.3d at 565, *cert. petitions pending*, Nos 19-431, 19-454; *Massachusetts v. United States Dep't of Health & Human Servs.*, 923 F.3d 209, 223-26 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 574 (9th Cir. 2018). And the substantial risk of harm to Nevada is supported by the Departments' own analysis about the expected impacts of expanding the exemption. *See, e.g.*, *Massachusetts*, 923 F.3d

at 223-24 (finding that Massachusetts's assertion of imminent fiscal injury from expansion of the exemption was supported by "rational economic assumptions" and the Departments' own analysis) (quoting *Adams v. Watson*, 10 F.3d 915, 923 (1st Cir. 1993)).

The district court acknowledged that Nevada satisfied three of the requirements for intervention as of right under Rule 24(a), recognizing that Nevada made a timely application; is not adequately represented by the federal defendants, who decline to defend the challenged provisions; and has interests that would be impaired by the disposition of the action. *See DeOtte v. Azar*, 332 F.R.D. 173, 181-85 (N.D. Tex. 2019); *see also* Fed. R. Civ. P. 24(a); *Texas v. United States*, 805 F.3d 653, 657 (5th Cir. 2015).

But the district court erred in finding that Nevada's interests were not sufficiently direct to satisfy the final requirement for intervention as of right. *See DeOtte*, 332 F.R.D. at 184-85. The "interest" prong of the intervention test is primarily a practical guide to disposing of lawsuits by involving as many apparently concerned persons as is compatible with efficiency and due process. *See Sierra Club v. Espy*, 18 F.3d 1202, 1207 (5th Cir. 1994). The directness requirement of that prong prohibits intervention where the proposed intervenor either: (i) relies on an economic interest that must subsequently be vindicated in a

separate action; or (ii) seeks to insert itself into litigation over a private dispute from which it is too removed. *See Wal-Mart Stores*, 834 F.3d at 568.

This case is no private dispute. Plaintiffs sued the federal government to resolve statutory questions impacting healthcare coverage nationwide, in an effort to unwind the effects of injunctive relief issued in another circuit. *See DeOtte v. Azar*, 332 F.R.D. 188, 191 (N.D. Tex. 2019). Nevada sought to intervene based on intertwined economic and public health harms and resulting impairment to its exercise of governmental functions. And the harms asserted here will not need to be vindicated by separate suit; existing law already protects Nevada, absent the district court's injunction.

Nor can Nevada fairly be deemed "removed" from the subject matter of the litigation. *See Wal-Mart Stores*, 834 F.3d at 568. Plaintiffs brought this suit in direct response to the preliminary injunctive relief issued by the Eastern District of Pennsylvania and later affirmed by the First Circuit—relief that would otherwise have protected Nevada from the harms it asserts here. *See DeOtte*, 332 F.R.D. at 191. Indeed, plaintiffs expressly asked the district court to adopt the federal government's RFRA analysis, rejected in the First Circuit, which had served as a justification for the now enjoined rules. *See id*. That RFRA analysis explicitly invoked the Departments' assumption that state and local governments would fill gaps in care resulting from an expanded exemption, thus acknowledging that states

such as Nevada will be responsible for ameliorating the public health impacts of weakening the mandate.[31]

The substantial risk of harms to Nevada's fiscal and sovereign interests resulting from weakening the mandate also supply Article III standing to seek this Court's review of the merits of the district court's rulings and its issuance of nationwide injunctive relief. *See Pennsylvania*, 930 F.3d at 565; *Massachusetts*, 923 F.3d at 223-26; *California*, 911 F.3d at 572. Nevada holds the requisite personalized stake in the outcome of its appeal needed "to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends[.]" *Cramer v. Skinner*, 931 F.2d 1020, 1027 (5th Cir. 1991). Its related, proprietary interests in protecting against impairment in its provision of services and protecting its investment in public health initiatives further supports its standing. *See Gladstone Realtors v. Vill. of Bellwood*, 441 U.S. 91, 111 (1979) (threatened impairment in provision of municipal services supported Article III standing); *see also Bank of Am. Corp. v. City of Miami, Fla.*, 137 S. Ct. 1296, 1304

[31] *See Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act*, 82 Fed. Reg. 47,792 (Oct. 13, 2017) ("Moreover, there are multiple Federal, State, and local programs that provide free or subsidized contraceptives for low-income women. . . . This existing inter-governmental structure for obtaining contraceptives significantly diminishes the Government's interest in applying the Mandate to employers over their sincerely held religious objections.").

(2017) (harm in the form of increased demand for city services supported prudential standing).

It is of no moment that some of the asserted harms supporting Article III standing will proceed in stages or involve predictable actions by third parties. What matters is not the "length of the chain of causation," but rather the "plausibility of the links that comprise the chain[.]" *Autolog Corp. v. Regan*, 731 F.2d 25, 31 (D.C. Cir. 1984) (citations omitted); *see also Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2566 (2019) (recognizing standing based on "predictable effects of Government action on third parties"); *Massachusetts*, 923 F.3d at 223 (recognizing Article III standing based on fiscal injury that "proceeds in steps"); *Adams*, 10 F.3d at 923 (recognizing standing based on asserted injury resulting from "chain of . . . events"). This Court should recognize Nevada's strong interest in participating in this litigation and adjudicate its appeal on the merits, to ensure that the important legal, policy, and practical issues presented here are resolved via robust adversarial testing and with due consideration of the substantial risk of harm to Nevada and its residents.

CONCLUSION

For the foregoing reasons as well as those argued by Nevada in its brief, amici urge this Court to reverse the order below denying Nevada's motion to intervene, vacate the order granting summary judgment to the plaintiffs, and

remand the case to the district court with instructions to enter judgment for the defendants, including intervenor-defendant Nevada.

Dated: December 26, 2019

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This brief complies with the type-volume limit set forth in Federal Rules of Appellate Procedure 29(a)(5) because it contains 4,241 words.

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CERTIFICATE OF SERVICE

I hereby certify that on December 26, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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