Nos. 19-431, 19-454

In the Supreme Court of the United States

LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME,
Petitioner,

v.

PENNSYLVANIA, ET AL., *Respondents.*

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

v.

PENNSYLVANIA, ET AL., *Respondents.*

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

Brief of Women Scholars as *Amicus Curiae* in Support of Petitioners

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INTEREST OF *AMICUS CURIAE*[1]

Amicus Women Scholars support the current Administration's expanded exemptions from the contraception mandate ("the mandate")[2] originally issued by the Department of Health and Human Services ("HHS"), because the mandate threatens religious freedom and proposes a reductionist and harmful understanding of women's freedom. As scholars we are further interested in the use of rational and evidence-based arguments in the formulation of law.

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[2] 45 C.F.R. 147.130(a)(1)(iv) (2013) (HHS); 29 C.F.R. 2590.715-2713(a)(1)(iv) (2013) (Labor); 26 C.F.R. 54.9815-2713(a)(1)(iv) (2013) (Treasury).

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SUMMARY OF THE ARGUMENT

Respondents cannot demonstrate that the contraception mandate furthers a "compelling state interest" sufficient under this Court's opinions to permit a substantial burden on the free exercise rights of the Little Sisters under the Religious Freedom Restoration Act ("RFRA"),[4] by forcing them to obtain insurance coverage for contraception.[5] RFRA's compelling state interest requirement has three prongs: the governmental interest must be "compelling"; the law's requirements have to be "in furtherance of" such an interest; and the compelling interest must be satisfied through application of the challenged law "to the person." Respondents cannot demonstrate that the government could meet each of these requirements for any of the claimed compelling interests in the contraception mandate. Every single proposed interest fails one or more prongs of RFRA's test.

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[4] Religious Freedom Restoration Act, Pub. L. No. 103-141, 107 Stat. 1488 (1993) (codified in scattered sections of 5 and 42 U.S.C.).

[5] Respondents have argued that the government lacks authority to exempt Petitioners from the contraception mandate in part because the mandate furthers compelling government interests under RFRA. *See, e.g.*, Mem. of Law in Supp. of Pls.' Mot. for a Prelim. Inj. at 3, 4, 16, 31, 45, *Pennsylvania v. Trump*, 351 F. Supp. 3d 791 (E.D. Pa. 2018), No. 2:17-cv-04540-WB, 2018 WL 7132545 (hereinafter "Mem. of Law in Supp. of Pls.' Mot."). This brief rebuts Respondents' arguments to this effect and supports the current Administration's conclusion that the mandate is not narrowly tailored in furtherance of compelling government interests. *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act, 83 Fed. Reg. 57536, 57546-57548 (Nov. 15, 2018).

First, prior cases concerning compelling state interests indicate that, at the very least, state interests in protecting against substantial threats to health and life itself will qualify. Likely also, interests long addressed by the government with significant lawmaking, policy and state apparatus, can qualify as "compelling interests." But a state "cannot be regarded as protecting an interest 'of the highest order' ... when it leaves appreciable damage to that supposedly vital interest unprohibited,"[6] either by the same law, or by other laws which could appreciably advance that interest.

Second, RFRA requires that a challenged law or policy be "in furtherance of" a compelling state interest. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*[7] suggests that this Court should consider both the quality of evidence the proponents of the law supply as well as the degree of progress toward the state interest that might be achieved through the chosen means.[8] This can be done by employing the standards articulated in the free speech opinion *Brown v. Entertainment Merchants Association*,[9] given that *Brown*, like the instant case, involves analysis of empirical claims about the efficacy of a governmental requirement that burdens a fundamental right.

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[6] *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547 (1993).

[7] 546 U.S. 418 (2006).

[8] *Id.* at 419.

[9] 564 U.S. 786 (2011).

Third, as *O Centro* reiterates, RFRA requires that the burden be compelling as "to the person"[10] challenging it, in this case the Little Sisters.

Every one of Respondents' claimed compelling interests fails RFRA's three-pronged test. Several are not even compelling on their face, by comparison with prior interests this Court has deemed compelling, or because it is clear that the Respondents do not demonstrate by their own actions that they have pursued these interests in a substantial or inclusive manner. Several others appear very important on their face, but fail the second prong because of significant evidence that the mandate will likely fail to further the government's interests. And several fail because it is clear that there is either no harm, or very insubstantial harm to these interests, that might follow upon granting the Little Sisters an exemption.

ARGUMENT

THE STATES HAVE FAILED TO DEMONSTRATE THAT GOVERNMENTAL INTERESTS IN THE CONTRACEPTION MANDATE SATISFY THE RELIGIOUS FREEDOM RESTORATION ACT'S THREE-PART COMPELLING STATE INTEREST TEST.

The Religious Freedom Restoration Act forbids the government from substantially burdening the exercise of religion unless, *inter alia*, it can demonstrate that "application of the burden to the person—(1) is in

[10] 546 U.S. at 424.

furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest."[11] There are three prongs of the compelling state interest requirement apparent from the face of the text. One, the governmental interest must be compelling. Two, the law's requirements have to be "in furtherance of" such an interest. Three, the compelling interest must be satisfied through application of the challenged law "to the person." In *O Centro*,[12] this Court interpreted the third prong to require the government to "demonstrate that the compelling interest test is satisfied through application of the challenged law [to] … the particular claimant whose sincere exercise of religion is being substantially burdened."[13] This requires looking "'beyond broadly formulated interests'" and "'scrutiniz[ing] the asserted harm of granting specific exemptions to particular religious claimants'—in other words, to look to the marginal interest in enforcing the contraceptive mandate in these cases."[14]

Respondents' claimed compelling interests in the contraception mandate cannot meet each of these requirements. Every proposed interest fails one or more prong of RFRA's test.

