
# NO COMPELLING INTEREST: THE "BIRTH CONTROL" MANDATE AND RELIGIOUS FREEDOM

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# NO COMPELLING INTEREST: THE "BIRTH CONTROL" MANDATE AND RELIGIOUS FREEDOM

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## I. INTRODUCTION

THE free exercise of religion is ordinarily and immediately understood as part of the canon of "human rights." One recent event, however, more than almost any other in recent memory, is challenging this understanding: a regulation issued by the U.S. Department of Health and Human Services ("HHS"), under the authority of the 2010 federal health care law ("ACA"),[1] requiring religious institutions to provide their employees health insurance covering birth control, sterilization, and emergency contraception ("ECs") with no co-pay.[2] This regulation ("the Mandate"), is not imposed upon entities based on their status as federal grantees, but applies to all group health plans and health insurance issuers offering group or individual health insurance coverage.[3]

What is the "story" the Mandate tells about the free exercise of religion? That the absolute maximum availability of birth control, sterilization, and drugs that can in some circumstances act to destroy a human embryo are somewhere near the heart of women's equality and freedom. It also claims that the government is on the side of women, but that churches, particularly the Roman Catholic Church, are not. Legally, the Mandate has put the Catholic Church in the exemption-seeking business—the business of seeking *not* to comply with laws billed as advancing human rights for women. This is a position more than a little disagreeable to anyone pushed to take it.

The source of the Mandate is what HHS Secretary Kathleen Sebelius calls the "scienti[fic]"[4] recommendations commissioned by the HHS from

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter "ACA"] (amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029).

2. For a further discussion of the Mandate's requirements, see *infra* notes 15–57.

3. 42 U.S.C. § 300gg-13(a) (2010).

4. Press Release, Dep't of Health & Human Servs., A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Jan. 20, 2012), *available at* http://www.hhs.gov/news/press/2012pres/01/20120120a.html (discussing purposes and contents of mandate).

the Institute of Medicine ("IOM"), a group of academics and scientists convened in order to provide advice to the federal government.[5] The IOM's case for the Mandate, spelled out on just eight pages of its two hundred and thirty-five page report, is the same case commonly forwarded on behalf of contraception and ECs in the past, usually by the leading proponents of a birth control and EC solution to the U.S. problems of "unintended pregnancy" and teen pregnancy (typically, though not always, an overlapping phenomenon).[6] On its face, it seems axiomatically true: contraception prevents pregnancy; unintended pregnancy is by definition unwanted by women; and greater usage of contraception should significantly reduce the unintended pregnancy problem. *A fortiori*, "free" contraception should increase usage of contraception in a way and to a degree that would cause unintended pregnancy rates to decline faster and more steeply.

It turns out, however, that this chain of reasoning does not work nearly as well as its proponents suggest when contraception is promoted on a *social* scale. Speaking quite generally, this is due both to the unique qualities of the sexual transaction, and to the way contraception affects the "marketplaces" for sex and marriage. In simple terms, contraception has the effect of lowering the "price" of sex, by separating sexual intercourse from the understanding that sex makes children who, in order to flourish, need their parents' commitment to one another and to the children, over a long period of time. This effect, in turn, tends to increase the demand for sex outside of marriage, which leads to more nonmarital pregnancies and abortions. Consequently, over the long run, large-scale contraception programs are not generally associated with steady declines in unintended pregnancy, which, in any event, is a difficult concept to measure.

Further, it seems likely that a legal Mandate will fail to accomplish its goal of closing the small gap between the current availability and use of contraception, and universal use by women at risk of unintended pregnancy. This is so because the group of women with the highest unintended pregnancy rates (the poor) are not addressed or affected by the Mandate, and are already amply supplied with free or low-cost contraception. It is also true because women have a true variety of reasons for not using contraception that the law cannot mitigate or satisfy simply by attempting to increase access to contraception by making it "free."

A possible way to overcome this thicket of obstacles to broader and more effective use of contraception—greatly stepped up usage of long-acting, reversible contraceptives ("LARCs")—poses its own risks and moral hazards, though it appears to constitute an important component of the strategy adopted by the Mandate and its supporters. But even if LARCs

5. For the IOM's formal self-description, see *infra* note 15.

6. STEPHANIE J. VENTURA, CTRS. FOR DISEASE CONTROL & PREVENTION, CHANGING PATTERNS OF NONMARITAL CHILDBEARING IN THE UNITED STATES (2009) (noting that about eighty-six percent of teen births are nonmarital; and rest take place within marriage).

could reduce "unintended pregnancy," there is another difficulty with the Mandate's goal to assist women's health via reducing unintended pregnancies: research may show a *correlation* between unintended pregnancy and various health conditions in women, but it does not clearly indicate a *causal* relationship.

What are the legal consequences of there being only an attenuated relationship, if any, between the Mandate and women's health? Most significantly, it eliminates the possibility that the government can show what the Religious Freedom Restoration Act of 1993[7] ("RFRA") requires in order for the government to burden free exercise: a "compelling governmental interest" and the "least restrictive means" of furthering that interest.[8] While this Article will not address the question of the "burden" on free exercise necessary to provoke a RFRA claim,[9] it will examine whether the government can demonstrate a "compelling governmental interest" for the Mandate. It will pursue this question by means of a close analysis of the document providing the basis for the Mandate, a report issued by the IOM entitled *Clinical Preventive Services for Women: Closing the Gaps*,[10] (the "Report" or "the IOM Report") as commissioned by HHS.[11]

Section II of this Article will set forth the current requirements of the HHS Mandate—I refer to the "current" requirements because the Obama Administration has promised that it will alter its language during 2013, and was in fact under court order to do so.[12] On February 1, 2013, the administration issued a proposed new rule,[13] which has no effect upon the arguments advanced in this Article. The new rule affects *how* the government will accomplish providing birth control, sterilization and ECs to the employees of certain types of religious institutions, so as to overcome such institutions' objections. But it does not rely upon different grounds for requiring health insurance policies generally to cover such drugs and devices. Section II will also discuss other, recent federal agency actions communicating equivalence between maximum access to contraception and women's freedom and equality; in so doing, it will highlight further the

7. Pub. L. No. 103-141, 107 Stat. 1488 (codified in scattered sections of 5 and 42 U.S.C.). The Supreme Court invalidated the RFRA with respect to state laws. City of Boerne v. Flores, 521 U.S. 506 (1999).

8. 42 U.S.C. § 2000bb-1(a)–(b).

9. For a complete discussion of the question of the Mandate's burden on free exercise, see Korte v. Sebelius, No. 12-3841, 2012 WL 6757353, at *3–4 (7th Cir. Dec. 28, 2012).

10. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (2011) [hereinafter IOM 2011 REPORT].

11. *Id.* at frontspiece ("This study was supported by Contract HHSP23337013T between the National Academy of Sciences and the U.S. Department of Health and Human Services.").

12. Wheaton Coll. v. Sebelius, No. 12-5273, 2012 WL 6652505, at *2 (D.C. Cir. Dec. 18, 2012).

13. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 8456, 8456–76 (Feb. 6, 2013).

theme emerging from the federal government that religion, particularly any religion opposing contraception, is the enemy of women's freedom.

Even should the Obama Administration effectively change the Mandate during 2013, this Article's review of the government's proffered empirical basis for its vociferously held stance that women's health and freedom requires free contraception, performs a useful service. The Administration's willingness to push the Mandate aggressively—by defending it in court against many challenges, by making regular use of both presidential and HHS bully pulpits, by making the Mandate a centerpiece of the presidential reelection campaign—on the basis of so weak an empirical argument, should be studied. Also, federal and state lawmakers are continuously asserting that their advocacy for contraception is tantamount to a woman's health and freedom agenda. They also continue to draw unfavorable comparisons with religions'—especially the Catholic religion's—refusal to facilitate access to contraception. Consequently, any long-term strategy in support of religious freedom ought to include attention to the empirical bases for the government's claims about the causal relationship between contraception and women's health.

Section III, the heart of this Article, will closely scrutinize the argument set forth in the IOM Report that free contraception, sterilization, and ECs are crucial for preserving women's health. It will conclude that the IOM's argument is poorly sourced, poorly reasoned, biased, and incomplete with respect to the questions of contraception and women's health.

Section IV will engage in a "compelling governmental interest" analysis of the government's case for free contraception, relying primarily on the Supreme Court's most recent and thorough review and discussion of that standard respecting a law also claimed to find support in ultimately discredited empirical data. This is the "violent video games" case of *Brown v. Entertainment Merchants Association*.[14]

Section V offers some concluding reflections about the clash specifically between the "contraceptive project" embodied in the Mandate and other federal messages, and religious teachings about freedom for women in the arena of sex and marriage. The phrase "the contraceptive project," includes not only the government's plan to advance usage of contraception via a health insurance regulation; it also includes, as Section II of the Article will describe, an intention to advance the message that freedom and equality for women is achieved in substantial measure by enabling women—if they wish—to engage in sexual expression without forming lasting relationships, either with the sexual partner, or with a child. Section V will suggest that religious teachings opposed to the contraceptive project might realistically assist women to attain the health outcomes the government claims to support via the Mandate. This finding suggests that

14. 131 S. Ct. 2729 (2011).

a health care system in which religious witness is allowed to flourish better promotes women's long-term health and freedom.

## II. THE MANDATE AND OTHER FEDERAL ENDORSEMENTS OF THE CONTRACEPTIVE PROJECT

### A. *The HHS Mandate*

The Mandate arose as a result of the "preventive services" provision of the ACA, which required group health plans and health insurance issuers offering group or individual health insurance coverage, to cover, without a co-pay, both evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF") and, with respect to women, "such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources Services Administration."[15] HRSA is an agency of HHS. HHS thereafter commissioned the IOM to produce recommendations. The IOM, by its own description, was "established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. . . . [And] to be an adviser to the federal government."[16]

The IOM issued the Report on preventive services for women on July 19, 2011, including the following recommendation which is the subject of this Article: "The committee recommends for consideration as a preventive service for women: the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity."[17] On August 1, 2011, solely on the strength of the IOM Report, HHS issued guidelines tracking the language of the Report, defining preventive services to include "[a]ll . . . [FDA] approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[18] The rule contained a very narrow religious exemption protecting an organization if: 1) its purpose is the inculcation of religious values; 2) it employs "primarily" persons who share the organization's religious tenets; 3) it serves "primarily" persons who share the or-

15. 42 U.S.C § 300gg–13(a)(4) (2006). Section 2713 of the ACA, Coverage of Preventive Health Services, provides that all "group health plan[s]" must cover "preventive care and screenings" for women without cost-sharing. *Id.*

16. IOM 2011 REPORT, *supra* note 10, at iv.

17. *Id.* at 109–10.

18. Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8725 (Feb. 15, 2012).

ganization's religious tenets; and 4) it qualifies under the IRS code as a church or religious order.[19]

Because almost all religious universities, hospitals, schools, and social services make their services available to persons regardless of their faith, and often hire persons of diverse faiths or persons with no faith, they are not eligible for this exemption. Additionally, Catholic educational, social service, and health care institutions were particularly impacted because the Catholic faith, alone among religions, has maintained for two millennia a tradition against both contraception and abortion.[20] Other religious institutions opposed only to abortion were affected by the Mandate's inclusion of ECs and other contraceptives, which, according to the federal government and their manufacturers, can act at some times as an abortifacient, i.e., to destroy a human embryo.[21] For religious employers who refuse to violate their consciences, the ACA imposed a fine that could amount to one hundred dollars per day per employee.[22]

Religious organizations and citizens sent hundreds of thousands of comments to HHS, objecting to the Mandate upon both constitutional (First Amendment) and legislative (Religious Freedom Restoration Act) grounds. On February 12, 2012, however, the regulation was finalized without any substantive change. Instead, HHS extended by one year the deadline by which "[n]onprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan," had to comply.[23]

Shortly thereafter, in March 2012, HHS issued a rambling Advanced Notice of Proposed Rulemaking,[24] which asserted that at some time in the undetermined future, HHS would try to devise a way to force religious institutions to provide contraception, sterilization and ECs to employees without enlisting the cooperation of the institutions—in other words to require employer-contracted insurance providers to "offer . . . coverage

19. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621, 46623 (Aug. 3, 2011).

20. PAUL VI, HUMANAE VITAE ¶ 14 (1968), *available at* http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html; JOHN PAUL II, EVANGELIUM VITAE ¶ 57 (1995), *available at* http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

21. For a further discussion of the potential post-fertilization mechanisms of action of the intrauterine device ("IUD") and some of the ECs endorsed by the FDA under the heading of "contraception," see *infra* notes 63–78.

22. *See* 26 U.S.C. § 4980(d) (2012); CYNTHIA BROUGHER, CONG. RESEARCH SERV., PREVENTIVE HEALTH SERVICES REGULATIONS: RELIGIOUS INSTITUTIONS' OBJECTIONS TO CONTRACEPTIVE COVERAGE 16 (2012), *available at* http://www.scribd.com/doc/100249369/CRS-Report-HHS-Contraception-Abortion-Mandate.

23. Dep't of Health & Human Servs., *supra* note 4; 77 Fed. Reg. at 8729.

24. Certain Preventive Services Under the Affordable Care Act, 77 Fed. Reg. 16501 (Mar. 21, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R pt. 147).

that does not include coverage for contraceptive services" to certain religious institutions, but simultaneously, "provide to the participants and beneficiaries covered under the plan separate health insurance coverage consisting solely of coverage for contraceptive services . . ." without "charge to the organization, group health plan, or plan participants or beneficiaries."[25]

On February 1, 2013, the Administration issued a proposed rule offering an exemption to religious institutions meeting only the fourth of its previous four requirements (being a church, an association of churches, or a religious order).[26] The government concluded that this reformulation would not "expand the universe of employer plans that would qualify for the exemption beyond that which was intended in the 2012 final rules."[27] The employees of other religious institutions—hospitals, social services, etc.—would be "automatically enrolled" to receive contraception, sterilization, and ECs without a co-pay via a separate insurance policy to be issued by the insurer chosen by the religious employer to provide general health insurance.[28] As discussed in the Introduction, however, the government's extended and aggressive posturing about a clash between religious freedom and women's freedom merits consideration no matter the final shape of the regulation, or the litigation. One reason of course, is that the theme of "contraception as women's freedom" seems to have staying power, such that religions will have to confront it regularly. This is indicated by particular features of the Mandate, by features of the government's litigation strategy respecting the Mandate, and by the shape of the "women's freedom" theme in the Obama reelection campaign and in several other federal regulations issued recently. Each will be addressed briefly below.

Beginning with the Obama presidential campaign, its main appeal to women was perhaps first famously sounded in a speech by campaign surrogate and Secretary of Health and Human Services, Kathleen Sebelius, at a fundraiser for the leading political arm of the abortion rights movement, NARAL Pro-Choice America.[29] There she stated: "We've come a long way in women's health over the last few decades, but we are in a war."[30] She was referring to Republicans' efforts to defund the largest abortion pro-

25. *Id.* at 16505–06.

26. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 8456, 8456–76 (Feb. 6, 2013).

27. *Id.* at 8461. The text accompanying the proposed rule stated that the government had finally concluded after reflection that only the fourth requirement was logically necessary in order to limit the exemption to the religious institutions intended to be exempted all along.

28. *Id.* at 8463.

29. Sam Baker, *Probe: Sebelius Broke the Law by Campaigning for Obama Reelection*, THE HILL (Sept. 12, 2012), http://thehill.com/homenews/administration/249187-probe-sebelius-violated-law-by-campaigning-for-obama.

30. Robin Marty, *Sebelius: "We Are in a War"*, RH REALITY CHECK (Oct. 6, 2011), http://www.rhrealitycheck.org/blog/2011/10/06/sebelius-0.

vider in the United States, Planned Parenthood, as well as their legislative proposals regarding federal funding for contraception and abortion generally. She equated these with "roll[ing] back the last 50 years in progress women have made in comprehensive health care in America."[31] Democratic Congresswomen picked up on the theme in the context of the first legislative hearing on the Mandate's effects upon religious freedom, using the sound bite, "Where are the women?"[32] They were referring to the all-male first panel of witnesses, taking no notice of two women on the second panel.[33]

This theme was then carried into the presidential campaign through a postcard campaign targeted to women ("Vote like your lady parts depend on it . . . because they kinda do"),[34] speeches at the Democratic National Convention, and a campaign speaking tour by an unmarried, non-Catholic law-student, Sandra Fluke, claiming that her Catholic law school owed her a free, daily supply of birth control as a matter of human rights. She further claimed that the school had denied an anonymous classmate the birth control pill in order to treat a physical disorder (endometriosis) unrelated to birth control, despite Catholic theology permitting such treatment.[35] Most revealing, perhaps, of the scope of the contraceptive project, was an Obama campaign television ad featuring an actress, Lena Dunham, from a show about the sex lives of unmarried women. Comparing voting for Obama to a first sexual experience, she closes with the suggestion that it is "super uncool to be out and about and someone says, 'Did you . . .' and you say 'No I wasn't ready.'" She adds, "Before I was a girl, now I was a woman," in both cases, comparing voting for President Obama to losing one's virginity.[36] These messages moved beyond the "women's health" tone and content of the IOM Report, appearing to celebrate female sexual expression per se as the essential element of women's freedom. Both Ms. Fluke and Ms. Dunham's messages, sponsored

31. *Id.*

32. Lines Crossed: Separation of Church and State. *Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?: Hearing Before the H. Comm. on Oversight and Government Reform*, 112th Cong. 1 (2012).

33. Dr. Allison Dabbs Garrett, the senior vice president for academic affairs at Oklahoma Christian University, and Dr. Laura Champion, the medical director at Calvin College Health Services, testified that the government mandate requiring religious institutions such as theirs to provide contraception, sterilization, and abortifacient drugs violated the First Amendment. *See id.* at 147–48.

34. For the text of the card, see Jonathon M. Seidl, *Obama Scrubs Controversial "Vote Like Your Lady Parts Depend on it" E-Card from Site*, THE BLAZE (Oct. 2, 2012 2:27 PM), http://www.theblaze.com/stories/obama-scrubs-controversial-vote-like-your-lady-parts-depend-on-it-e-card-from-site/.

35. *See* Joe Scott, *Can I Use Birth Control for Medical Reasons and not to Prevent Pregnancy?*, BUSTED HALO, http://bustedhalo.com/questionbox/can-i-use-birth-control-for-medical-reasons-and-not-to-prevent-pregnancy (last visited Feb. 14, 2013); Ira Stoll, *Sandra Fluke's Amazing Testimony*, WALL ST. J. (Mar. 9, 2012), http://online.wsj.com/article/SB10001424052970204603004577269491399954950.html.

36. BarackObamadotcom, *Lena Dunham—Your First Time*, YOUTUBE (Oct. 25, 2012), http://www.youtube.com/watch?v=o6G3nwhPuR4.

and made nationally famous by the current Administration, are constitutive elements of the contraceptive project.

During his campaign, President Obama also associated himself frequently with the self-branded champion of women, and the premier promoter of a linkage between birth control, abortion, and women's freedom: the Planned Parenthood Federation of America. Planned Parenthood donated 15 million dollars of campaign advertisements to the President's re-election campaign.[37] And the President continued strenuously to support both federal and state grants for Planned Parenthood, for hundreds of millions dollars annually, as well as to deploy his Administration's Department of Justice to states where legislatures had re-directed their family planning funds away from local Planned Parenthoods, in favor of providers without an abortion connection. The Department of Justice threatened these states with the withdrawal of all federal Medicaid funding for all services for the poor.[38] Very likely, President Obama's close association with Planned Parenthood strengthened his campaign's and his Administration's publicity regarding their support for women. It also raised questions about the objectivity of the Mandate and the Report supporting it—both of which were mirror images of Planned Parenthood's agenda, and that of its former research affiliate, the Guttmacher Institute, respecting contraception and religious objectors.[39]

The Administration's "theme" about the clash between religious freedom and women's freedom is further displayed in the structure of the Mandate and in the federal government's litigation strategy. First, the Mandate effectively allows only houses of worship and religious orders to buy health insurance consistent with their faith. If a religious institution comes into contact with persons who are *not* members of the same faith, however, either as employees or as "clients," (students, patients, etc.), they must buy insurance covering services contradicting their faith. The impression given is that general audiences should be "shielded" from the religion's opposition to contraception, a teaching which other Administration statements characterize again and again as unreasonable and even contrary to the basic human rights of women.

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37. Press Release, Planned Parenthood, Obama Reelection Is "Resounding Victory for Women" (Nov. 6, 2012), *available at* http://www.plannedparenthoodaction.org/elections-politics/press-releases/planned-parenthood-obama-reelection-resounding-victory-women-1300.htm.

38. *See, e.g.*, Karla Dial, *Obama Administration Sues Arizona*, CITIZENLINK (Oct. 5, 2012), http://www.citizenlink.com/2012/10/05/obama-administration-sues-arizona/.

39. Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 GUTTMACHER POL'Y REV. 7 (2011); *see, e.g.*, *Birth Control Matters: Making Prescription Birth Control Affordable for America's Women*, PLANNED PARENTHOOD OF THE GREAT NW., http://www.plannedparenthood.org/ppgnw/birth-control-matters-32835.htm (last visited Feb. 14, 2013) ("We . . . believe that prescription birth control should be covered with no co-pays, so that more women can afford the method of birth control that works best for them.").

The Administration's litigation strategy against corporate plaintiffs also effectively seeks to shield persons (employees) outside a religion from the religious teachings held by their employers. In the religious freedom cases commenced by Hercules Industries, Inc. and other companies, the Obama Administration argued that for-profit, corporate, secular entities are barred from asserting free exercise claims—that there is no such thing as a constitutionally cognizable "conscience" where such entities are concerned.[40]

### B. *Other Federal Regulations Pursuing the Narrative: Contraception Equals Women's Flourishing*

The HHS Mandate is the leading, but not the only indicator of a larger "story" or theme about a clash between religious freedom and women's freedom and the Administration's choosing women's side by facilitating access to contraception. Another indicator was the imposition of a new requirement for recipients of federal anti-trafficking grants under the Victims of Trafficking and Violence Protection Act of 2000.[41] The text of the law does not demand that grantees provide access to contraception and abortion, but the Administration in 2011 imposed such a demand via agency grant-making guidelines.[42] Thus, although beginning in 2005, HHS had selected the U.S. Conference of Catholic Bishops ("USCCB") as the general contractor, and imposed no requirements related to contraception or abortion, in 2011, when the contract with the USCCB was about to expire, the Administration denied USCCB's application. Although the Administration had praised the USCCB's earlier work in public documents,[43] groups with lower competence scores—groups deemed even "noncompetitive" by professional program staff—received federal money

40. *See, e.g.*, Defendants' Memorandum in Support of Their Motion to Dismiss the First Amended Complaint and Amended Memorandum in Opposition To Plaintiffs' Motion for Preliminary Injunction, Newland v. Sebelius, No. 1:12-cv-01123 (D. Colo. July 13, 2012).

41. Pub. L. 106-386, 114 Stat. 1464.

42. ADMIN. FOR CHILDREN & FAMILIES, DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HUMAN TRAFFICKING VICTIM ASSISTANCE PROGRAM 6 (2011), *available at* http://www.acf.hhs.gov/grants/open/foa/view/HHS-2011-ACF-ORR-ZV-0148 ("Taking into consideration the particular health risks posed to victims of trafficking, preference will be given to grantees under this FOA that will offer all victims referral to medical providers who can provide or refer for provision of treatment for sexually transmitted infections, family planning services and the full range of legally permissible gynecological and obstetric care . . . .").

43. *See, e.g.*, Defendants' Memorandum in Opposition to Plaintiff's Motion for Summary Judgment, Am. Civil Liberties Union of Mass. v. Sebelius, 821 F. Supp. 2d 474 (D. Mass. 2012) (No. 09-10038). The government in this case praised USCCB as a contractor, saying: "Rather, HHS weighed USCCB's overall proposal against religiously-neutral criteria and determined that USCCB provided the best proposal for assisting human trafficking victims at the best value." *Id.* at 5–6. The government also wrote: "the primary effect of the contract has been the provision of a wide range of assistance to human trafficking victims on a nationwide scale." *Id.* at 11.

instead of the USCCB.[44] Another example of the narrative linking access to contraception and abortion with women's freedom, is a more subtle shift in the regulations applicable to the funding for the President's Emergency Program for AIDS Relief ("PEPFAR"). This Bush Administration program was begun in 2003 to provide HIV prevention and care.[45] The original program barred grantees who performed abortion, even with separate funds. Contraception was a component of PEPFAR, but prior to 2009, religious providers had been permitted to apply for grants limited to abstinence or fidelity programs. Consequently, Catholic Relief Services ("CRS")—the largest private provider of charitable services in the United States—became a major PEPFAR grantee.[46] Just days after President Obama assumed office in early 2009, however, he rescinded the rule limiting abortion providers' participation in the PEPFAR program.[47] Further, while he permitted grantees with religious or moral objections to contraception, the organization was required to notify U.S. officials of its objection prior to submitting its application.[48]

Considering together these Obama Administration funding decisions with the structure of and litigation concerning the Mandate, and the President's reelection campaign, it is easy to see the strong emergence of the theme that access to contraception, and in some cases abortion, is an essential and basic aspect of women's health care and even overall flourishing. Other influential groups and organizations—e.g., the United Nations and leading medical organizations—recently made a similar claim.[49] Re-

44. Jerry Markon, *Health, Abortion Issues Split Obama Administration and Catholic Groups*, WASH. POST (Oct. 31, 2011), http://www.washingtonpost.com/politics/health-abortion-issues-split-obama-administration-catholic-groups/2011/10/27/gIQAXV5xZM_story_1.html.

45. United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, Pub. L. No. 108-25, 117 Stat. 711 (codified at 22 U.S.C. § 7601 (2006)); *see also PEPFAR and the Global Health Initiative*, AVERT: AVERTING HIV AND AIDS, http://www.avert.org/pepfar.htm (last visited Feb. 11, 2013).

46. Letter from USCCB and Catholic Relief Services to Members of Congress (Feb. 6, 2008), *available at* http://old.usccb.org/sdwp/international/2008-02pepfar_cong_ltr.pdf.

47. Mexico City Policy and Assistance for Voluntary Population Planning, 74 Fed. Reg. 4903 (Jan. 23, 2009), *available at* http://www.whitehouse.gov/the_press_office/MexicoCityPolicy-VoluntaryPopulationPlanning.

48. USAID, IMPLEMENTATION OF THE UNITED STATES LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA ACT OF 2003, AS AMENDED—CONSCIENCE CLAUSE IMPLEMENTATION, MEDICALLY ACCURATE CONDOM INFORMATION AND OPPOSITION TO PROSTITUTION AND SEX TRAFFICKING (2012), *available at* http://transition.usaid.gov/business/business_opportunities/cib/pdf/aapd12_04.pdf.

49. Press Release, American Academy of Pediatrics, AAP Recommends Emergency Contraception Be Available to Teens (Nov. 26, 2012), *available at* http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Recommends-Emergency-Contraception-Be-Available-to-Teens.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token; *By Choice, not by Chance: Family Planning, Human Rights and Development*, UNITED NATIONS FAMILY PLANNING ASSOCIATION, http://www.unfpa.org/swp (last visited Feb. 24, 2012).

ligious organizations, then, particularly the Catholic Church, which hope to preserve their free exercise rights, cannot avoid addressing the matter of the government's claims regarding contraception. Seeking exemptions from laws imposing contraception mandates is of course, still possible, and a necessary part of any religious freedom strategy. But more will be needed in order to secure religious freedom—and, as my conclusion will suggest, perhaps women's freedom too, over the long run.

The Supreme Court's 1990 decision in *Employment Division v. Smith*[50] suggests an additional reason why religions ought to address the government's substantive claims regarding contraception and women's health. In *Smith*, the Court held that states may burden the free exercise of religion so long as they employ "neutral laws of general applicability," which bear a rational relationship to a legitimate state interest.[51] This remains true even if the burden upon religion is heavy and even if a core religious principle is at stake. Consequently, respecting state laws, religions must "win" their freedom in legislatures, because courts are far less obligated than in pre-*Smith* times, to protect their free exercise. The situation could be less difficult in states with their own Religious Freedom Restoration Acts, or with a religion-protective interpretation of their state's constitutional free exercise provision.

RFRA is more protective of free exercise as well, and has been applied to federal law by the Supreme Court.[52] RFRA requires a federal law burdening free exercise to be supported by a "compelling governmental interest" realized by the "least restrictive means."[53] Especially in recent years, however, religions' prospects even under RFRA have dimmed when the burden at issue involves women's access to contraception. As sketched above, access to contraception or even abortion—promoted and enforced by the government, and subsidized even by unwilling private persons and organizations—is increasingly framed as a "human right" by federal and other authorities. This is intrinsically powerful terminology.

In response to such arguments, religions' position on ECs and women's freedom must be fully developed. There are, logically, two steps to such a project. The first is the most important, and can be dispositive: to assess, and to critique the government's best case. Assuming, as this Article does, that the Mandate burdens religious freedom, the government must bear the burden of demonstrating a compelling state interest. The second step is to put forth the religious argument in terms appealing to all

50. 494 U.S. 872, 879 (1990) ("[T]he right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability . . . .'"), *superseded by statute*, Religious Land Use and Institutionalized Persons Act of 2000, 42 U.S.C. § 2000cc et seq., *as recognized in* Sossamon v. Texas, 131 S. Ct. 1651 (2011).

51. *Id.* at 879.

52. *See* Gonzales v. O Centro Espirita Beneficiente Uniao do Vegetal, 546 U.S. 418 (2006); City of Boerne v. Flores, 521 U.S. 507 (1997).

53. 42 U.S.C. § 2000bb-1(a)–(b) (2006).

persons of good will. Because the first step requires a (surprisingly) lengthy consideration, this Article focuses almost exclusively upon it. It shows that the government has fallen far short of demonstrating a compelling governmental interest in forcing religious persons and institutions to provide insurance covering contraception and ECs.

## III. THE IOM REPORT

The most important and direct argument the federal government has made on the link between contraception and ECs, and women's health and flourishing is contained in the IOM Report furnishing, according to the federal government, nearly the entire basis for the Mandate. This is apparent from the virtually identical language of the IOM recommendation and the Mandate, from the public statements issued by Secretary Sebelius,[54] and from the government's nearly exclusive reliance upon the IOM Report in its briefs filed in defense of lawsuits challenging the Mandate.[55] It should be noted here too, that HHS and the President understood in advance that this Report would be closely scrutinized given how much controversy swirled about the "preventive" services provision of the ACA when it was first introduced, largely on the grounds that skeptics predicted that it was a stalking horse for possible abortion and contraceptive mandates.[56]

Upon close scrutiny, however, it turns out that the IOM Report is quite weak and cannot support the government's claim to demonstrate a "compelling governmental interest." It fails to show the required links between forcing employers to provide free contraception and ECs, and improving the health of women and girls.