This brief will gather the claimed compelling state interests asserted by Respondents in this litigation, and those noted by this Court in the earlier

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[11] 42 U.S.C. § 2000bb–1(b).

[12] 546 U.S. 418 (2006).

[13] *Id.* at 430-31.

[14] *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 726-27 (2014) (quoting *O Centro*, 546 U.S. at 431).

contraception mandate opinion, *Burwell v. Hobby Lobby Stores, Inc.*[15] They largely overlap. It will then set forth the standards this Court has employed to evaluate each prong of RFRA's compelling interest test and apply these to the instant controversy.

Respondents have advanced myriad governmental interests in the contraception mandate in the course of this litigation. In their 2018 Memorandum of Law in Support of Plaintiffs' Motion for a Preliminary Injunction before the federal district court, they included: promoting women's access to contraception as "necessary preventive healthcare"; lowering unintended pregnancy, and the "adverse impacts unintended pregnancy may have on mothers"; saving the lives of women with diseases or disorders for which pregnancy is contraindicated; alleviating "medical harm to women who rely on contraceptives for a wide range of medical reasons"; "enhanc[ing] and improv[ing] women's health care"; and allowing women to "be able to aspire, achieve, participate in and contribute to society based on their individual talents and capabilities … to have equal opportunities at work, at school and in the public sphere."[16] Respondents additionally claimed that the mandate could further these interests because, without it, many women would "go without contraception entirely" and that this would "fall most on lower-income women, women of color, and younger women."[17]

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[15] 573 U.S. 682 (2014).

[16] Mem. of Law in Supp. of Pls.' Mot. at 3, 4, 16, 31, 45.

[17] *Id.* at 39–40.

Members of this Court addressed the compelling state interest prong of RFRA in *Hobby Lobby*, noting similar but not identical state interests. The *Hobby Lobby* majority wrote that the asserted "important interests," which were "couched in very broad terms," included "promoting 'public health' and 'gender equality.'"[18] The majority also observed that in addition to these "very broadly framed interests," the government advanced the importance of "access to all FDA-approved contraceptives without cost sharing" and the claim that "even moderate copayments for preventive services can deter patients from receiving those services."[19] These latter two assertions are not statements about interests; the first is a restatement of the mandate and the second refers to one of the means by which the government assumes that the mandate will further its interests.

Justice Kennedy's concurrence in *Hobby Lobby* opined that several interests could be deemed "compelling": "protect[ing] the health of female employees"; redressing the claim that women's insurance coverage is "significantly more costly than for a male employee"; and preventing pregnancy in cases involving "medical conditions for which pregnancy is contraindicated."[20]

Finally, a dissenting opinion in *Hobby Lobby* asserted a wide variety of compelling interests: "the ability of women to participate equally in the economic

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[18] 573 U.S. at 726.

[19] *Id.* at 727.

[20] *Id.* at 737 (Kennedy, J., concurring).

and social life of the Nation";[21] "public health and women's well being"; avoiding the health problems created by unintended pregnancy; "safeguard[ing] the health of women for whom pregnancy may be hazardous"; and the health benefits of contraception unrelated to pregnancy, including "certain cancers, menstrual disorders, and pelvic pain."[22] The dissent also stated that providing free contraception would lead to more frequent use of drugs and devices deemed more effective for preventing pregnancy.[23]

A. Respondents' asserted interests cannot satisfy all three of RFRA's compelling state interest requirements.

A governmental interest must satisfy all three of RFRA's compelling state interest requirements. None of Respondents' interests can do so. The standards for satisfying each requirement are set forth below.

In prior free exercise cases acknowledging the existence of a compelling state interest, the importance of the asserted interests was readily apparent to this Court. In *Wisconsin v. Yoder*,[24] for example, the Court easily recognized the state's asserted interest in "universal compulsory education."[25] It called this

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[21] *Id.* at 741 (Ginsburg, Sotomayor, Breyer and Kagan, JJ., dissenting) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992)).

[22] *Id.* at 761.

[23] *Id.*

[24] 406 U.S. 205 (1972).

[25] *Id.* at 215.

interest "paramount,"[26] and of "admittedly high social importance."[27]

In *O Centro*, the Court had no difficulty accepting the government's characterization of its general interests in protecting citizens' life and health against "exceptionally dangerous"[28] substances sought for use by the religious group involved. It did not dispute that the drugs had a high potential for abuse, could severely threaten physical health,[29] and had no accepted medical use in the United States.[30]

In *Holt v. Hobbs*,[31] the Court did "not question the importance of the Department's interests in stopping the flow of contraband and facilitating prisoner identification."[32]

There was no sustained discussion in any of these cases about what renders a state interest "compelling." And none involved what is at stake here: a governmental demand to private employers to provide a claimed health benefit. At the very least, however, these prior cases inform the instant case by allowing the Court to conclude that state interests in protecting against substantial threats to health and to life itself

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[26] *Id.* at 213.

[27] *Id.* at 214.

[28] 546 U.S. at 432.

[29] *Id.* at 426.

[30] *Id.* at 430.

[31] 574 U.S. 352 (2015).

[32] *Id.* at 356.

qualify as compelling. They might also indicate that interests long addressed with significant lawmaking, policy, and state apparatus, including both education and healthcare, are candidates for "compelling interests."

The Court has also held that the importance of a governmental interest can be evaluated by the breadth or inclusivity of the government's response to the claimed interest. As this Court stated in *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*,[33] "[i]t is established in our strict scrutiny jurisprudence that 'a law cannot be regarded as protecting an interest "of the highest order" ... when it leaves appreciable damage to that supposedly vital interest unprohibited.'"[34]

As applied to the instant case – to a federal benefit that Respondents claim is essential to women's life itself, health, freedom and equality – it is rational to ask not only whether the Respondent states have previously legally offered benefits toward these ends in their own jurisdictions, but also whether or not they have addressed the myriad other benefits that their arguments indicate are necessary for women's life itself, health, freedom and equality. If they have not, they have exhibited the "under-inclusivity" *Lukumi* describes.