The Administration claims the IOM Report demonstrates that employers must provide women and girls contraception and ECs with no copay,[57] because free contraception will lead to increased and more effective usage of these drugs and devices to prevent "unintended pregnancies" among women currently experiencing these, which pregnancies cause va-

54. Press Release, Dep't of Health & Human Servs., *supra* note 4.

55. *See, e.g.*, Defendants' Memorandum in Support of Their Motion to Dismiss the First Amended Complaint and Amended Memorandum in Opposition To Plaintiffs' Motion for Preliminary Injunction at 5–9, Newland v. Sebelius, No. 1:12-cv-01123 (D. Colo. July 13, 2012).

56. *Mikulski Amendment Would Include Planned Parenthood in Health Care Bill, Says Pro-Life Leader*, CATHOLIC NEWS AGENCY (Dec. 6, 2009), http://www.catholicnewsagency.com/news/mikulski_amendment_would_include_planned_parenthood_in_health_care_bill_says_prolife_leader/; Amie Newman, **Updated* Victory for Women's Health: Senate Passes Mikulski's Women's Health Amendment*, RH REALITY CHECK (Dec. 3, 2009), http://www.rhrealitycheck.org/blog/2009/12/03/victory-womens-health-senate-passes-mikulskis-womens-health-amendment.

57. For the sake of length, this Article will occasionally use the term "free contraception and ECs," although it is an outstanding question who will absorb the extra costs of contraception, if any, covered by an employer-sponsored health insurance plan.

rious bad outcomes for women during the pregnancy and afterwards including: domestic violence, drinking, smoking, and depression. To a far smaller degree, the Report suggests that preventing abortions is another positive outcome linked to free contraception, on the grounds that unintended pregnancy rates drive abortion rates. The IOM argument seems intuitive on its face, which is perhaps the reason that the Report's asserted chain of causation, and the sources it relies upon, have not been closely scrutinized since it was issued in mid-2011. The following sections attempt to remedy this important oversight.

### A. *The Report Relies upon Claims About Children's Health, Which, While Separately Important, Are Irrelevant to its Claims Regarding Women's Health, as Well as Outside the Charge Given to the IOM By HHS*

#### 1. *Not Relevant to the Charge*

The IOM Report devotes a significant amount of early attention to the claims that children's health is compromised by a lack of contraception leading to unintended pregnancy. The threats to children's health addressed include: mothers' delayed entry into prenatal care, preterm birth, low birth weight, and less breastfeeding.[58] The Report also refers to outcomes for children when claiming that unintended pregnancy is associated with more smoking and alcohol consumption during pregnancy as "behaviors that present risks for the developing fetus."[59] Both sets of problems are linked to the necessity of providing women free contraception.

But there is of course an obvious logical problem with this portion of the Report's chain of reasoning. Even if it were the case that the Report was directed to boosting children's health, children's health is not boosted by their being prevented from coming into being. It is boosted by health services encouraging mothers to seek prenatal care, breastfeed, and avoid smoking and drinking during pregnancy. But the USPSTF already requires, among other services which *must* be insured without cost-sharing, prenatal care counseling on tobacco and alcohol usage, breastfeeding, and other matters related to the health of both mother and child.[60]

But perhaps more importantly, the material on children's health is not at all related to the "charge" given the IOM by HHS. The charge states, rather: "The Institute of Medicine will convene an expert committee to review *what preventive services are necessary for women's health and well-being* and should be considered in the development of comprehensive

58. IOM 2011 REPORT, *supra* note 10, at 103.

59. *Id.*

60. *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVS. TASK FORCE, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last visited Feb. 17, 2013); *see also* 42 U.S.C § 300gg–13(a)(4) (2006) (making "A" and "B" rated Task Force recommendations mandatory).

guidelines for preventive services for women."[61] The material on children's health might have been folded into the charge in the IOM Report had it suggested that it was harmful to women's health to take care of children with health problems associated with the claimed consequences of unintended pregnancy; but nowhere in the Report's eight pages of treatment of contraception is such a subject broached.[62] Though this is speculation, perhaps the government did not want to be associated with the argument that women ought generally to avoid taking care of sick children, for the sake of their own health. In any event, the material on children's health does not give any weight to the government's case about the necessity of free contraception for women's health.

2. *Causation Versus Correlation and Children's Health*

It is logically possible within the thesis of this Article to say nothing further about the Report's treatment of children's health. Yet, two further observations are helpful in order to grasp the Report's overall lack of rigor.

First, the section of the Report considering children's health does no more than suggest *correlation* (as opposed to *causation*) between unintended pregnancy and health outcomes for children. This is the same shortcoming the Report demonstrates on the very *relevant* matter of the link between unintended pregnancy and *women's* health.

Perhaps the most egregious example of the Report's poor methods respecting the children's material is its citing an utterly irrelevant source regarding a connection between unintended pregnancy and low birth weight; that source instead addresses an increased risk of cardiovascular disease in young women following gestational diabetes mellitus.[63] The other three studies the IOM cites regarding children's outcomes, in their actual texts, claim only to show an "associat[ion]," not causation, between shorter pregnancy intervals and low birth weight.[64] The claims about smoking and drinking during pregnancy will be addressed below, in the event the IOM Report is also suggesting that these behaviors affect a mother's health and are caused by unintended pregnancy. The cited stud-

61. IOM 2011 REPORT, *supra* note 10, at 2 (emphasis added) (quoting Office of Assistant Secretary for Planning and Evaluation (ASPE) of HHS, Statement of Task to Committee on Preventive Services for Women).

62. *Id.* at 102–11.

63. Baiju R. Shah, Ravi. Retnakaran & Gillian. L. Booth, *Increased Risk of Cardiovascular Disease in Young Women Following Gestational Diabetes Mellitus*, 31 DIABETES CARE 1668 (2008).

64. IOM 2011 REPORT, *supra* note 10, at 103 (citing Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 J. AM. MED. ASS'N 1809 (2006)); E. Fuentes-Afflick & N. A. Hessol, *Interpregnancy Interval and the Risk of Premature Infants*, 95 OBSTETRICS & GYNECOLOGY 383 (2000); B.P. Zhu, *Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent U.S. Studies,* 89 INT'L J. GYNECOLOGY & OBSTETRICS S25, S25–S33 (2005).

ies also do not indicate a causal relationship between unintended pregnancy and these behaviors.

Second, even were the Report's claims about children's health well-supported, its recommendation to increase access to drugs and devices that can sometimes act to destroy the life of a child prenatally contradicts its apparent concern with children's flourishing during their prenatal existence. In other words, the IOM Report endorses women's access to free ECs, which can, according to the FDA and their manufacturers' statements, sometimes destroy prenatal life at the embryonic stage.[65] Furthermore, and according to a scientist relied upon in the IOM Report[66]: "[t]o make an informed choice, women must know that [ECs] . . . may at times inhibit implantation . . . ."[67]

While groups advocating abortion and ECs regularly employ the term "pregnancy" to mean the time after which the human embryo has attached itself to the mother's womb, according to many classic medical textbooks, though not all, genetically unique human life begins at the uniting of the male gamete with a female gamete ("fertilization") to produce a single-celled zygote. At the very least, it must be said that a thorough review of medical dictionaries' references to "conception" or "pregnancy" reveals no medical or scientific consensus in favor of implantation-based definitions of either term, and a more common acceptance of a "fertilization" based definition.[68] Yet the Secretary of HHS has acknowledged that some of the drugs covered by the Mandate can act to prevent implantation, stating: "The Food and Drug Administration has a category [of drugs] that prevent fertilization *and implantation.* That's really the scientific definition."[69] She added: "[t]hese covered prescription drugs are specifically those that are designed *to prevent implantation.*"[70] The FDA approved package insert for Plan B reads: "Plan B may prevent a fertilized

65. On Plan B, see *How Does Plan B One-Step Work?*, PLAN B ONE-STEP, http://www.planbonestep.com/faqs.aspx (last visited Feb. 18, 2013); FOOD & DRUG ADMIN., PLAN B APPROVED LABELING (2006), *available at* http://www.accessdata.fda.gov/drugsatfda_docs/nda/2006/021045s011_ Plan_B_PRNTLBL.pdf. Regarding Ella, see WATSON PHARM., INC., ELLA LABELING INFORMATION (2010), *available at* http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf.

66. *See* IOM 2011 REPORT, *supra* note 10, at 105 (citing Princeton University's Dr. James Trussell).

67. JAMES TRUSSELL & ELIZABETH G. RAYMOND, EMERGENCY CONTRACEPTION: A LAST CHANCE TO PREVENT UNINTENDED PREGNANCY 7 (2013), *available at* http://ec.princeton.edu/questions/ec-review.pdf.

68. CHRISTOPHER M. GACEK, FAMILY RESEARCH COUNCIL, CONCEIVING "PREGNANCY": U.S. MEDICAL DICTIONARIES AND THEIR DEFINITIONS OF "CONCEPTION" AND "PREGNANCY" (2009), *available at* http://downloads.frc.org/EF/EF09D12.pdf.

69. Kelly Wallace, *Health and Human Services Secretary Kathleen Sebelius Tells iVillage "Historic" New Guidelines Cover Contraception, Not Abortion*, IVILLAGE (Aug 2, 2011), http://www.ivillage.com/kathleen-sebelius-guidelines-cover-contraception-not-abortion/4-a-369771 (alteration in original) (emphasis added).

70. *Id.*

egg from attaching to the womb (implantation)."[71] Regarding Ella, another EC, the European equivalent to the FDA, the European Medicines Agency (EMEA), calls Ella "embryotoxic" at low doses in animals, and even cites numerous studies showing Ella causes abortions in animals.[72]

Although not a scientific source, a *New York Times* article claiming that post-coital drugs were not embryocidal has gained so much attention that it merits brief attention.[73] The most complete response was written by Dr. Marie Hilliard,[74] a bioethicist who demonstrates that the reporter relied heavily upon one study with a very small sample size and inconclusive results about post-fertilization effects, as well as a second study[75] wherein the author was equally uncertain, concluding: "studies on the impact of LNG-EC on endometrial parameters involved in endometrial receptivity are not consistent, and current knowledge on cellular and molecular markers of endometrial receptivity in the human is insufficient to resolve this controversy."[76] Hilliard also points out that the reporter omitted to mention the most significant "study of studies" on the subject. This latter study clearly supports a post-ovulation effect.[77] Respecting the accuracy of the *New York Times* reporter, Dr. Hilliard also highlights the author's own admission that the FDA has refused—in the face of several requests by a Plan B manufacturer—to delete the reference to "implantation effects."[78]

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71. *FDA's Decision Regarding Plan B: Questions and Answers*, Food & Drug Admin., http://www.fda.gov/Drugs/EmergencyPreparedness/BioterrorismandDrugPreparedness/ucm109795.htm (last updated Apr. 30, 2009); FOOD & DRUG ADMIN., BIRTH CONTROL GUIDE (2012), *available at* http://www.fda.gov/downloads/ForConsumers/ByAudience/forWomen/FreePublication/UCM282014.pdf.

72. EUROPEAN MEDS. AGENCY, CHMP ASSESSMENT REPORT FOR ELLAONE (2009), *available at* http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/001027/WC500023673.pdf.

73. Pam Belluck, *Abortion Qualms on Morning-After Pill May Be Unfounded*, N.Y. TIMES (June 5, 2012), http://www.nytimes.com/2012/06/06/health/research/morning-after-pills-dont-block-implantation-science-suggests.html?pagewanted=all&_r=0.

74. Marie T. Hilliard, *Are Journalists Now Scientists? A Reporter Loses Sight of Data on Plan B*, NAT'L CATHOLIC BIOETHICS CTR. (June 2012), http://www.ncbcenter.org/document.doc?id=444&erid=0.

75. Gabriela Noé et al., *Contraceptive Efficacy of Emergency Contraception with Levonorgestrel Given Before or After Ovulation*, 81 CONTRACEPTION 414 (2010).

76. *See* Hilliard, *supra* note 74; *see also* P.G.L. Lalitkumar et al., *Mifepristone, But Not Levonorgestrel, Inhibits Human Blastocyst Attachment to an In Vitro Endometrial Three-Dimensional Cell Culture Model*, 22 HUMAN REPROD. 3031, 3031–37 (2007).

77. Rafael T. Mikolajczyk & Joseph B. Stanford, *Levonorgestrel Emergency Contraception: A Joint Analysis of Effectiveness and Mechanism of Action*, 88 FERTILITY AND STERILITY 565 (2007) (examining data from multiple clinical studies reporting wide discrepancy between LNG-EC effectiveness in preventing pregnancy—between fifty-eight percent and ninety-five percent—and its effectiveness in preventing ovulation—between eight percent and forty-nine percent). The authors conclude that this may be explained, in part, by mechanisms of action other than ovulation disruption, including post-fertilization mechanisms. *Id.*

78. Belluck, *supra* note 73.

### B. *Women's Health*

Turning to the material in the Report addressing specifically women's health, the Report's conclusion—and the basis for the Mandate—is the claimed chain of causation between access to free contraception and women's improved health as a consequence of preventing unintended pregnancy. Each link in this chain is addressed below.

#### 1. *The Claim that Access to Contraception Can Reduce Unintended Pregnancy at the Population Level Has Many Weak Links*

##### a. Unintended Pregnancy: An Uncertain Measure

It should first be noted that scholars disagree over how to measure "unintended pregnancy." The Report does not acknowledge this despite claims about rises and falls in the rate of unintended pregnancy, which constitute the heart of its argument. The notion of unintended pregnancy has been, according to a relevant white paper written by University of South Carolina Professor Austin L. Hughes,[79] "poorly and inconsistently defined."[80] Professor Hughes's paper, as well as an earlier report on unintended pregnancy by the IOM itself ("IOM 1995 Report"),[81] note that the literature recognizes two main categories of "unintended pregnancy": (1) unwanted (the mother did not want to become pregnant at all); and (2) mistimed (the mother was not seeking to become pregnant at that *time*). But different studies over time may assign to one or the other of these categories, or neither, other "situations," that are far less defined. These might include disagreement between partners regarding wantedness or timing, or even indifference to pregnancy. Also, a woman's opinion might shift over the course of the pregnancy. Further, "substantial literature addresses the difficulty of studying 'unintended pregnancy' through survey data because people's memory and/or interpretation of their past attitudes can change over time."[82] Despite these many difficulties with measuring unintended pregnancy, the IOM Report: "relies entirely on questionnaire survey data, and for purposes of analysis the responses are divided into just two categories: intended and unintended."[83]

A good example of the problems inherent in making simplistic claims regarding unintended pregnancies is the one and only study the IOM relies upon to claim that 49% of all pregnancies in the United States are

79. Austin L. Hughes, The Case for a Compelling Government Interest in the HHS Mandate: Examining the Scientific Evidence (Dec. 2012) (unpublished manuscript) (on file with author).

80. *Id.* at 13.

81. INST. OF MED., THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (1995) [hereinafter IOM 1995 Report].

82. Hughes, *supra* note 79, at 3.

83. *Id.* at 2–3.