Should the contraception mandate survive this first prong of RFRA's compelling interest scrutiny, it must be shown to be "in furtherance of" a compelling state interest (the second prong). Here, the Court should

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[33] 508 U.S. 520 (1993).

[34] *Id.* at 547 (citations omitted).

evaluate both the quality of evidence the government supplied to justify the contraception mandate as well as the degree of progress toward the governmental ends that the mandate might generally achieve. The *O Centro* Court indicated an openness to this inquiry when it wrote that the standards applying in free speech cases requiring the showing of a compelling state interest are also relevant to RFRA cases. The Court opined that "Congress' express decision to *legislate* [RFRA's] compelling interest test indicates that RFRA challenges should be adjudicated in the same manner as [the test's] *constitutionally* mandated applications," including in contests concerning content-based speech restrictions.[35]

The most complete and pertinent evaluation of whether or not a law generally forwards the government's stated goals unfolded in *Brown v. Entertainment Merchants Association.*[36] In a case involving a California law claiming a nexus between violent acts and violent video games, this Court deemed insufficient merely "predictive judgments" of causal links based upon competing and contradictory studies.[37] It also dismissed "ambiguous proof."[38] Instead, it required the government to show that the matter regulated is the "cause" of the harm it seeks to prevent. Evidence of mere "correlation" was deemed insufficient, as were studies with "significant, admitted

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[35] *Id.* at 429–30 (emphasis added).

[36] 564 U.S. 786 (2011).

[37] *Id.* at 799–800.

[38] *Id.* at 800.

flaws in methodology."[39] And even if the state could prove causation, the Court continued, evidence that the claimed effects will be "small" and "indistinguishable" from effects that could be produced by things not regulated, renders the legislation fatally "underinclusive."[40] The government must show more than a "modest gap"[41] (20% in *Brown*) between the government's goal and the current situation. The "government does not have a compelling interest in each marginal percentage point by which its goals are advanced."[42]

Like the state in *Brown*, the states here rest their arguments largely upon empirical claims. *Brown* is this Court's most complete statement about the sufficiency of such empirical arguments, and thus should be applied here.

Finally, the law's proponents must show the burden to be compelling as "to the person" challenging it, in this case the Little Sisters.[43]

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[39] *Id.*

[40] *Id.* at 800, 802.

[41] *Id.* at 803.

[42] *Id.* at 803 n.9.

[43] *O Centro*, 546 U.S. at 424 (2006) (quoting RFRA).

B. Each of the Respondents' claimed compelling interests is either not compelling, and/or not adequately furthered by the mandate, and/or not undermined by a failure to apply the contraception mandate to the Little Sisters.

Preliminarily, it should be noted that the panel (the Institute of Medicine, "IOM") upon whom HHS relied to make the initial recommendations[44] (hereinafter "the IOM Report") should not be credited as either "expert" or "independent," despite claims to the contrary by both the *Hobby Lobby* dissenters and the Respondents here.[45] The Respondents further claim that the IOM provided strictly "evidence-based scientific and medical conclusions."[46]

But neither the personnel involved nor the processes employed to produce the IOM Report were genuinely independent. Nor were their conclusions scientifically complete or balanced.

First, regarding the personnel and the process, the dissent to the IOM Report authored by panel member Dr. Anthony Lo Sasso stated:

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[44] Clinical Preventive Services for Women: Closing the Gaps, *Institute of Medicine of the National Academies* (2011), http://www.nationalacademies.org/hmd/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx [hereinafter IOM 2011 Report].

[45] *See* Mem. of Law in Supp. of Pls.' Mot., *supra* note 16; *see also Hobby Lobby*, 573 U.S. 682, 741–42 (2014) (Ginsburg, Sotomayor, Kagan and Breyer, JJ., dissenting).

[46] *Id.* at 30–31.

> [T]he committee process for evaluation of the evidence lacked transparency and was largely subject to the preferences of the committee's composition. Troublingly, the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy.[47]

The prior commitments of the majority of panel members support his conclusion. At least nine of the sixteen panel members had close ties with the nation's then-largest provider of government-subsidized birth control – Planned Parenthood. Together, they had recently donated over one hundred thousand dollars to that organization. Other members founded or worked directly for various contraception and abortion advocacy groups.[48] Invited witnesses were also disproportionately from interest groups promoting contraception and abortion, and there were no panel members or witnesses from the leading private providers of health care to women in the United States – religious providers.[49]

Second, Respondents wildly overstate the quality of the evidence in support of their claims and ignore much contrary evidence. They make the unequivocal assertion that there is "no debate over the efficacy or

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[47] IOM 2011 Report, *supra* note 44, at 232.

[48] *See Letter from Anna Franzonello, Ams. United for Life, to Ctrs. for Medicare and Medicaid Servs*. (Sept. 29, 2011), https://aul.org/wp-content/uploads/2020/03/20110929_AmericansUnitedforLifepreventiveservicescomment.pdf

[49] Helen M. Alvaré, *No Compelling Interest: The "Birth Control" Mandate and Religious Freedom*, 58 Vill. L. Rev. 379, 430–31 (2013).

benefits of contraception," and claim the support of leading health authorities for the notion that it is impossible for anyone to effectively dispute this "already-settled matter[] of science, medicine, and the well-being of women."[50]

But Respondent's unequivocal statements are easily disproved. Obviously contraception usage is widespread. It is relatively inexpensive[51] and readily available. According to the Centers for Disease Control ("CDC"), 99% of sexually active women have "ever used" contraception, and over 64% of women between 15 and 44 are using it now.[52] Between 2011-15, 61.6% of women between 15 and 44 were using contraception, and 62.2% between 2006-10.[53] These figures are remarkably close to the goal announced by the American College of Obstetricians, which reported that

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[50] Mem. of Law in Supp. of Pls.' Mot. 33–35.

[51] Susannah Snider, *The Cost of Birth Control*, U.S. News & World Report (May 2, 2019), https://money.usnews.com/money/personal-finance/family-finance/articles/the-cost-of-birth-control.

[52] William D. Mosher & Jo Jones, *Use of Contraception in the United States: 1982–2008*, Vital & Health Stats.: U.S. Dept. of Health & Human Services 5 (2010), http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf; Kimberly Daniels & Joyce C. Abma, *Current Contraceptive Status Among Women Aged 15–49: United States, 2015–2017*, 327 Nat. Ctr. for Health Statistics Brief 1 (2018), http://www.cdc.gov/nchs/data/databriefs/db327-h.pdf.

[53] Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics, *Health, United States 2017-Data Finder*, *Table 8. Contraceptive use in the past month among women aged 15-44, by age, race and Hispanic origin, and method of contraception: United States, selected years 1982 through 2011-15*, http://www.cdc.gov/nchs/data/hus/2017/008.pdf.

about 66% of women of reproductive age wish to avoid or postpone pregnancy.[54]

But contraception has not been the panacea for women that Respondents imagine. The situation is far more complicated. Leading medical authorities are far more cautious and nuanced in their discussion of contraception. A close analysis of each of Respondents' claimed compelling state interests will illustrate why.

The Little Sisters have already set forth highly persuasive arguments in the course of this litigation showing that the contraception mandate does not further any "compelling" interests. They have pointed out, *inter alia*, that: (1) the government declined to impose the mandate on small businesses, grandfathered plans, churches, and government-sponsored plans; (2) the Respondent states "either have no contraceptive mandate (Pennsylvania) or a narrower mandate that includes cost-sharing (New Jersey) and a religious exemption broader than that in the federal mandate"; and (3) the federal government has finalized a Title X[55] rule to provide contraception to women unable to obtain it through their insurance due to their employers' religious or moral objections.[56]

But there are additional arguments fatal to Respondents' claims that the government possesses compelling state interests sufficient to satisfy RFRA.

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[54] Am. Coll. of Obstetricians & Gynecologists: *Guidelines For Women's Health Care* 343 (4th ed. 2014).

[55] Family Planning Services & Population Research Act of 1970, 42 U.S.C. §§ 300 to 300a-6 (2018).

[56] 84 Fed. Reg. 7714 (May 3, 2019).

1. Respondents' claimed compelling interest in public health does not satisfy RFRA.

The first claimed compelling interest is "public health." On its face it likely satisfies the first prong of RFRA's compelling interest test, but not the third. It likely satisfies the first prong because it is a more broadly stated version of the interest acknowledged in *Hobbs* and *O Centro*. There is extensive apparatus at both the federal and state levels to promote and defend public health.

While there are outstanding questions regarding contraception's health effects,[57] it is not necessary to consider these here because "public health" must fail the third prong of RFRA's compelling state interest test. *Hobby Lobby* articulated this failure. The majority there called "public health" a "very broadly framed interest[]"[58] and "couched in very broad terms."[59] Thus it could not answer the "more focused" inquiry RFRA contemplates, which requires a court to "'scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants'—in other words, to look to the marginal interest in enforcing the contraceptive mandate in these cases."[60]

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[57] *See infra* B.3.

[58] 573 U.S. 682, 727 (2014).

[59] *Id.* at 726.

[60] *Id.* at 726–27 (citing *O Centro*, 546 U.S. at 431).

2. Respondents' claimed compelling interest in gender equality does not satisfy RFRA.

Respondents' second claimed interest is gender equality, tying contraception to women's ability to enjoy equal opportunities with men. Gender equality is likely a compelling state interest on its face, but fails at least the third prong of RFRA's compelling state interest test. Equality of persons is a matter of constitutional significance. It is the subject of a series of important Supreme Court decisions and myriad civil rights laws. While there are outstanding questions regarding contraception's effects upon gender equality,[61] it is not necessary to consider them here, given that this interest certainly fails the third prong of RFRA's compelling state interest test. Again, the *Hobby Lobby* opinion articulates this. The majority wrote that a claimed interest in "gender equality" is "couched in very broad terms,"[62] and does not answer the "more focused" inquiry RFRA demands.

One often-highlighted element of the claimed "gender equality" interest merits special attention, given that it is framed more narrowly. Various mandate advocates suggest that contraception is responsible for the disparity between men's and women's health costs, and that free contraception will

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[61] *See infra* B.5.

[62] 573 U.S. at 726.

close this gap. Justice Kennedy's *Hobby Lobby* concurrence stated this, as did the IOM report.[63]

At first glance, this interest seems strong. But there are two reasons why it is not "compelling." First, Respondents have not demonstrated that they believe this interest is compelling; they leave enormous damage to it unaddressed. To wit, the greatest disparities between women and men's health care costs are not during women's child-bearing years, but between the ages of 45 to 64.[64] Furthermore, according to the CDC and HHS Medicaid offices, the higher cost of women's health care during child-bearing years is due, *not* to contraception, but to women's choosing to bear children.[65] Also, women are far more likely than

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[63] *Id.* at 737 (Kennedy J., concurring); *see also* IOM 2011 Report, *supra* note 44, at 19, 109.

[64] Gary M. Owens, *Gender Differences in Health Care Expenditures, Resource Utilization, and Quality of Care*, 14 J. Managed Care & Specialty Pharmacy S2, S2–S5 (2008).