"unintended"—a study by Finer and Henshaw published in 2006.[84] A review of the study by Professor Hughes concluded:

> This study was based on survey responses of samples of women aged 15-44 in 1995 (10,847 women) and 2002 (7,643 women), conducted by the National Survey of Family Growth (NSFG; Finer and Henshaw 2006). In Finer and Henshaw's (2006) analysis, all "unwanted" and "mistimed" pregnancies were grouped as "unintended." Furthermore, Finer and Henshaw (2006) added an estimate of the number of abortions to the "unintended" category. Finer and Henshaw (2006) did not use the NSFG data themselves to estimate abortion rates (even though such data were included in the NSFG), because they believed abortions to be "underreported" in the NSFG. Rather, they attempted to estimate rates of abortion from other population data, then applied these estimates to the NSFG sample, adding the estimated numbers of abortions to the category "unintended pregnancy." Such a process is perilous because the NSFG samples may not in fact have been comparable to the populations from which the abortion data were taken. Thus, the estimates provided by Finer and Henshaw (2006) and relied on by IOM (2011) regarding the rate of "unintended pregnancy" in the U.S. are based on a number of questionable assumptions and may be considerably inflated.[85]

Adding a historical and evolutionary perspective, Professor Hughes adds that, by Finer and Henshaw's definition, "essentially every member of the U.S. population over the age of 45 is the result of an 'unintended pregnancy.' Likewise all those born over all of human history prior to the 1960's. If there are deleterious consequences to 'unintended pregnancy,' these should be demonstrated by data on populations born prior to the 1960's, as well as on contemporary populations."[86] He further observes:

> Being able to "plan" a pregnancy with any degree of precision, as a result of reliable contraceptive methods, represents a novel phenomenon in human history, for which we are adapted neither at the biological nor at the cultural level. For this reason, it might be reasonable to hypothesize that truly *intended* pregnancies might have deleterious consequences arising from our lack of adaptation for such a phenomenon. However, no study to date appears to have addressed the latter hypothesis.[87]

The elusiveness of the definition of unintended pregnancy is well known in the literature. The IOM was aware of this, referring to it in its

84. *Id.* (citing IOM 2011 REPORT, *supra* note 10, at 102).

85. *Id.* at 3.

86. *Id.*

87. *Id.* at 4 (citations omitted).

1995 report on unintended pregnancy. But in 2011 the IOM Report failed completely to acknowledge this important complexity.

b. Does Greater Access to Contraception Really Reduce Unintended Pregnancy?

Even if we accepted the IOM Report's claims regarding how to define unintended pregnancy, it is not clear that the Report's recommendation would lower rates of unintended pregnancy. The Report makes the straightforward cause-and-effect claim that "greater use of contraception within the population produces lower unintended pregnancy . . . rates nationally."[88] In fact, this is one of the centerpieces of the Report (along with its claim that unintended pregnancy diminishes women's health).

Preliminarily, it should be noted that the Report and the Mandate are centrally about increasing "*access*" to contraception and ECs by making them free within the context of employer provided health insurance, and thereby seeking to reduce a claimed cause of illness in women, unintended pregnancy. This is precisely how Secretary Sebelius summarized the Mandate's intention.[89] Of course, this is all the government *could* do, short of coercive measures. It can give women access to contraception but it cannot force them to use it. Yet the Report does appear to claim to be able to affect women's overall decision to *use* contraception given that its explicitly articulated argument is that increased "use"[90] has in the past reduced unintended pregnancy; unless increased *access* translates into increased *usage*, it is difficult to see how increased access will achieve the government's hoped-for results. This Article will therefore take a close look at whether the government has met its burden of establishing each of the following linkages: greater access with greater usage, greater usage with reduced unintended pregnancies, and reduced unintended pregnancies with women's improved health.

A closer look at each reveals the Report's fatal weaknesses. For it turns out that there are many and varied reasons why women choose not to use contraception, most of which have nothing to do with cost. There is also the fact that due to both method and use failures, contraception usage does not guarantee the prevention of pregnancy. In fact, the Centers for Disease Control reports that more than 12 out of every 100 women using contraception will become pregnant in a given year, and that this figure essentially has not changed since 1995.[91] There is also the fact that

88. IOM 2011 REPORT, *supra* note 10, at 105.

89. Press Release, Dep't of Health & Human Servs., *supra* note 4 ("Today the department is announcing that the final rule on preventive health services will ensure that women with health insurance coverage will have *access* to the full range of the Institute of Medicine's recommended preventive services, including all FDA-approved forms of contraception.") (emphasis added).

90. IOM 2011 REPORT, *supra* note 10, at 105.

91. WILLIAM D. MOSHER & JO JONES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., USE OF CONTRACEPTION IN THE UNITED STATES: 1982-2008 5 tbl.A (2010)

the Report, and the Mandate it supports, address *employed women and the female children of employed parents provided employer-sponsored health care*, but that studies on the incidence of unintended pregnancy univocally report that unintended pregnancy is highly concentrated among low income women—who are already amply provided free or very lost cost contraception by federal and state governments.

The two studies on which the Report rests its entire claim are insufficient, separately or together, to overcome these oversights. Also, the Report ignores substantial evidence contradicting or substantially undermining its claims—including evidence available from the same sources the Report relies upon throughout the section on contraception: the Centers for Disease Control, the Guttmacher Institute, and a prior IOM report about unintended pregnancy in the United States.[92] The Report also ignores well-known and acclaimed studies considering the way that normalizing and facilitating access to birth control, and sometimes abortion, changes the "sex and mating markets" so as to produce a higher volume of nonmarital sexual encounters, pregnancies, births, and abortions; this literature appears to have a great deal of explanatory power respecting data from the last several decades. In short, the Report—the basis for the Mandate—treats a complex subject *simplistically. It fails in its essential claim.*

Turning now to the Report's evidence for its claims regarding greater access causing reduced rates of unintended pregnancy. As already noted, it relies upon two studies,[93] a 2010 report by Santelli and Melnikas,[94] and a study issued by the Guttmacher Institute.[95] It should be noted immediately here that Dr. Santelli is a senior fellow of the selfsame Guttmacher Institute, and a longtime supporter of large-scale birth control and abortion. He is a dedicated opponent of abstinence programs.[96] The Guttmacher Institute is the former research affiliate of the nation's largest network of providers of abortion and contraception, Planned Parenthood.

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(estimating 1-year typical-use failure rates for selective contraceptive methods in United States).

92. *See* IOM 1995 REPORT, *supra* note 81.

93. IOM 2011 REPORT, *supra* note 10, at 105.

94. 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).

95. HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES (2006), *available at* http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf.

96. *See John Santelli, Senior Fellow*, GUTTMACHER INST., http://www.guttmacher.org/media/experts/santelli.html (last visited Feb. 17, 2013); *see also* Press Release, Guttmacher Inst., Review Finds No Evidence to Support Funding of Rigid Abstinence-Only Programs (Sept. 16, 2008), *available at* http://www.guttmacher.org/media/nr/2008/09/16/ (advertising series of articles that identify major flaws in abstinence-only education, including problems with accuracy, effectiveness and ethics, all published in special edition of journal *Sexuality Research and Social Policy*, guest edited by John S. Santelli and Leslie M. Kantor).

Regarding the two cited studies, the Report claims that the Santelli and Melnikas study *associates* increased contraceptive *usage* in teens over a ten-year period (early 1990s to early 2000s), with reductions in their pregnancy rates. The Guttmacher study considers unmarried women from 1982 to 2002; the Report claims it shows that increased contraceptive usage was *associated* with lowered unintended pregnancy and abortion rates. Obviously both studies on their face fail to prove the claim that greater use of contraception will produce lower rates *nationally*, i.e., within the population. Each has considered only a fraction of the population over a particular slice of the time during which contraception has been readily available. Neither is certainly generalizable to the entire population or to every period of time during which contraception and abortion have been available. Neither shows that increased *access* to contraception translated into increased *usage*, and thereby, lowered rates of unintended pregnancy.

Additionally, a 1995 IOM Report and a 2010 IOM Report seem at least to call into question the 2011 Report's global statements about cause and effect over the last three decades, with global statements of their own which were ignored in the 2011 Report. For example, the 1995 report states that "unintended pregnancy" is a "health condition of women for which little progress in prevention has been made despite the availability of safe and effective preventive methods."[97] The 2010 Report states that: "The committee considers that there has been no major progress in prevention of unintended pregnancy in light of the lack of decrease in rates over time and in comparison with rates in other countries."[98]

I will now consider the two cited studies on their own merits—insofar as their own content address the conclusions of the Report or the Mandate—and then as they have been criticized or called into question by other empirical scholars. Looking first at the Santelli and Melnikas study,[99] the Report cites it for the proposition that greater "*use*" of contraception "*produces* lower unintended pregnancy rates."[100] But when summarizing the study, the Report claims only that it demonstrates an "*association*" between rates of contraceptive use by adolescents from about the early 1990s to early 2000, and rates of unintended pregnancy.[101] In short, the Report itself acknowledges that the source does not prove what the Report claims.

Even if the Report sought to rely upon Santelli and Melnikas for the narrower proposition that among the *teen* population, greater access to contraception reduced unintended pregnancy, the Santelli and Melnikas study is unavailing. In parts not referenced by the Report, the study acknowledged the possibility that increasing access to contraception can

97. IOM 1995 REPORT, *supra* note 81, at 104.

98. INST. OF MED., WOMEN'S HEALTH RESEARCH: PROGRESS, PITFALLS, AND PROMISE 143 (2010).

99. Santelli & Melnikas, *supra* note 94.

100. IOM 2011 REPORT, *supra* note 10, at 105.

101. *Id.*

have the effect of altering sexual behavior in a way that leads to a higher probability of pregnancy, stating that an *increase in teen sexual activity* "followed closely the introduction of modern contraception in the 1960s."[102]

The Report also did not acknowledge that portion of Santelli and Melnikas in which the authors estimated that high school teens' abstinence from sexual activity contributed to at least 50% of the decline in teen pregnancy rates during the stated time period, with increased contraception usage contributing the other 50%,[103] nor did it reference the study's extended treatment of the many other factors that "may" have influenced rates of unintended pregnancy among teens, including the economy, changes in population composition, changes in family dynamics, social mores, the HIV/AIDS pandemic, or the media. Santelli and Melnikas concluded this discussion with the statement that they "*do not attempt to resolve this debate" about the "causes and consequences of teen pregnancy.*"[104] Yet the IOM Report treats this source precisely as if it has so resolved the debate.

Equally important, the Report failed to note that Santelli and Melnikas's conclusions are hotly disputed by other scholars who claim that greater abstinence and less frequent sexual activity were the most important factors driving the decline in teen pregnancies during the 1990s. In particular, a 2003 article in *Adolescent Health* concluded that: 67% of the reported decline in teen pregnancies from 1991-95 was due to increased abstinence and 35.3% was likely attributable both to increased contraceptive use, less frequent sexual activity, or both.[105]

The Report, further, did not even mention the significant body of expert literature suggesting an even more fundamental shortcoming of studies like Santelli and Melnikas's: the body of research showing that while declines in teen pregnancies may occur after contraception is rendered more accessible to teens who were *already* sexually active but not using it, with respect to teens who were *not* sexually active, increased access to contraception is associated with the normalization of nonmarital sex and an increase in teen sexual behaviors leading to *more* teen pregnancies and abortions overall. One of the most important studies in this vein was published by Duke University Professor Peter Arcidiacono. His analysis of data from the 1997 National Longitudinal Survey of Youth suggested that while access to contraception decreases teen pregnancy in the short run, it increases teen pregnancy in the long run by encouraging sexual activity.[106] As noted above, Santelli and Malnikas acknowledged this dynamic

102. *Id.* at 375.

103. *Id.* at 376.

104. Santelli & Melnikas, *supra* note 94, at 373, 377–78 (emphasis added).

105. Joanna K. Mohn, Lynne R. Tingle & Reginald Finger, *An Analysis of the Causes of the Decline in Non-Marital Birth and Pregnancy Rates for Teens from 1991 to 1995*, 3 ADOLESCENT & FAMILY HEALTH 39 (2003).

106. PETER ARCIDIACONO ET AL., HABIT PERSISTENCE AND TEEN SEX: COULD INCREASED ACCESS TO CONTRACEPTION HAVE UNINTENDED CONSEQUENCES FOR TEEN

once in their piece, but do not apply it to any period past the 1960s. Worse, they appear to endorse the normalizing of teen sexual experience which has been associated in the past with rising rates of unintended pregnancy. To wit, at the end of their paper they state that the United States "could learn much about reducing teen fertility by examining the *success* of Western European countries . . . For example, Dutch parents. . . are much more likely to *normalize teen sexual activity* and contraception use."[107]

The Report and the Mandate's decision to include ECs also likely undercut their goal of reducing unintended pregnancy, especially among teens. ECs were hoped by many to be the "answer" to teens' notoriously inconsistent or incorrect use of contraception. Yet not only have ECs failed to lower teen pregnancy rates according to every relevant study in myriad countries, but they are disturbingly and regularly associated with increases in teen pregnancy and abortion rates.[108] Teens even admitted to researchers in two studies conducted in 2000 and 2005 that they "had been more careless about birth control and more likely to have had unprotected sex" when ECs were easily available.[109]

EC is similarly ineffective at the population level. In a meta-analysis of twenty-three studies evaluating the effectiveness of Plan B, Princeton's Dr. James Trussel, whose work was relied upon by the IOM report elsewhere,[110] concluded that "*no study* has shown that increased access to [Plan B] reduces unintended pregnancy or abortion rates on a population level."[111]

Finally, the Report never grapples with Santelli and Melnikas's conclusion that unintended pregnancy is highest among a group which will *not* be affected by the Mandate: poor teenagers.[112] They consistently suffer the highest rates of teen pregnancy, but are covered by myriad govern-

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PREGNANCIES? (2005), *available at* http://public.econ.duke.edu/~psarcidi/addicted13.pdf.

107. Santelli & Melinkas, *supra* note 94, at 379–80 (emphasis added).

108. Jose Luis Dueñas et al., *Trends in the Use of Contraceptive Methods and Voluntary Interruption of Pregnancy in the Spanish Population during 1997-2007*, 83 CONTRACEPTION 82 (2011) (showing that over ten year period, 63% increase in contraceptive use was accompanied by 108% increase in abortion rate); *see also* David Paton, *The Economics of Family Planning and Underage Conceptions*, 21 J. HEALTH ECON. 207 (2002) (indicating that results such as those obtained in Spain, are results that logic and economics would predict).

109. Roni Caryn Rabin, *Teenagers and the Morning-After Pill*, N.Y. TIMES (Dec. 3, 2012), http://well.blogs.nytimes.com/2012/12/03/teenagers-and-the-morning-after-pill/?ref=ronicarynrabin.

110. IOM 2011 REPORT, *supra* note 10, at 108.

111. Elizabeth G. Raymond, James Trussel & Chelsea B. Polis, *Population Effect of Increased Access to Emergency Contraceptive Pills: A Systematic Review*, 109 OBSTETRICS & GYNECOLOGY 181 (2007) (emphasis added).

112. Santelli & Melinkas, *supra* note 94, at 373.

ment programs offering them free contraception. A recent Congressional Research Service report on teen pregnancy prevention,[113] explains why:

> An October 2006 study by the National Campaign to Prevent Teen Pregnancy estimated that, in 2004, adolescent childbearing cost U.S. taxpayers about $9 billion per year: in child welfare benefits, $2.3 billion; in health care expenses, $1.9 billion; in spending on incarceration (for the sons of women who had children as adolescents), $2.1 billion; in lost tax revenue because of lower earnings of the mothers, fathers, and children (when they were adults), $6.3 billion; and in offsetting public assistance savings (younger teens receive less annually over a 15-year period than those who give birth at age 20–21), $3.6 billion.[114]

Consequently, Congress has created a wide variety of federal programs to address teen pregnancy. In 1970, it created the National Family Planning Program, known as Title X of the Public Health Service Act.[115] In 2010, Title X–funded sites served more than five million patients, sixty-nine percent of whom were at or below the poverty level, via eighty-nine public and private grantees who in turn supported 4,389 individual service sites in all fifty states and the District of Columbia.[116] Teenagers represented one in four contraceptive clients served by publicly funded family planning centers in 2006, when they served nearly two million women younger than age twenty.[117] In fiscal year 2010, 317 million federal dollars were allocated for Title X family planning programs.[118] Likewise, both Title XIX of the Social Security Act (Medicaid)[119] and Title XX of the Social Security Act[120] provide federal funds to states for use in supporting pregnancy prevention services among both adolescents and older patients. The federal Maternal and Child Health Block Grant also funds 610 school-based or

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113. CARMEN SOLOMON-FEARS, CONG. RESEARCH SERV., TEENAGE PREGNANCY PREVENTION: STATISTICS AND PROGRAMS (2011), *available at* http://www.napcwa.org/home/docs/CRS_TeenPregPrevstats.pdf.

114. *Id.* at 3–4.

115. Title X Family Planning Program (Population Research and Voluntary Family Planning Programs), 42 U.S.C. § 300 (2006).

116. CHRISTINA FOWLER ET AL., RTI INT'L, FAMILY PLANNING ANNUAL REPORT: 2010 NATIONAL SUMMARY 7-8, 21 (2011), *available at* http://www.hhs.gov/opa/pdfs/fpar-2010-national-summary.pdf.

117. *Facts on Publicly Funded Contraceptive Services in the United States*, GUTTMACHER INST. (May 2012), http://www.guttmacher.org/pubs/fb_contraceptive_serv.html.

118. *See* FOWLER ET AL., *supra* note 116, at 1.

119. 42 U.S.C. § 1396 et seq. (2010).

120. *Id.*; *see also* GUTTMACHER INST. & KAISER FAMILY FOUND., MEDICAID: A CRITICAL SOURCE OF SUPPORT FOR FAMILY PLANNING IN THE UNITED STATES (2005), *available at* http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf.

"school-linked" health clinics.[121] These clinics provide "family planning" advice and services to adolescents.[122] In short, even the "association" between contraceptive access and unintended pregnancies among teenagers is called into question when the teens already receiving an extraordinary amount of free contraception account for the highest rates of teen pregnancy, according to one of two studies cited for the central proposition in the IOM Report.

Turning to the second study cited by the Report for the claimed connection between increased access to contraception and lower unintended pregnancy rates, a Guttmacher Institute report[123] cited for the specific proposition that: "as the rate of contraceptive use by unmarried women increased in the United States between 1982 and 2002, rates of unintended pregnancy and abortion for unmarried women also declined."[124] On its face, the use of this report poses several problems.

First, this Guttmacher report considers unmarried women only, and only for a twenty-year period. It cannot be generalized to *all* women in a population, nor can it suffice to prove that rising contraceptive usage during *all* periods will cause declines in rates of unintended pregnancy and abortion.

Second, this Guttmacher source is contradicted by other data, not mentioned in the Report, but also produced by the Guttmacher Institute. For example, two Guttmacher journal studies show that while unintended pregnancy rates were about 54% in 1981, and declined to 44.7% in 1994,[125] they increased by 2001 to 51%, and remained flat or edged higher through 2006.[126] This period nearly overlaps with the period considered in the source cited in the Report, a period during which the cited source claims that women's use of contraception *increased* from 80% to 86%.[127]

Also, looking at an even longer stretch of time—the period from the 1970s to today—a period during which both a Guttmacher journal and the CDC report that the percentage of women who had "ever used" con-

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121. Title V, Social Security Act, 42 U.S.C. §§ 701–710 (2010), *amended by* Pub. L. No. 112-240, 126 Stat. 2313 (2012); *see also* SOLOMON-FEARS, *supra* note 113, at 7.

122. U.S. DEP'T OF HEALTH & HUMAN SERVS., OMB NO: 0915-0172, GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT 50 (n.d.), *available at* ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf (focusing on Form 11 titled, "Tracking Performance Measures").

123. BOONSTRA ET AL., *supra* note 95.

124. IOM 2011 REPORT, *supra* note 10, at 105.

125. Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSP. 24 (1998).

126. 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); MOSHER & JONES, *supra* note 91 at 376-77.

127. IOM 2011 REPORT, *supra* note 10, at 105 (citing BOONSTRA ET AL., *supra* note 95, at 18).

traception rose from about 90% to 99%—unintended pregnancy rates in the U.S. population rose from 35.4%[128] to approximately 49% today.[129]

Additional studies cast doubt upon the Report's reliance on just the one Guttmacher study for its claim of a causal connection between increased usage of contraception and lowered unintended pregnancy rates among unmarried women generally. One of these studies is a CDC report tracking the use of contraception from 1982 to 2008. It concluded that "[c]hanges in contraceptive method choice and use have not decreased the *overall* proportion of pregnancies that are unintended between 1995 and 2008."[130] Another study, a Guttmacher report on unintended pregnancy between 2001 and 2006, reached the same conclusion.[131] It did so despite CDC data showing that more women in the years between 2002 and 2008 were accessing methods of contraception deemed "more effective" by the IOM, the CDC, and Guttmacher. To wit: between 2002 and 2008, women's resort to ECs rose from 4% to 10%, to sterilization from 13% to 17%, to the pill from 15.6% to 17.3%, and to injectable contraceptives from 0% to 2%.[132]

It should also be remembered that the rise in unintended pregnancy rates from 44.7% to 51% between 1994 and 2001—before they settled at the rate of approximately 49% from 2001 to 2006—occurred during a period of time when, as the Report acknowledges, twenty-eight states passed laws quite similar to the Mandate.[133] These laws required a greater degree of private insurance coverage for contraception,[134] with seventeen of the twenty-eight requiring further that insurance cover the associated outpatient visit costs.[135] This is an important dynamic that the Report completely neglected to address.

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128. Christopher Tietze, *Unintended Pregnancies in the United States, 1970-1972*, 11 FAM. PLAN. PERSP. 186, 186 n.* (1979) ("A recent report estimates that in 1972, 35.4% percent of all U.S. pregnancies were 'unwanted' or 'wanted later', thus providing, from, an independent source, an estimate very close to the one used here.").

129. Finer & Henshaw, *supra* note 126.

130. Jo Jones, William Mosher & Kimberly Daniels, *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, NAT'L HEALTH STAT. REP., Oct. 2012, at 1, 11, *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf.

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

132. MOSHER & JONES, *supra* note 91, at 5.

133. IOM 2011 REPORT, *supra* note 10, at 108.

134. For a discussion of the twenty-eight states which, between 1996 and 2007, passed some form of contraceptive mandate, see *Insurance Coverage for Contraception Laws*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/insurance-coverage-for-contraception-state-laws.aspx (last updated Feb. 2012).

135. IOM 2011 REPORT, *supra* note 10, at 108, (citing GUTTMACHER INST., INSURANCE COVERAGE OF CONTRACEPTIVES (2011)).

There are four final points regarding the insufficiency of the IOM Report's treatment of the link between access to contraception and rates of unintended pregnancy, three brief and one longer. First, there are many reasons why even if women have access to contraception, they do not use it. These are treated below, tracing the link between the Mandate's assumption that increasing "access" by eliminating co-pays, will increase "usage." The Report does not even touch upon these reasons.

Second, there are many, many factors affecting rates of unintended pregnancy that were not identified or taken into account by the Report. They are understandably difficult to isolate and measure. Their prevalence might easily vary among different age cohorts within the U.S. population. These might include poverty rates, increasing rates of cohabitation (linked to higher rates of unintended pregnancy), later age at first marriage, and declining taboos associated with nonmarital sex, pregnancy, and birth.[136] Each of these factors might lead, for example, to indifference regarding pregnancy, mixed intentions, or competing intentions as between a father and an expectant mother. The IOM Report does not even allude to these, nor does it suggest that the two studies it relied upon to demonstrate a causal relationship between contraception and unintended pregnancy claimed to have controlled for the influence of these other factors.

Third, while there *is* a strategy that might work to produce lower rates of unintended pregnancies via increased access to contraception, it is not the same as the strategy advanced by the Report or the Mandate, and it raises as many questions and concerns as it answers. It involves providing free long-acting, reversible contraception to lower income women. It is a strategy endorsed by the IOM, which stated that "it is thought that the greater use of long-acting reversible contraceptive methods . . . might help further reduce unintended pregnancy rates. Cost barriers to use of the most effective contraceptive methods are important . . . ."[137] The American College of Obstetricians and Gynecologists has written that LARCs should be "first line" choices for young women.[138]

This strategy was tested in a recent study[139] the conclusions of which were widely publicized in 2011, and celebrated by Professor John Santelli,

136. *Facts on Unintended Pregnancy in the United States*, GUTTMACHER INST., http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html (last updated Jan. 2012).

137. IOM 2011 REPORT, *supra* note 10, at 108.

138. ACOG Committee on Practice Bulletins, *Clinical Management Guidelines for Obstetricians-Gynecologists; Intrauterine Device*, 105 OBSTETRICS & GYNECOLOGY 223 (2005); *see also Increasing Use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, ACOG Comm. Opinion (Am. Coll. of Obstetricians & Gynecologists, Washington, D.C.), Dec. 2009, at 2, *available at* http://www.acog.org/About%20ACOG/ACOG%20Departments/Long%20Acting%20Reversible%20Contraception/~/media/Departments/LARC/co450.pdf.

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

author of one of the two articles cited by the IOM Committee,[140] as conclusive evidence for the wisdom of the Report's recommendations and the Mandate. The study involved recruiting women from the St. Louis area, a disproportionate percentage of whom were poor (37% public assistance), African American (50%), and less educated (35% with high school degree or less). They were encouraged to switch to longer acting contraceptive drugs and devices ("LARCs") for a three to ten year period. Researchers contacted the patients seven times over the first three years of use in order to monitor and encourage continued usage. After three years, rates of teen births and abortions declined significantly.

The study's findings have been called into question—given its lack of a control group, its indirect and incomplete manner of measuring "effects," and the possibility of a selection effect, i.e., the women and girls enrolled were more highly motivated to avoid a future pregnancy, many of them having been recruited from abortion clinics where they had recently undergone an abortion.[141] Also, for several reasons, its strategy of encouraging women toward specific, and "more effective" methods of contraception, raises as many questions and concerns as it answers, both about women's health and women's freedom. First, women are often dissatisfied with what are considered the "more effective" methods of birth control urged by the researchers conducting this study. According to a CDC report, relied upon in the IOM Report, 30% of women "ever" using the pill discontinued it because they were "dissatisfied with it." This is also true of 43% of women who ever used the Depo Provera injectable and 50% of women who ever used the contraceptive patch.[142] A very low percentage of women, about 5%, have ever chosen to use the IUD.[143] In the St. Louis study, only 5% of women had chosen LARCs prior to participation in this study; but researchers ultimately persuaded 75% of the women involved to take them up.

Second, this pattern raises some red flags related to the moral hazard of encouraging particularly less-privileged women to use LARCs. It should not be forgotten that only two decades ago, no fewer than seven states were seriously proposing offering Norplant TM—a surgically implanted hormonal contraceptive, lasting about five years—to women and girls, as a

140. Brian Alexander, *Free Birth Control Cuts Abortion Rate Dramatically, Study Finds*, NBC NEWS (Oct. 4, 2012), http://vitals.nbcnews.com/_news/2012/10/04/14224132-free-birth-control-cuts-abortion-rate-dramatically-study-finds?lite ("'What the study suggests to me,' said John Santelli, professor at Columbia University's Mailman School of Public Health, 'is that it's totally supportive of the president's provisions on reproductive care and preventive services for women in the Affordable Care Act.'").

141. Michael J. New, *New Study Exaggerates Benefits of No-Cost Contraception*, NAT'L REV. ONLINE (Oct. 10, 2012), www.nationalreview.com/corner/329898/new-study-exaggerates-benefits-no-cost-contraception-michael-j-new.

142. MOSHER & JONES, *supra* note 91, at 13.

143. *See, e.g.*, *Contraceptive Use in the United States*, GUTTMACHER INST. (last visited Feb. 21, 2013), http://www.guttmacher.org/pubs/fb_contr_use.html.

*quid pro quo* for ordinary or increased welfare benefits. The vast majority of the targeted populations were African American.[144] Also, once these young women are temporarily sterilized, with drugs and devices sometimes requiring surgical implantation and removal such that they "require less action by the women"[145] for three to ten years, the government, and likely the affected women and girls, are more than likely to fall into the trap of believing that all relevant consequences of sex are being managed. The psychological or spiritual consequences of sex without marriage, or a lesser form of commitment, and the consequences for rates of sexually transmitted diseases, discussed below, will almost certainly be neglected.

Third, it appears that the longer acting contraceptive drugs and devices more often pose both increased health risks for women, treated below, and the potential to act to destroy already-formed embryos, as discussed above.

Fourth and finally—and requiring a bit more extensive consideration—there is a growing body of scholarship, treated below, indicating that the persistence or worsening of high rates of unintended pregnancy, abortion, and sexually transmitted diseases, and also our nation's high rates of nonmarital births (the chief predictor of female poverty), are the "logical" result—in economic and psychological terms—of the new marketplace for sex and marriage made possible by increasingly available contraception (in some cases, combined with available abortion).

It is widely acknowledged that while contraception is often effective on an individual level to avoid conception, or birth, its effects on a social level might well be different. It was acknowledged by John Santelli, in his study cited favorably by the Report.[146] It has been written about from sociological and historical perspectives.[147] The twin rise in the availability of contraception and rates of nonmarital sexual encounters, pregnancies and births, was also predicted by its inventors and supporters, at the time when the "pill," was introduced at a population-wide scale. Dr. Min-Chueh Chang, for example, one of the co-developers of the birth control pill, reflected: "I personally feel the pill has rather spoiled young people. It's made them more permissive."[148] Dr. Alan Guttmacher, former director of the International Planned Parenthood Federation, further suggested that legal abortion would render contraception even less effective. "[W]hen an abortion is easily obtainable contraception is neither actively nor diligently used. . . . [I]f we had abortion on demand, there would be no

144. Jeanne L. Vance, Note, *Womb for Rent: Norplant and the Undoing of Poor Women*, 21 HASTINGS CONST. L.Q. 827, 853 (1994), *available at* http://www.hastingsconlawquarterly.org/archives/V21/I3/Vance.pdf.

145. IOM 2011 REPORT, *supra* note 10, at 108.

146. *See* Santelli & Melnikas, *supra* note 94.

147. Judith Treas, *How Cohorts, Education, and Ideology Shaped a New Sexual Revolution on American Attitudes Toward Nonmarital Sex*, 45 SOC. PERSP. 267 (2002).

148. Charles E. Rice, *Nature's Intolerance of Abuse*, ALL ABOUT ISSUES 6 (Aug. 1981).

reward for the woman who practiced effective contraception."[149] More recently, economists have taken on the question of the relationship between contraception (and sometimes abortion) and rates of nonmarital sex, pregnancy, and abortion. None of their material is referenced by the IOM Report. Yet it is a vast and respected literature which can only be treated in summary form here.