[65] Ctrs. for Medicare & Medicaid Servs., *Health Expenditures by Age and Gender, 2014 Highlights,* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/AgeandGenderHighlights.pdf; *see also* Ctrs. for Disease Control, Nat'l Ctr. for Health Statistics, Health*, United Stated 2017–Data Finder*, *Table 65. Health care visits to doctor offices, emergency departments, and home visits within the past 12 months, by selected characteristics: United States, selected years 1997–2016* Ctrs. for Disease Control, Nat'l Ctr. for Health Statistics, *Visits to physician offices, hospital outpatient departments, and hospital emergency departments by age, sex, and race: United States, selected years 1995–2011* (2012); Ctrs. for Disease Control, Nat'l. Ctr. for Health Statistics, *Expenses for health care and prescribed medicine, by selected population characteristics: United States, selected years 1987–2010* (2012).

men to visit a variety of doctors and hospitals when they are younger,[66] and their life expectancy is nearly five years longer than men's.[67] All of these are leading reasons for the disparity in health expenditures. Yet Respondents have not demanded or enacted laws or regulations mandating no-cost medical services for women or no-cost pregnancy and childbirth services.

Second, even if contraception accounted for the difference between men's and women's health care costs, it would be surprising if a several-hundred-dollars-per-year difference[68] – paid by middle class and wealthier women, given that the poor receive free or cheap contraception in government programs – would be declared a "compelling" governmental interest. It is certainly not commensurate with previously recognized compelling state interests: an educated citizenry; protecting the life, health and safety of persons in situations portending violence or substance abuse. Furthermore, there is no telling how much these costs are offset by the cost of treating women for any negative health effects of contraception,[69] or men's greater health care expenditures as they age.[70]

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[66] *Id.*

[67] Klea D. Bertakis et al., *Gender Differences in the Utilization of Health Care Services*, 49 J. Family Practices 147 (2000).

[68] *See infra* B.5.

[69] *See* B. 3, *infra*.

[70] Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics, *Visits to physician offices, hospital outpatient departments, and hospital emergency departments by age, sex, and race: United States, selected years 1995-2011* (2012); Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Statistics,

In the absence of any clear evidence that contraception costs render women's health care more expensive than men's, the mandate's demand to make contraception free is not "in furtherance of" the state's interest in this aspect of gender equality.

3. Respondents' claimed compelling interest in enhancing women's health care does not satisfy RFRA.

The third asserted compelling state interest – enhancing women's health care – is also likely compelling on its face, but too general to satisfy the third prong of the Respondents' required showing on compelling interests. This interest is compelling for the same reasons as "public health" and "women's equality" are compelling, but also for additional reasons: it is well accepted that disproportionately little attention was previously paid for many years to women's health concerns. Recognizing this, the National Institutes of Health has made important strides toward closing this gap with an entire office now devoted to research on women's health.[71]

There remain serious questions, however, about contraception's overall effects on women's health. Obviously, the vast majority of women choose to use contraception; but many experience serious side- and health-effects. Contrary to Respondent's assertions

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Expenses for health care and prescribed medicine, by selected population characteristics: United States, selected years 1987-2010 (2012).

[71] Nat'l Insts. of Health, Office of Research on Women's Health, https://orwh.od.nih.gov/.

that leading health organizations are unanimously confident about the benefits of contraception, these organizations regularly publish information cautioning users about health effects and contraindications. Leading cancer associations[72] and the World Health Organization ("WHO") refer to estrogen-progesterone oral contraceptives as "known carcinogens."[73] HHS itself bluntly conceded numerous problems with hormonal contraceptives in a 2013-14 solicitation to researchers inviting them to invent additional nonhormonal contraception, writing that: "hormonal contraceptives have the disadvantage of having many undesirable side effects," and "are associated with adverse events, and obese women are at higher risk for serious complications such as deep venous thrombosis."[74] Importantly, the National Institutes of Health ranks 40% of U.S. female adults as obese.[75]

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[72] Am. Cancer Soc'y, *Known and Probable Human Carcinogens Introduction,* http://www.cancer.org/cancer/cancercauses/othercarcinogens/generalinformationaboutcarcinogens/known-and-probable-human-carcinogens; Int'l Agency for Research on Cancer, *Monographs on the Evaluation of Carcinogenic Risks to Humans,* http://monographs.iarc.fr/ENG/Monographs/vol72/index.php.

[73] World Health Org., *Carcinogenicity of Combined Hormonal Contraceptives and Combined Menopausal Treatment* (Sept. 2005), http://www.who.int/reproductivehealth/topics/ageing/cocs_hrt_statement.pdf; Steven A. Narod et al., *Oral Contraceptives and the Risk of Breast Cancer in BRCA1 and BRCA2 Mutation Carriers*, 94 J. Nat'l Cancer Inst. 1773 (2002).

[74] Dep't of Health and Human Servs., *Female Contraceptive Development Program* (Nov. 2013), https://grants.nih.gov/grants/guide/rfa-files/RFA-HD-14-024.html.

[75] Dep't of Health & Human Servs., Nat'l Insts. of Diabetes and Digestive and Kidney Diseases, *Overweight and Obesity Statistics*

Recent expert literature shows a heightened risk of breast cancer for some pill users,[76] and important links between injectable LARCs and HIV transmission.[77] And a highly regarded 2016 study in the American Medical Association's psychiatry journal indicated that all hormonal contraceptives posed a significant risk of depression for many women.[78] A recent book by evolutionary psychologist Dr. Sarah Hill–*This is Your Brain on Birth Control: The Surprising Science of Women, Hormones and the Law of Unintended Consequences*[79] – details hormones' effects on brain structure, emotions, attraction, stress responses, mood and even learning.

In sum, while most women choose to use contraception, there remain substantial concerns about its health impacts. That women bear with these is not equivalent to an argument that contraception unequivocally promotes women's health, let alone that

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(Aug. 2017), https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity.