In perhaps the most well-known paper on this subject—*An Analysis of Out-of-Wedlock Childbearing in the United States*[150]—Nobel prize-winning economist George A. Akerlof and his colleagues describe the path of women's increased participation in nonmarital sexual relations as a result of "technical changes": the increased availability and legalization of both contraception and abortion. The authors claim that, as compared with other explanations of nonmarital pregnancies and births—including but not limited to welfare theory or job theory—their "technology shock" hypothesis, combined with the declining stigma of a nonmarital birth—can better explain the magnitude and timing of changes in the numbers and rates of nonmarital pregnancies and births. They conclude that the current sex and mating market enabled by contraception and abortion operates to the disadvantage of women, and the relative advantage of men, due to a series of incentives structured by their availability. First, "[w]hen the cost of abortion is low, or contraceptives are readily available, potential male partners can easily obtain sexual satisfaction without making . . . promises [to marry in the event of pregnancy] and will thus be reluctant to commit to marriage."[151] Single women thus feel "pressured," because if they do not participate in sex, they are at a classic "competitive disadvantage" because "[s]exual activity without commitment is increasingly expected in premarital relationships."[152] "If they ask for . . . a guarantee [of marriage in the event of pregnancy], they are afraid that their partners will seek other relationships."[153] Even women who want children, reject contraception and abortion, and want a marriage guarantee as a condition for sex, have nonmarital sex anyway because it is the price of entering the mating market. Such a market is therefore likely to produce higher rates of sexual activity, nonmarital pregnancy, nonmarital births, and abortions all at the same time. This is indeed what has happened since the widespread legalization and availability of both contraception and abortion, despite predictions by pro-choice groups that widespread contraception would reduce all other named outcomes, and that legalized abortion would reduce nonmarital births.

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149. Alan Guttmacher, Speech at the Law, Morality, and Abortion Symposium, Rutgers University Law School (Mar. 27, 1968), *in* 22 RUTGERS L. REV. 415, 437 (1968).

150. George A. Akerlof, Janet L. Yellen & Michael L. Katz, *An Analysis of Out-of-Wedlock Childbearing in the United States*, 111 Q.J. ECON. 277 (1996).

151. *Id.* at 290.

152. *Id.* at 280.

153. *Id.* at 290.

Economist Timothy Reichert brings additional insight to the question of the effects of contraception on the "mating market," as he depicts women's current situation as a case of what economists call the "prisoners' dilemma."[154] A prisoners' dilemma is any "social setting wherein all parties have a choice between cooperation and noncooperation, and . . . all parties would be better off if they choose cooperation," but—like prisoners being held for questioning in separate chambers—none can "effectively coordinate and enforce cooperation, [so] all parties choose the best *individual* choice, which is non-cooperation."[155] As a result, everyone involved is worse off.

According to Reichert, the prisoners' dilemma operates for women in the mating market as follows: first, contraception "lowers the costs of premarital and extramarital sexual activity below the level necessary for a separate sex market to form."[156] In other words, sex without the "cost," of pregnancy becomes the norm, such that sexual partners do not even have to consider the possibility of marriage. To this point, Reichert's analysis is quite similar to Akerlof, Yellen, and Katz's. Next, however Reichert takes a new, albeit not contradictory, approach, and claims to explain yet another negative consequence of the current mating market—women's marital unhappiness. He claims that more women than men begin populating what he calls the "marriage market" at a younger age because women generally want to have children sometime during their lives, but are biologically constrained to have them when they are younger. Women also know that stable marriage is better for children. By their early 30s, therefore, most women have entered the marriage market. Men have no similar, inbuilt impetus to leave the sex market and enter the marriage market. Thus, women have more "power" in the sex market, where they are relatively scarce, but face more competition in the marriage market, where they are competing with more women for fewer men. Reichert reasons that this translates into women more often striking "bad deals" at the margins in the marriage market, leading to a later desire for divorce. In fact, it is well-established today that women file for divorce approximately two times as often as men. Reichert suggests that women will eventually go along with attaching a lesser stigma to divorce, too, since they may want to exercise this option someday. This, in turn, leads to their entering marriage with less commitment, and with more concern to invest in income-producing skills in the event they need to support themselves and their children alone. Men respond rationally by doing the same.

In sum, according to Reichert, women are disadvantaged in the current mating market at least respecting their hopes to marry, to marry in time to have children, and to remain stably married. He further suggests that women are disadvantaged with respect to abortion because contracep-

154. Timothy Reichert, *Bitter Pill*, 203 FIRST THINGS 25 (2010).
155. *Id.* at 33.
156. *Id.* at 26.

tion leads to greater demand for abortion. Contraception promises to allow "women [to] rationally plan their human capital investments,"[157] but if things go awry and threaten their investments, abortion appears necessary.

Considering this scholarship in the "women's health" terms adopted by the IOM Report, at the very least it is possible, rationally, to conclude that the normalization of sex dissociated from commitment, marriage, or children might harm women over the long run. Sexual relationships without commitment, nonmarital pregnancies and births, abortion, and divorce are all associated with diminished mental, emotional, and sometimes physical outcomes for women. The Report's failure even to consider these renders its conclusion about contraception and women's health at best premature and simplistic, and at worst wrong.

c. Does Unintended Pregnancy Cause Harm to Women's Health?

Even if it could be demonstrated that greater access to contraception, by eliminating co-pays, could reduce unintended pregnancy rates, there is little persuasive evidence that the health conditions the Report claims women suffer while unintentionally pregnant, or thereafter, are *caused* by the unintended pregnancy. Evidence indicates rather that that causation might occur in the reverse order, *or* that both the unintended pregnancy and the health conditions—smoking, drinking, domestic violence, and depression—proceed from a third factor which is associated with *both* the claimed independent variable (unintended pregnancy) and claimed dependent variable (the health condition). In the case of unintended pregnancy, some literature suggests that the third factor might be "risk taking" or "poverty." According to the analysis of the IOM Report by Professor Austin Hughes:

> When a statistically significant association is reported between any two phenomena, it is important to be aware of the possible explanations for such an association. It is always possible that a statistically significant association might occur in a given data set by chance alone; thus, it is important that any study reporting a significant association be replicated on as many different populations as possible. Assuming that chance alone is not responsible for an observed association, there are three possible causal patterns that might account for it. Consider an association between two phenomena, A and B. It is possible that A causes B, or that B causes A. Furthermore, it is possible that there is a third phenomenon (C) that causes both A and B. Both IOM (1995) and IOM (2011) fail to provide a straightforward discussion of these logical alternatives.[158]

157. *Id.* at 30.

158. *See* Hughes, *supra* note 79, at 5.

Furthermore, in addition to the material set forth immediately above about the link between contraception and increased rates of unintended pregnancies, nonmarital births, abortion, and even divorce, there is additional evidence that greater use of contraception, including particularly the LARCs favored by the IOM Committee and its witnesses, can *harm* women's health.

The material in this subsection considers the Report's evidence, and what it omitted, concerning a relationship between unintended pregnancy, and women's health. The Report claims that unintended pregnancy can cause the following harms to women's health: excessive smoking and drinking during pregnancy, depression, and domestic violence.[159] Immediately it should be noted that the IOM's prior extensive report on unintended pregnancy acknowledged freely that "research is limited" regarding negative outcomes from unintended pregnancy.[160] It also stated in the same report that studies regarding women's health and unintended pregnancy are *not* able to demonstrate definitively "whether the effect is *caused by* or *merely associated with* unwanted pregnancy."[161] Yet the 2011 Report several times uses the language of "causality" or "the consequences" of unintended pregnancy, while failing to cite studies demonstrating causality.[162]

Turning to the Report's claim regarding domestic violence and depression as consequences of unwanted pregnancy, the Report cites the meta-analysis—a review of numerous papers treating a single topic—written by Gipson.[163] But the Report fails to reveal that the Gipson study's authors concluded there that, "[a]ssessing the relationship between pregnancy intention and its potential health consequences is fraught with a number of measurement and analytical concerns."[164] It also stated that "although longitudinal data may provide some inferences about the observed associations, *causality is difficult if not impossible to show*."[165] Regarding psychosocial health and unintended pregnancy, the authors state "In light of the paucity of studies . . . and their limitations in terms of establishing causality, the existing research should only be considered to be suggestive of such an impact."[166] In its conclusion, the authors stated:

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159. IOM 2011 REPORT, *supra* note 10, at 103.

160. IOM 1995 REPORT, *supra* note 81, at 103.

161. *Id.* at 65. Although the Report insists that it is not important to sort this out, this is both irrational and not the legal standard required in connection with a compelling governmental interest.

162. IOM 2011 REPORT, *supra* note 10, at 103.

163. *See id.*; *see* also Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 STUD. FAM. PLAN. 18 (2008).

164. Gipson et al., *supra* note 163, at 19.

165. *Id.* at 20 (emphasis added).

166. *Id.* at 29.

> The existing evidence on the impact of unintended pregnancy on child and parental health outcomes is mixed and is limited by an insufficient number of studies for some outcomes and by the aforementioned measurement and analytical concerns.[167]

Echoing Professor Hughes, it further notes "[a]n additional concern . . . that both health outcomes and pregnancy intentions may be jointly determined by a single, often unobserved factor."[168]

On the question of women's depression after a birth, Professor Hughes states that within the Gipson paper, the most relevant paper cited is a 1991 Australian study comparing rates of anxiety and depression immediately before, and up to six months after, a birth, between mothers whose pregnancies were described as "wanted" at the time of pregnancy and mothers whose pregnancies were described as "unwanted."[169] For mothers with no history of mental illness prior to pregnancy, 5.1% of mothers of "unwanted" infants experienced depression six months after birth, as compared with 2.6% of mothers of "wanted" infants. Causation could not clearly be established. Further, given the Australian study's reliance on the categories of wanted/unwanted, it is not clear whether it included both "mistimed" and "unintended" pregnancies (the subject of the Report) in the "unwanted" category. Further, even though the rate of depression was nearly twice as high in the mothers with "unwanted" infants as in mothers with "wanted" infants, the rates of depression were actually quite low in both groups.[170] In short, the 2011 Report did not offer any clear or significant causal relationship between depression and unintended pregnancy.

The 2011 Report also reads as if domestic violence is caused by unintended pregnancy, treating such violence in the paragraph about the "consequences of an unintended pregnancy for the mother."[171] It cites the IOM 1995 Report for this proposition although, as quoted immediately above, that report said that studies regarding women's health and unintended pregnancy were *not* able to demonstrate definitively "whether the effect is caused by or merely associated with unwanted pregnancy."[172] Furthermore, the 2011 Report failed to divulge the literature showing that the causation may well be reversed: i.e., domestic abuse may be a causal factor for unintended pregnancy. Scientists have proposed the likelihood of this chain of causation due to the tendency of abusive relationships to create an environment in which the likelihood of unintended pregnancy

167. *Id.* at 20.

168. *Id.*

169. *See* Hughes, *supra* note 79, at 8 (citing J.M. Najman et al., *The Mental Health of Women 6 Months After They Give Birth to an Unwanted Baby: A Longitudinal Study*, 32 SOC. SCI. & MED. 241 (1991)).

170. *See id.*

171. IOM 2011 REPORT, *supra* note 10, at 103.

172. IOM 1995 REPORT, *supra* note 81, at 65.

is increased—including in an article co-authored by Dr. Santelli, whose study on teen pregnancy is one of the two studies the Report cites for claiming a relationship between contraception access and rates of unintended pregnancy among teens.[173]

Regarding the claimed effects of unintended pregnancy on women's smoking and drinking, the IOM's 1995 Report had earlier admitted, respecting this alleged relationship, that these figures "drop significantly where studies control for other causes."[174] Furthermore, other studies indicate, quite plausibly, that causation regarding excess drinking and smoking may also be reversed, or that there is a third factor—a woman's risk-taking preferences—which accounts both for her unintended pregnancy and her smoking and drinking habits.[175] There is also the fact that virtually all mothers who smoke during pregnancy were smokers before getting pregnant.[176]

Given all of these possibilities—none seriously considered by the Report—the Report's recommendation to increase access to contraception in order to prevent women's smoking and drinking during pregnancy, whether these are directed toward the woman's health, or the child's, as discussed above, and to prevent depression and domestic violence, might easily be unavailing or ineffective. Also, and as already reported above, the preventive services recommended by the USPSTF, already required by the ACA to be provided without a co-pay, include counseling for pregnant women concerning smoking and drinking. And domestic violence prevention is a separately recommended preventive service for women within the 2011 IOM Report itself.[177]

The Report further failed to consider that increasing access to contraception—associated with a message of sexual expression as freedom, and the good of sexual expression outside of the context of a relational commitment, or parenting—might itself harm women's health. This is undoubtedly quite contested territory, but there is relevant evidence of two types: first, about a possible relationship between large contraception programs and increasing rates of sexually transmitted infections ("STIs"); and second, about the effects of contraceptive drugs and devices on women's

173. Jacquelyn C. Campbell et al., *The Influence of Abuse on Pregnancy Intention*, 5 WOMEN'S HEALTH ISSUES 214 (1995); Patricia M. Dietz et al., *Unintended Pregnancy Among Adult Women Exposed to Abuse or Household Dysfunction During Their Childhood*, 282 J. AM. MED. ASS'N 1359 (1999) (noting that this is co-authored by, among others, Dr. John S. Santelli).

174. IOM 1995 REPORT, *supra* note 81, at 68–69, 75.

175. Timothy S. Naimi et al., *Binge Drinking in the Preconception Period and the Risk of Unintended Pregnancy: Implications for Women and Their Children*, 111 PEDIATRICS 1136 (2003); Carolyn Westhoff et al., *Smoking and Oral Contraceptive Continuation*, 79 CONTRACEPTION 375 (2009); Gregory J. Colman & Ted Joyce, *Trends in Smoking Before, During, and After Pregnancy in Ten States*, 24 AM. J. PREVENTIVE MED. 29 (2003).

176. Colman & Joyce, *supra* note 175, at 29-35.

177. IOM 2011 REPORT, *supra* note 10, at 117.

bodies and health. On the first matter, Professor Hughes has summarized that there exists:

> [E]pidemiological evidence support[ing] the hypothesis that the widespread availability of contraception in the U.S. after the 1960's was accompanied by an unprecedented epidemic in STIs. From 1966 to 1987, the number of genital human papilloma virus infections in the U.S. increased about sevenfold, and the number of genital herpes virus infections increased eleven fold in the same period. Gonorrhea and syphilis infections, which had decreased greatly by the 1950's due to the availability of antibiotics, rebounded substantially after the 1960's. At the present time, diseases caused by the sexually transmitted bacteria *Chlamydia trachomatis* and *Neisseria gonorrhoeae* are the most commonly reported notifiable diseases (i.e., diseases that must be reported by law) in the U.S. And of course a newly emerged STI, human immunodeficiency virus-1 (HIV-1), gained a foothold in the U.S. population during the same period.
>
> Because STIs are spread almost entirely by sexual activity with multiple partners, the problems of determining cause and effect that usually plague studies of epidemiological associations do not arise in this case. The STI epidemic is itself *prima facie* evidence that contemporary U.S. society has seen a substantial increase in non-marital, multiple-partner sexual activity. There is abundant evidence that availability of contraception was accompanied by widespread changes in attitudes toward non-marital sexual activity in the U.S. population. Therefore, it is reasonable to conclude that the current STI burden on the U.S. population is at least in part a consequence of widespread access to contraception.[178]

Additional research has replicated this result: among women in a U.S. city who used an injectable contraceptive versus women who did not use a hormonal contraceptive,[179] and among young women given increased pharmacy access to emergency contraception,[180] STI rates increased in both cases.

It has also been observed theoretically in a law and economics analysis, that it makes sense that lowering the price of sex increases the quantity demanded. Speaking first about the causal relationship between legaliz-

178. Hughes, *supra* note 79, at 12 (citations omitted).

179. Charles S. Morrison et al., *Hormonal Contraceptive Use, Cervical Ectopy, and the Acquisition of Cervical Infections*, 31 SEXUALLY TRANSMITTED DISEASES 561 (2004).

180. Christine Piette Durrance, *The Effects of Increased Access to Emergency Contraception on Sexually Transmitted Disease and Abortion Rates*, ECONOMIC INQUIRY (Dec. 5, 2012), http://onlinelibrary.wiley.com/doi/10.1111/j.1465-7295.2012.00498.x/abstract.

ing abortion and increased rates of certain STIs, two economics scholars write:

> What is clear, however, is that the CDC and medical authorities in general have not . . . considered that changes in institutions can cause changes in the relative prices faced by individuals. Instead, the medical community tends to attribute the changes in STD rates to fluctuating social mores, changing demographics, and changing diagnosis patterns. As indicated by our results, ignoring the effects of changing incentives precludes an accurate understanding and modeling of this epidemiological phenomenon.[181]

Respecting the effects of an increased access to contraception, the authors then conclude that: "As an unplanned pregnancy is one of the costs of sexual activity, the effect of contraception availability is similar to the effect of abortion availability. If contraception is used . . . the expected costs decline, leading to an increase in the quantity of sex demanded."[182] STIs being, intrinsically, a measure of multiple-partner sexual activity,[183] they are likely to increase with an increase in the quantity of non-monogamous sex in a population.

Nowhere does the IOM Report consider a potential relationship between its recommendation, and a potential for further "lowering the price of sex," in a way that might result in higher rates of STIs.

Finally, the IOM does not consider in sufficient detail the potential negative health effects of contraception upon women.[184] The Report says only that "for women with certain medical conditions or risk factors, some contraceptive methods may be contraindicated,"[185] and that there are "side effects" which are "generally considered minimal."[186] It adds an exception for "oral contraceptive users who smoke."[187] Several brief re-

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181. Jonathan Klick & Thomas Stratmann, *The Effect of Abortion Legalization on Sexual Behavior: Evidence from Sexually Transmitted Diseases*, 32 J. LEGAL STUD. 407, 431-32 (2003) (footnote omitted).

182. *Id.* at 410.

183. *See* Hughes, *supra* note 79, at 12.

184. A brief filed in one of the cases against the Mandate takes up in detail the question of the threat to women's health posed by some contraception. *See* Brief Amici Curiae of Women Speak for themselves, Bioethics Defense Fund, and life Legal Defense Foundation in Support of Plaintiffs-Appellants, O'Brien v. Dep't of Health & Human Servs., No. 12-3357 (8th Cir. 2012). It argues that "the Government entirely failed to consider the robust body of medical evidence indicating that hormonal contraceptives have biological properties that significantly increase women's risk of breast, cervical, and liver cancer, stroke, and a host of other diseases including the acquisition and transmission of human immunodeficiency virus (HIV)." *Id.* at 3.

185. IOM 2011 REPORT, *supra* note 10, at 105.

186. *Id.*

187. *Id.*

sponses highlight the insufficiency of the Report's treatment on this matter.

First, as of 2008, over 18% of American women smoke—i.e., approximately 21.1 million women.[188] This is a large cohort of women who might both receive free hormonal contraception as a consequence of the Report and the Mandate, while being admittedly quite susceptible to harms from hormonal contraceptives.

Second, there is an irony within the Report relative to women's health. While the Report states that women with particular health difficulties need to avoid becoming pregnant,[189] and may have a greater need for contraception, it fails to note that these *very women* might be at the greatest risk from using especially the more highly recommended methods, LARCs. Among the diseases the Report highlights are included: pulmonary hypertension, cyanotic heart disease, and Marfan Syndrome (a connective tissue disorder). Yet these are precisely the diseases for which leading, specialized medical associations recommend cheaper barrier or natural contraceptive methods, as distinguished from many of the more expensive hormonal methods the Report hopes to incentivize.[190]

Third, the Report ignores a large and deep literature about the negative effects of particular contraceptives, especially LARCs. As summarized by Professor Hughes:

> Although contraceptive methods prescribed in the U.S. are believed to be without harmful side-effects in most cases, there is a long history of discussion and controversy regarding the potential deleterious side-effects of certain contraceptives, especially [oral contraceptives]. To consider just one example, a recent meta-analysis found a small but significant association between increased breast-cancer risk and long-term [oral contraceptive] use. Not all studies have found such an association; and, as with

188. *Women and Tobacco Use*, AM. LUNG ASS'N, http://www.lung.org/stop-smoking/about-smoking/facts-figures/women-and-tobacco-use.html (last visited Feb. 20, 2013).

189. IOM 2011 REPORT, *supra* note 10, at 103–04.

190. *See, e.g.*, *Patient Information: Marfan Syndrome*, HEART DISEASE & PREGNANCY, http://www.heartdiseaseandpregnancy.com/pat_mar_mom.html (last visited Feb. 20, 2013); *ACHA Q and A: Birth Control for Women with Congenital Heart Disease*, HEART MATTERS (2008), http://www.achaheart.org/Portals/0/pdf/Library%20Education/ACHA-Q-and-A-Birth-Control-for-Women-with-CHD.pdf (reporting that "barrier methods" are "safe for all users," but that risks are greater regarding various of hormonal methods, especially pills containing estrogen, and certain IUDS); PULMONARY HYPERTENSION ASS'N, BIRTH CONTROL AND HORMONAL THERAPY IN PAH (2002), *available at* http://www.phassociation.org/document.doc?id=1684 (reporting that "[t]he two safest methods of birth control are 1) the barrier method, which may include condoms in men and/or a diaphragm with spermacide in women, and 2) a vasectomy in the male partner for a woman with PAH in a monogamous (one partner) relationship. . . . [N]early half of the specialists did not advocate using BCP for their patients, and some actively discouraged patients from doing so . . . .").

> any association study, this association does not necessarily imply a causal relationship. However, there are over 200,000 new breast cancer cases per year in the U.S., with a medical care cost per patient of $20,000-$100,000. If even a small fraction of these cases are due to [oral contraceptives], this would add substantially to the public health and economic costs of contraceptive use.[191]

Referring to the "long history of discussion and controversy" referenced by Professor Hughes, one should note that it is well known to the point of coverage in the *New York Times* that "taking a combination hormone birth control pill—which contains estrogen and a progestin hormone—can increase the risk of stroke and blood clots in the legs and lungs."[192] Further, various forms of birth control pills[193] and IUDs,[194] the latter with and without hormonal elements, have been the subject of myriad class action lawsuits in which leading pharmaceutical corporations have paid hundreds of millions of dollars to settle. The World Health Organization continues to list some hormonal contraceptives as a group 1 carcinogen.[195] Leading cancer associations including the American Cancer Society[196] and the International Agency for Research on Cancer (IARC)[197] as well as the World Health Organization, and the National Cancer Institute refer especially to estrogen-progesterone oral contraceptives as "known carcinogens."[198]

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191. Hughes, *supra* note 79, at 12 (citations omitted).

192. Natasha Singer, *Health Concerns over Popular Contraceptives*, N.Y. TIMES (Sept. 25, 2009), http://www.nytimes.com/2009/09/26/health/26contracept.html?n=Top%252fNews%252fBusiness%252fCompanies%252fBayer%20A%252eG%252e&_r=1&.

193. Howard Ankin, *Bayer Healthcare Reaches Settlement in Yaz/Yasmin Lawsuits*, ANKIN LAW OFFICE L.L.C. (May 7, 2012), http://www.ankinlaw.com/blog/bayer-healthcare-reaches-settlement-in-yazyasmin-lawsuits/.

194. *Mirena IUD Lawsuit Update: Mirena IUD Adverse Event Reports to the FDA Exceed 45,000*, SFGATE (Nov. 26, 2012), http://www.sfgate.com/business/prweb/article/Mirena-IUD-Lawsuit-Update-Mirena-IUD-Adverse-4067514.php#ixzz2GYR9cWxp.

195. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*, INT'L AGENCY FOR RESEARCH ON CANCER, http://monographs.iarc.fr/ENG/Monographs/vol72/index.php (last visited Feb. 22, 2013).

196. *Known and Probable Human Carcinogens Introduction*, AM. CANCER SOC'Y, http://www.cancer.org/cancer/cancercauses/othercarcinogens/generalinformationaboutcarcinogens/known-and-probable-human-carcinogens (last visited Feb. 20, 2013).

197. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*, *supra* note 195.

198. WORLD HEALTH ORG., CARCINOGENICITY OF COMBINED HORMONAL CONTRACEPTIVES AND COMBINED MENOPAUSAL TREATMENT (2005), *available at* 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).

Additionally, quite recently, a study also suggested strongly that injectable LARCs may double the risk of contracting and transmitting HIV,[199] to the point that even the World Health Organization is considering "re-evaluating . . . clinical recommendations on contraceptive use."[200]

Finally, in a report concerning preventive health care for women which does indicate, albeit far too briefly, some of the negative health effects of contraception, it is curious to see a recommendation for contraception for women and girls *only*. In other words, it is at least surprising that there is no suggestion at all regarding placing any of the burden of contraception upon males. Male contraception is neither addressed nor recommended in the Report. Yet fifty-two years after the launch of the birth control pill, no pharmaceutical company has seen fit to develop hormonal or other birth control products for men for reasons having to do with the burdens and side-effects of contraceptive usage. In the words of *Mother Jones Magazine*:

> A male pill might have to be easier on the body than female contraceptives, too. Women have long complained of weight gain, moodiness, and other birth control side-effects . . . . A recent clinical trial for a male contraceptive delivered via injection (similar to Depo-Provera for women) was ended early despite promising early results due to participants' complaints about side-effects such as depression, increased libido, and mood changes.
>
> Diana Blithe, a program director at the National Institute for Child Health and Human Development, says that "The reality is we could get a product out there very quickly if companies would aggressively take on the process of making it happen," she said. But until consumers really ask for that product, or until marketing studies show it would really sell, US companies really have little to gain by developing a male contraceptive. Since condoms are widely available, protect against STDs, and have very few if any side-effects, it may be a long wait.[201]

This divergent treatment of men and women is simply "built in" to the Report, not questioned.

To conclude this section on the health consequences of contraceptives themselves, it should at least be noted that it is very curious that a government report on the subject of preventive care for women does not pay greater deference to important statements about the health risks to

199. Renee Heffron et al., *Use of Hormonal Contraceptives and Risk of HIV-1 Transmission: A Prospective Cohort Study*, 12 LANCET 19 (2012).

200. Pam Belluck, *Contraceptive Use in Africa May Double Risk of H.I.V.*, N.Y. TIMES (Oct. 3, 2011), http://www.nytimes.com/2011/10/04/health/04hiv.html?pagewanted=all.

201. Jen Quraishi, *Birth Control for Men: Why the Wait?*, MOTHER JONES (June 17, 2011), http://www.motherjones.com/blue-marble/2011/06/hormonal-contraceptives-men-why-wait.

women, particularly of hormonal contraception, articulated by the World Health Organization and USAID. This Article is not a scientific study, and does not make the claim that most contraceptives are intrinsically dangerous to most women. But it can assert, on the evidence available, that there are serious and ongoing disputes over the safety and the negative external consequences of widely available contraception, especially when this is paired with the notion that sex and procreation are not weighty or important matters—the latter notion being an element of the contraceptive project, as described earlier.

Rather than consider any of the relevant data, however, the Report devotes a total of six lines of text to risks of contraceptives. By contrast, it devotes hundreds of lines of text to contraception's claimed powers of preventing the birth of unintended children, and an additional ten lines to the benefits of contraceptive "separate from the ability to plan one's family and attain optimal birth spacing."[202] These latter benefits include its claimed potential for reducing endometrial and ovarian cancer—the second noted to be a more tenuous proposal—and treating "menstrual disorders, acne or hirsutism [hairiness] and pelvic pain."[203]

2. *Abortion Rates and Women's Health*

While the Report does not squarely identify abortion as a problematic health outcome for women that contraception could prevent, it certainly suggests that avoiding abortion is a good outcome of increased contraceptive usage.[204] Obviously, the thrust of the Report concerns the relationship between contraception and unintended pregnancy. But lowered abortion rates are nonetheless mentioned. Such an outcome is regularly mentioned by supporters of large-scale contraception programs such as the Guttmacher Institute and Planned Parenthood, even while the same groups regularly support unlimited access to legal abortion. It is understandably designed to attract the support of Americans opposed to legal abortion.

For the proposition that increased contraception usage lowers abortion rates, the Report cites a Guttmacher report entitled "Abortion in Women's Lives,"[205] the same study used to support the claim that more contraception usage drives down rates of unintended pregnancies. A later section amply documents that this latter claim is at least doubtful at the population level; this section raises similar doubts about the claim regarding abortion rates. Like the link with unintended pregnancy rates, the link between contraception and abortion rates seems intuitively true. Yet again, what might be true on an individual scale for a contraception user who is motivated to avoid pregnancy, turns out not to be true on a social

202. IOM 2011 REPORT, *supra* note 10, at 107.
203. *Id.*
204. *Id.* at 103.
205. *Id.* at 105 (citing BOONSTRA ET AL., *supra* note 95).

scale. First, I will take a closer look at the Guttmacher source used, and then look at relevant evidence the Report did not consider.

Page 18 of the Guttmacher source cited in the Report claims that among *unmarried* women between 1982 and 2002 there was a 6% rise in the proportion of women using contraception and a decline in both unintended pregnancy rates and abortion rates—it acknowledges that *married* women's abortion rates did not change significantly.[206]

First, it should be noted that the Guttmacher report is a claim about unmarried women only, not about the population; the Report and the Mandate, however, are about all women of childbearing age at risk for unintended pregnancy.

Second, the Guttmacher source does not assert causation between contraceptive usage and abortion rates. Many factors affect abortion rates: the economy, mores, and changes in relationship and family structures, to name just a few. The cited Guttmacher study makes no effort to control for all of these factors. It simply says that contraceptive usage "*accompanied*" lower rates in unintended pregnancies and that the latter are a "key determinant" of abortion rates.[207] Then, without further evidence it concludes: "Thus, the increase in contraceptive use *contributed* significantly to the decrease in abortion rates among unmarried women."[208] Third, the Guttmacher report concerns one slice of time (1982-2002) over a long period of time during which both contraception and abortion have been legally available—1973 to today.

Fourth, on the page following the page relied upon by the IOM, the Guttmacher source states that: "[w]hen the desire for small families takes hold in a society, the initial result is often an increase in both contraceptive use and abortion. Over time, however, increasing levels of contraceptive use are accompanied by falling abortion rates."[209] The chart illustrating this claim, figure 3.3 on page 17, showed data from about 1983 to 2002. Beginning in 1983, it showed a rise in the percentage of unmarried women at risk of unintended pregnancy using contraceptives, and a corresponding decrease in unintended pregnancies per 1,000 unmarried women. But the chart omits reporting on the years 1970 to 1982; during these years, access to contraception was rising—especially due to the passage of the federal Title X program distributing large quantities of contraception—but abortion rates were *climbing* not falling. These rates climbed from about 14 per 1,000 women of childbearing age in 1973 to 24 per 1,000 in 1979—the rate increased all the way to 29 per 1,000 in 1980. It was only after this simultaneous *rise* in rates of contraception usage and abortion that abortion rates began to fall.