[76] Ajeet Singh Bhadoria et al., *Reproductive factors and breast cancer: A case-control study in tertiary care hospital of North India*, 50 Indian J. of Cancer 316 (2013).

[77] Renee Heffron et al., *Use of Hormonal Contraceptives and Risk of HIV-1 Transmission: A Prospective Cohort Study*, 12 Lancet Infectious Diseases 19 (2012).

[78] Charlotte Wessel Skovlund et al., *Association of Hormonal Contraception With Depression*, 73 JAMA Psychiatry 1154 (2016), doi:10.1001/jamapsychiatry.2016.2387.

[79] Sarah E. Hill, Ph.D., *This is Your Brain on Birth Control: The Surprising Science of Women, Hormones and the Law of Unintended Consequences* (2019).

the government has a compelling interest in promoting it further via a mandate.

4. Respondents' claimed compelling interest in preventive health care does not satisfy RFRA.

A fourth asserted compelling interest is assuring necessary preventive healthcare for women. On its face this appears likely to qualify as compelling. It is quite similar to the state's interests in public health or women's health. The CDC's major initiative, HealthyPeople2020, highlights the crucial role preventive health care plays in reducing death and disability.[80]

But contraception is not a recommended "preventive health care." It is true that the mandate's roots are said to be in Congress' charge to HHS to recommend "preventive care and screenings" for women.[81] And it was anticipated that the IOM Report's recommendations would "be recommended by the U.S. Preventive Services Task Force ["USPSTF"], an independent panel of experts," according to the dissenters in *Hobby Lobby*.[82] But to date, eight years after the mandate was first promulgated, the USPSTF has not included contraception in its

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[80] U.S. Dep't of Health and Human Servs., *Clinical Preventive Services* (2020), https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Clinical-Preventive-Services.

[81] *Hobby Lobby*, 573 U.S. at 697 (citing 42 U.S.C. § 300gg–13(a)(4) (2010)).

[82] *Id.* at 741 (Ginsburg, Sotomayor, Breyer and Kagan, J.J., dissenting).

recommendations.[83] The USPSTF is the only organization upon which the U.S. Congress relies for an annual report about the status of preventive services in the United States and about priority areas for preventive health care.[84] Given the unique status of the USPSTF, and its failure to recognize contraception as preventive health care, the claim that free contraception is a compelling interest as preventive health care, must fail the second prong of the compelling interest inquiry.

5. Respondents' claimed compelling interest in reducing unintended pregnancy does not satisfy RFRA.

The fifth, and most frequently asserted, compelling interest respecting the mandate is reducing unintended pregnancy. It would seem intuitive that this constitutes a compelling interest and that contraception would further it. Unintended pregnancy is frequently featured as an important goal in HHS materials.[85] But even a brief review of the evidence casts a great deal of doubt on both of these intuitions. Instead, unintended pregnancy is a highly uncertain measure, persistently contested by scientists. Furthermore, the relationship

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[83] *See* U.S. Preventive Servs. Task Force, *Published Recommendations* (Feb. 2020), https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.

[84] U.S. Preventive Servs. Task Force, *About the USPSTF* (Mar. 2019), https://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf.

[85] *See, e.g.*, Dep't of Health and Human Servs., *Healthy People 2020, Family Planning*, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning.

between unintended pregnancy rates and free contraception is a great deal more complicated than Respondents acknowledge. This asserted interest fails all three prongs of RFRA's compelling interest test.

First, a wide array of scientists, including the IOM, acknowledge that unintended pregnancy is extremely difficult to measure.[86] The reasons are easy to grasp. "Unintended" covers both unwanted and merely mistimed pregnancies, as well as pregnancies to which women are indifferent.[87] Interpretation and memory change retrospectively. Partners disagree. The one study relied upon in the IOM Report exhibits all of these flaws and more: to reach the total number of unintended pregnancies, the authors added together unwanted and mistimed pregnancies, those to which the woman was "indifferent," and their own abortion estimate.[88] But it is well accepted that some women abort wanted pregnancies.[89] A more recent study[90] exhibits similar flaws.

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[86] Inst. of Med., *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 21–25 (1995).

[87] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 New England J. Med. 843, 844 (2016).

[88] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 Persp. On Sexual & Reprod. Health 90 (2006).

[89] Donald Paul Sullins, *Affective and Substance Abuse Disorders Following Abortion by Pregnancy Intention in the United States: A Longitudinal Cohort*, 55 Medicina 741 (2019) (finding that about one in seven abortions involves a wanted child).

[90] Finer & Zolna, *supra*, at 844.

A recent paper by Guttmacher Institute researchers about measuring unintended pregnancy[91] conceded that: "our field has long struggled with conceptual and framing issues related to pregnancy intentions"; "prospectively measured desires don't always match with retrospective ones"; "the components used to calculate indicators – counts of births, abortions and fetal loss, coupled with survey-based pregnancy intention measures – come from different data sources, which bring different kinds of measurement error"; and "pregnancy intentions as a binary construct – intended vs. unintended – is a 'long recognized conceptual problem.'"[92]

Because of the uncertainty surrounding even the measurement of "unintended pregnancy," this numerical goal is a poor candidate for a "compelling state interest." The state would always be unsure of the contents of its goal, let alone the means to reach it.

There is also ample evidence that, even were the goal of reducing unintended pregnancy definable, it is not at all certain that a contraception mandate would "further" it to any notable degree, as required by RFRA, and as evaluated with the help of *Brown v. Entertainment Merchants*. Rates of insurance coverage for contraception were quite high (89%) pre-mandate.[93] As noted above, the CDC reports that 99% of sexually

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[91] Kathryn Kost & Mia Zolna, *Challenging unintended pregnancy as an indicator of reproductive autonomy: a response*, 100 Contraception 5 (2019).

[92] *Id*. at 5–8.

[93] IOM Report, *supra*, at 49.

active women have "ever used" contraception, and 64.9% of women between 15 and 44 are using it now.[94] This figure is remarkably close to the goal announced by the American College of Obstetricians, which reported that about 66% of women of reproductive age wish to avoid or postpone pregnancy.[95]

Given that women decline to use contraception for a wide variety of reasons ranging from health- and side-effects to moral and religious and other reasons, it is merely speculative to conclude that reducing its costs will result in significantly increased usage. Current usage is very near ACOG's reporting of women's preferences. Instead, this is a perfect example of a scenario insufficient to show a compelling state interest according to both *Brown* and *Hobby Lobby*, under both the second and third prongs of RFRA's compelling state interest test. To wit, any claimed effects of the mandate would be small. There is only a "modest gap" (20% in *Brown*) between the ultimate goal and the current situation. And as *Brown* concluded, the "government does not have a compelling interest in each marginal percentage point by which its goals are advanced."[96] This mirrors *Hobby Lobby's* inquiry regarding the

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[94] Daniels & Abma, *supra*, at 1; and W.D. Mosher & J. Jones, *Use of contraception in the United States: 1982-2008*, 23 Vital Health Stats. 1, 5 (2010).

[95] Am. College of Obstetricians and Gynecologists, *Guidelines For Women's Health Care* 343 (4th ed. 2014).

[96] 564 U.S. at 803 n. 9.

government's "marginal interest in enforcing" the challenged government action.[97]

Also important is that rates of unintended pregnancy do not regularly demonstrate a direct relationship with the passage of mandates, or even with rates of contraceptive usage. For example, 29 state level contraception mandates enacted over the last 20 years have not lowered unintended pregnancy and abortion rates in the relevant jurisdictions.[98] And unintended pregnancy rates are *highest* among the poorer women who have received free or low-cost contraception via government programs for decades.[99]

In the IOM Report informing the mandate, only two studies are cited[100] for the claimed causal link between contraception and unintended pregnancy. Both cherry pick the cohorts and periods of time during which they measure a correlation between contraception and

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[97] *Hobby Lobby*, 573 U.S. at 726–27 (quoting *O Centro*, 546 U.S. at 431) (alteration in original).

[98] Michael J. New, *Analyzing the Impact of State Level Contraceptive Mandates on Public Health Outcomes*, 13 Ave Maria L. Rev. 345, 368 (2015).

[99] Guttmacher Inst., *Fact Sheet: Unintended Pregnancy in the United States* (Jan. 2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[100] IOM Report, *supra*, at 105 (citing John S. Santelli & Andrea J. Melnikas, *Teen Fertility in Transition: Recent and Historic Trends in the United States*, 31 Ann. Rev. Pub. Health 371 (2010); Heather D. Boonstra et al. *Abortion In Women's Lives*, Guttmacher Inst. (2006), http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf).

unintended pregnancy.[101] Neither claims to demonstrate an actual *causal* link between contraceptive usage and lowered rates of unintended pregnancy.[102] The Guttmacher study cited also does not show that increased contraception usage reduced rates of unintended pregnancy. It states rather that "the decline in unintended pregnancy in the U.S. seems to have stalled," even with "nearly universal" use of contraceptives.[103] Two other Guttmacher studies show unintended pregnancy rates rising from 49% in 1994[104] to 51% by 2001, and remaining flat or edging higher through 2006,[105] during the period when women's contraceptive usage *increased* from 80% to 86%.[106]

This seemingly surprising finding is supported by a significant body of literature suggesting that wide-spread contraception and abortion access can help drive up rates of unintended pregnancy, abortion, and nonmarital births due to "risk compensation" effects, or because of the new "marketplace" for sex and marriage

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[101] Santelli & Melnikas, *supra*, at 371 (teens from 1990s to early 2000s); Boonstra et al., supra, at 18 (unmarried women, 1982-2002).

[102] *See, e.g.*, Santelli & Melnikas, *supra*, at 377–79.

[103] Boonstra et al., *supra*, at 32.

[104] Stanley K. Henshaw, *Unintended Pregnancy in the United States,* 30 Fam. Plan. Persp. 24 (1998).

[105] Finer & Henshaw, *supra*, at 90; Mosher & Jones, *supra*, at 1.

[106] Boonstra et al., *supra*, at 18.

they facilitate.[107] The Respondents never consider or challenge this literature.

But even if the Respondents could survive the first two prongs of RFRA's compelling state interest test, they would fail the third prong because they cannot demonstrate that granting an exemption to the Little Sisters will noticeably harm the state's interest.

First, the Little Sisters do not employ those women dramatically more likely to report an unintended pregnancy: low-income women. In fact, low-income women have more than five times the rate of unintended pregnancy of women earning more than 200% of the federal poverty level.[108] But the health care law requires the Little Sisters to insure full-time employees who work an average of thirty or more hours per week in any month.[109]

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[107] Peter Arcidiacono et al., *Habit Persistence and Teen Sex: Could Increased Access To Contraception Have Unintended Consequences For Teen Pregnancies?* (Oct. 3, 2005), http://public.econ.duke.edu/~psarcidi/addicted13.pdf.; John Richens et al., *Condoms and Seat Belts: the Parallels and the Lessons*, 355 The Lancet 400 (2000); Michael M. Cassell et al., *Risk compensation: the Achilles' heel of innovations in HIV prevention?*, 332 Brit. Med. J. 605 (2006), www.bmj.com/cgi/pdf_extract/332/7541/605?ct.; Timothy Reichert, *Bitter Pill*, 203 First Things 25 (2010).

[108] Guttmacher Inst., *Unintended Pregnancy in the United States: A Fact Sheet* (2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

[109] *See* 26 U.S.C. § 4980H(c)(2) (2018); 26 U.S.C. § 4980H(c)(4)(A) (2018).

Second, any employee who wants contraception, but is unable to receive it because of Petitioners' religious convictions, will likely obtain it under the federal government's Title X expansion.[110]

In sum, reducing unintended pregnancy is an unintelligible and uncertain, and therefore not compelling, state interest. Even, however, if this Court deems it a compelling interest, it is not generally furthered by the contraception mandate. Or if this Court believes that it is generally furthered by the mandate, there is no notable harm to the state's interest flowing from granting the Little Sisters an exemption.

6. Respondents' claimed compelling interest in reducing the asserted effects of unintended pregnancy on women's health does not satisfy RFRA.

A sixth claimed compelling interest is the "adverse impacts of unintended pregnancy on women." Respondents cannot advance this interest without first proving all three of RFRA's compelling state interest prongs with respect to the claimed interest in reducing unintended pregnancy, discussed in B.5, *supra*. Because this cannot be done, it is not necessary to treat extensively Respondents' related claim about health consequences assertedly *resulting from* unintended pregnancy.

The Guttmacher Institute has recently and plainly expressed uncertainty about claimed links between

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[110] *See* 42 C.F.R. § 59.2 (2).

unintended pregnancy and particular health conditions of women, writing: "[p]ast research has documented a relationship between unintended pregnancy and negative outcomes, though the association is not always as clear…. [T]here is value in improving the ability to identify which pregnancies may be at higher risk of negative consequences."[111] A close analysis of both the IOM Report and numerous studies on unintended pregnancy further highlights the speculative nature of this claimed linkage.[112]

In short, the claimed health effects of unintended pregnancy cannot be demonstrated in a way that would satisfy any of the three prongs of RFRA's compelling state interest requirements. There is insufficient evidence of a relationship between each of them and unintended pregnancy.

7. Respondents' claimed compelling interest in preventing pregnancy among women with pre-existing conditions contraindicating for pregnancy does not satisfy RFRA.

Respondents claim that contraception can save women's lives by preventing pregnancy among women with pre-existing conditions contraindicating for pregnancy.[113] The IOM report names pulmonary

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[111] Kost and Zolna, *supra*, at 8.

[112] Helen M. Alvaré, *No Compelling Interest, supra* at 411-14.

[113] Mem. of Law in Supp. of Pls.' Mot. 11.

hypertension, cyanotic heart disease, and Marfan Syndrome."[114]

Were contraception a life-saving medicine, a mandate might qualify as a compelling interest. But this would raise the question as to why Respondents do not mandate that *all* life-saving medicines be provided for free; the states' extreme under-inclusivity on this point suggests strongly that they do not actually believe their own claims.

But the Court need not address this first prong directly because Respondents' claim readily fails the second prong of RFRA's compelling state interest test – that the contraception mandate is "in furtherance of" the claimed interest. In fact, completely undoing Respondents' claims, experts on the diseases and disorders for which Respondents deem contraception "life-saving" regularly caution women suffering these conditions to avoid the health risks posed by hormonal contraceptives and rather use cheaper barrier methods.[115]

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[114] IOM Report, *supra*, at 103–04.

[115] *See* Heart Disease & Pregnancy, *Patient Information: Marfan Syndrome*, http://www.heartdiseaseandpregnancy.com/pat_mar.html; Adult Congenital Heart Ass'n, *Q & A: Birth Control for Women with Congenital Heart Disease*, https://www.achaheart.org/media/1211/birth-control.pdf (reporting that barrier methods are safe but risks are greater of hormonal methods, especially pills containing estrogen, and certain IUDS); Pulmonary Hypertension Ass'n, *Birth control and hormonal therapy in pulmonary arterial hypertension* (July 2002), https://phassociation.org/medicalprofessionals/consensusstatements/birth-control/ (reporting that barrier methods are "safest" and that "nearly half of … specialists did not advocate using [pills] for

8. Respondents' claimed compelling interest in other asserted beneficial health effects of contraception does not satisfy RFRA.

The Respondents' final asserted compelling interest is preserving the claimed *non*-contraceptive health benefits of contraception. The IOM Report highlighted cancers, menstrual disorders, and pelvic pain."[116] Respondents refer to a "wide range of medical reasons" including certain forms of cancer.[117]

Were Respondents serious about this interest, they would require employers to provide coverage for *any* medical procedure for which there was plausible evidence that it alleviated *any* health problem. In addition to the lack of feasibility of Respondent's proposal, its dramatic under-inclusivity undercuts any claim that it represents a compelling state interest.

But it is unnecessary for the Court to decide whether this interest survives the first two prongs of RFRA's compelling interest test, because it easily fails the third. The Little Sisters agreed in earlier mandate litigation that they have no objection to providing contraception for non-contraceptive purposes. In the course of the *Zubik* litigation, Mother Loraine of the Little Sisters declared that the Little Sisters' are concerned only with the abortive or contraceptive uses

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their patients, and some actively discouraged patients from doing so . . . .").

[116] IOM Report, *supra*, at 107.

[117] Mem. of Law in Supp. of Pls.' Mot. 34, 52.

of the mandate's required drugs/devices, which would not be at issue with non-contraceptive uses. *Zubik,* JA at 979.

In other words, Respondents cannot demonstrate the third prong of the compelling state interest test: that application of the mandate "to the person" of the Little Sisters would further in any way the state's declared interest in women's access to contraception for non-contraceptive purposes.

CONCLUSION

For the foregoing reasons, this Court should reject Respondents' arguments that the contraception mandate furthers compelling government interests, contrary to the current Administration's determination, and reverse the decision of the court below.

Respectfully submitted,

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