206. BOONSTRA ET AL., *supra* note 95, at 18.
207. *Id.*
208. *Id.*
209. *Id.* at 19.

Turning now to material concerning the relationship between contraception and abortion, which material is not considered in the Report. First, it should be noted that some of the drugs and devices covered by the Report and the Mandate act as embryocides, i.e., early abortifacients. It is not accurate to claim that a drug or device that *causes* an early abortion *prevents* abortion.

Second, at the level of the larger society, normalizing sex dissociated from commitment and from parenting, can lead to higher, not lower abortion rates, as people become simultaneously more willing to risk sex without a marital commitment, and less willing to tolerate the frustration of their intentions to avoid pregnancy. This explanation not only forms the basis for the law and economics' analyses linking greater contraceptive access to higher abortion rates,[210] but also helps explain two phenomena. First, using contraception is associated with a greater inclination to pursue abortion. For many years, it has been the case that women using contraception in the month they became pregnant are more likely to seek an abortion than women who were not using contraception at all.[211] It is also the case, as demonstrated by the most recent St. Louis study in which women were strongly encouraged to use, and continue using, LARCs over a period of three to ten years, that use of LARCs was associated with lower numbers of abortions, but *higher abortion ratios.* In other words, ordinarily, one of four pregnancies is aborted in the United States,[212] but in the St. Louis study, there was *one abortion for every one live birth* among a group of women encouraged in large numbers to use what they were told were the most effective contraceptives.[213] Their intention to avoid childbirth may thereby have been strengthened, leading to a greater willingness to seek and undergo an abortion. Third, the Report presumes that the *only study it cites* about the linkage between contraception and abortion relies upon accurate data about abortion rates over time. But reported abortion rates are notably unreliable.[214] The Centers for Disease Control has never made abortion reporting mandatory. Only forty-five states have consistently reported data to the CDC since 1999.[215] Historically, its results undercounted abortion as compared with the results reported by the Guttmacher Institute, although even Guttmacher would have difficulty

210. For a further discussion, see *supra* notes 88–157 and accompanying text.

211. RACHEL K. JONES ET AL., GUTTMACHER INST. CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008 7-8 (2010), *available at* http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf.

212. KAREN PAZOL ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, ABORTION SURVEILLANCE—UNITED STATES, 2007 (2011), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6001a1.htm.

213. *See* Peipert et al., *supra* note 139, at 6.

214. CHARLES A. DONOVAN & NORA SULLIVAN, CHARLOTTE LOZIER INST., ABORTION REPORTING LAWS: TEARS IN THE FABRIC 1, 14 (2012), *available at* http://www.lozierinstitute.org/wp-content/uploads/2012/12/American-Report-Series-ABORTION-REPORTING-LAWS.pdf.

215. *Id.* at 4.

getting reliable results from states which refrain from reporting at all, or which have only voluntary reporting. Several of these states have vast populations and are believed to have some of the highest rates of abortion in the nation. These include:[216] California, Washington, D.C., New Jersey, and Maryland.[217]

Even with the evidence of record, however, the Report is likely incorrect to conclude that "evidence exists" that "greater use of contraception within the population produces lower . . . abortion rates nationally."[218] Rates of contraception usage have not been associated consistently with lowered abortion rates. Even more importantly, abortion rates may decline for a time *only after* there had previously taken place a twin rise in the availability of contraception and in the rates of abortion. Interestingly, the only countries the cited 2006 Guttmacher report discusses at length regarding a time series from *before* the introduction of contraception to the present, are countries with what might be called an "amoral" resort to abortion: Hungary, Russia, and South Korea.[219] In other words, there is evidence that in each of those countries, abortion was not regarded as a real moral dilemma, of the wrenching nature it is considered in the United States;[220] it was rather the major form of "birth control" before true forms of contraception were introduced on a large scale. Not surprisingly, the introduction in those countries of contraception reduced the resort to abortion, although even in two out of three of those countries, contraceptive access was *first* correlated with rising rates of abortion. The United States is different from these types of countries. Abortion was and is a significantly fraught moral issue, personally and politically. When contraception was introduced here, its major effect was not to replace abortion and drive abortion rates down, but first to drive up rates of nonmarital sexual intercourse, and associated nonmarital pregnancies and abortions, before, in some selected years, helping to reduce the abortion rate. Its future effects are by no means certain.

3. *Will the Mandate, by Making Contraception and EC's "Free," Increase Effective Usage and Depress Unintended Pregnancy Rates?*

Even assuming that the Report employed a reliable measure of unintended pregnancy rates, *and* showed a causal relationship between increased contraception usage and rates of unintended pregnancy, *and* showed that unintended pregnancy is causally related to worse health outcomes for women, the Report has not shown that the government has a "compelling state interest" in forcing employers to offer "free" contracep-

216. *Id.* at 8.

217. *Id.*

218. IOM 2011 REPORT, *supra* note 10, at 105.

219. BOONSTRA ET AL., *supra* note 95 at 19.

220. *See, e.g.*, Kate Pickert, *40 Years Ago, Abortion Rights Activists Won an Epic Victory With* Roe v. Wade*: They've Been Losing Ever Since*, TIME, Jan. 14, 2013, *available at* http://www.time.com/time/covers/0,16641,20130114,00.html.

tion and ECs, unless it demonstrates further that this last command increase the effective *usage* of contraception so as to lower unintended pregnancy rates among the population. This section will demonstrate that the Report fails to meet this challenge.

First, the Mandate, and the IOM Report on which it is based, is addressed to an audience—employed women and the daughters of the employed receiving health insurance from an employer—which is not responsible for the vast majority of unintended pregnancies in the United States. These occur among poorer Americans who are already amply provided free or very low cost contraception. Second, there is the fact that even among users of contraception, pregnancy occurs with great regularity. Third, there are many factors affecting women's decisions regarding contraceptive usage. Cost is one of them, but it is not a large factor. Also, to the degree cost is important at all, it applies for the most part to women with lesser incomes, who, as stated above, are already amply supplied with free or low cost contraception by a myriad of federal and state programs.

On the first point, regarding the targeted audience: rates of unintended pregnancy are highest among groups the mandate will not affect—the poorest adolescents and women who are already served by myriad federal and state programs. The Report itself makes this observation; it notes that non-use of contraception is particularly likely among women who "have a low income, who are not high school graduates, and who are members of a racial or ethnic minority group."[221] Many other private and public studies conclude similarly,[222] as does the Finer and Henshaw study relied upon by the IOM Report on page 102. That study states the rate of unintended pregnancy for women below the poverty line is three times that of women above 200% of the poverty level.[223] The rate among college graduates is 26 per 1,000 women, but for women who did not finish high school, 76 per 1,000 women.[224] Another source trusted by the IOM Committee, the Guttmacher Institute, concludes in its January 2012 fact sheet on unintended pregnancy that the rate of unintended pregnancy among low income women is five times the rate of the highest income women.[225]

The Report already acknowledges that low income women are amply supplied with free or almost free contraception. Page 108 of the Report refers to contraceptive coverage as "standard practice for most federally funded insurance programs."[226] It cites its availability in community

221. IOM 2011 REPORT, *supra* note 10, at 102.

222. *See, e.g.*, Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 294, 297-98 tbl.3 (2002) (noting that Table 3 displays percent of women obtaining abortions who had not been using contraceptive method in month of conception).

223. Finer & Henshaw, *supra* note 126, at 90.

224. MOSHER & JONES, *supra* note 91.

225. *Facts on Unintended Pregnancy in the United States*, *supra* note 136, at 108.

226. IOM 2011 REPORT, *supra* note 10, at 108.

health centers, family planning centers, and Medicaid. It goes further with respect to Medicaid, and points out that since 1972 it has "required coverage for family planning in all state programs and has exempted family planning services and supplies from cost-sharing requirements."[227] It points out that twenty-six states also have their own Medicaid family programs for women who do not technically qualify for Medicaid.[228] In congressional testimony, Secretary Sebelius has also added that contraception is available at many other places including "community health centers, public clinics, and hospitals with income based support."[229] An editorial in the *New England Journal of Medicine* estimates that community health centers may be serving as many as 40 million Americans (up from 20 million) in coming years.[230] Additionally, of course, there are drug stores, large retail chains and Planned Parenthood, and other clinics receiving hundreds of millions of dollars of federal and state aid annually.

On the second point, contraception fails, even among regular users, with the CDC estimating that twelve percent of all women using contraception will become pregnant each year,[231] and with contraceptive users constituting the majority of patients of abortion clinics. Even for women using LARCs, a Guttmacher Institute journal estimated "first year" failure rates of the condom at fourteen percent, with eight percent for the pill, and four percent for LARCs.[232] Fourteen or twelve percent or four percent of users across a large population is still a large number of women experiencing an unintended pregnancy. These numbers indicate that even if the Mandate could narrow the gap between the eighty-nine percent of "at risk" women currently using contraception today, and one hundred percent, the result in terms of the total percentage of unintended pregnancies would be quite small. If one further considers that most women still will not choose LARCs, perhaps as many as ten percent of the new eleven percent of users would experience unintended pregnancy. And of course, any calculations about the overall effects of increased access to contraception should take into consideration the possibility that this might lead to more women and girls becoming sexually active.

Third, with the possible exception of its effect on the uptake of LARCS, as already discussed and critiqued, a Mandate making contraception "free" for employed women and the daughters of the employed, is not likely to close or even substantially narrow the small gap between the vast majority of such women currently using contraception effectively, and those who are not, because the latter have many reasons other than cost—

227. *Id.*

228. *Id.*

229. Press Release, Dep't of Health & Human Servs., *supra* note 4.

230. Eli Y. Adashi et al., *Health Care Reform and Primary Care—The Growing Importance of the Community Health Center*, 362 NEW ENG. J. MED. 2047, 2048 (2010).

231. MOSHER & JONES, *supra* note 91, at 4.

232. Nalini Ranjit et al., *Contraceptive Failure in the First Two Years of Use: Differences Across Socioeconomic Subgroups*, 33 FAM. PLAN. PERSP. 19, 21 (2001).

reasons not addressed at all by the Mandate—for avoiding some or all contraception usage. In order to pursue this claim, I will first treat the matter of the currently high rates of usage of contraception, then indicate that the group targeted by the Mandate is already using it at rates exceeding the national average, then consider the many reasons other than price why some women are not using contraception.

On the matter of current usage of contraception, the IOM acknowledges that usage rates are high. With regard to extant private insurance coverage, for example, the Report states that: "contraceptive coverage has become standard practice for most private insurance and federally funded insurance programs."[233] It adds that that "private employers have also expanded their coverage of contraceptives as part of the basic benefits packages of most policies."[234] It reports on a 2010 survey indicating that eighty-five percent of large employers and sixty-two percent of small employers already offer coverage of FDA-approved contraceptives.[235] Further, according to the Guttmacher Institute, nine of ten employer-based insurance plans already cover the full range of prescription contraceptives.[236] The Report continues, saying that about ninety-nine percent of women ages fifteen to forty-four who had *ever* had sexual intercourse with a male had used at least one contraceptive method.[237] The Guttmacher Institute adds that among women seeking to avoid pregnancy eighty-nine percent are already practicing contraception.[238]

On the matter of contraceptive usage by the women targeted by the Mandate, the material immediately above indicates that employed women and the daughters of the employed already have a high level of access to contraception via their employer plans. Also women with more education and income generally use contraception at higher rates than the poor. This is a well-documented and persistent phenomenon.[239] Finally, more affluent women not only use contraception more regularly, but they also tend to use what researchers call "more effective methods," more often than their poorer sisters.[240]

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233. IOM 2011 REPORT, *supra* note 10, at 108.

234. *Id.*

235. *Id.* at 109.

236. *Contraceptive Use in the United States*, *supra* note 143 (citing Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 36 PERSP. ON SEXUAL AND REPROD. HEALTH 72 (2002)).

237. IOM 2011 REPORT, *supra* note 10, 103, (citing MOSHER & JONES, *supra* note 91).

238. *Contraceptive Use in the United States*, *supra* note 143.

239. Jones et al., *supra* note 222, at 298; *Contraceptive Use in the United States*, *supra* note 143 (citing Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 36 PERSP. ON SEXUAL AND REPROD. HEALTH 72 (2002)); *Facts on Induced Abortion in the United States*, GUTTMACHER INST. (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

240. *See, e.g.*, Tanya M. Phares et al., *Effective Birth Control Use among Women at Risk for Unintended Pregnancy in Los Angeles, California*, 22 WOMEN'S HEALTH ISSUES 351 (2012).

Regarding cost as a factor respecting usage, several indicators suggest that it is at most, a small factor. The Report does not cite a single source indicating otherwise. First, as a very general matter, it should be noted that contraception is used *at higher rates* by those who pay *more* for it, than among those who receive it *free* or at very low cost, indicating in a general way that cost is not a very significant factor.[241] Second, myriad surveys of women and girls in the United States reveal that many other factors trump cost with regard to women's decision not to use contraception. In fact a CDC report cited in the Report for the ninety-nine percent "ever use" figure,[242] shows that, among the eleven percent of American women and girls at risk of unintended pregnancy who are *not* practicing contraception, lack of access is not a significant reason.[243] Rather among the subset of women who experienced "unintended pregnancy," leading reasons included: they did not think they could get pregnant (44%); they did not expect to have sex (14%); they "didn't really mind" if they got pregnant (23%); or they were "worried about the side effects" of birth control methods (16%). The proportions of women citing other reasons were much smaller. In fact, of its list of "frequently cited reasons for nonuse" the CDC did not list financial reasons at all.[244]

A 1996 study of adolescents listed as the "most frequently cited reasons for not using contraceptives prior to conception": "I didn't mind getting pregnant" (20%) and "I wanted to get pregnant" (17.5%), followed by "I was using birth control but it didn't work (broke)" (12%), "I thought there was something wrong with me and I couldn't get pregnant" (9%), and "I just didn't get around to it" (9%).[245] Again, cost was not mentioned as a factor. Finally, in Guttmacher and CDC reports on the rise in unintended pregnancies in the early 2000s among women in their 20s and 30s, unintended pregnancy rates among women ages twenty-five to twenty-nine rose from 66 to 71 per 1,000 women, and among ages thirty to thirty-four, from 38 to 44 per 1,000, the authors did not include the cost of birth control among the explanations. Rather they listed: more sexual activity, inconsistent use of birth control, ambivalence about getting pregnant, and worries about the "biological clock."[246] A CDC report on women's choice of birth control methods also indicates that women are not for the most part leaving the more effective methods of contraception due to cost, but rather because of side effects they attribute to the method.[247]

241. Jones et al., *supra* note 222; *Facts on Induced Abortion in the United States*, *supra* note 239.

242. IOM 2011 REPORT, *supra* note 10, at 103.

243. MOSHER & JONES, *supra* note 91, at 6.

244. *Id.* at 14.

245. Catherine Stevens-Simon et al., *Why Pregnant Adolescents Say They Did Not Use Contraceptives Prior to Conception*, 19 J. ADOLESCENT HEALTH 48 (1996).

246. Amy DePaul, *Unintended Pregnancy Down Among Teens But Up for Young Adults*, ALTERNET (Sept. 13, 2007), http://www.alternet.org/story/62429/unintended_pregnancy_down_among_teens_but_up_for_young_adults.

247. MOSHER & JONES, *supra* note 91, at 13–14.

Finally, Professor Austin Hughes points out that in a Guttmacher source the IOM Report overlooked,[248] only 3.7% of the total sample of women who were seeking abortions listed financial reasons as the cause for their not using contraception. The authors of the study did not investigate further to determine what percentage of 3.7% of women could not objectively afford it, or how many were eligible for free or low cost contraception via one or more government programs.

Finally, regarding the relationship between income and contraceptive usage, long-term studies of contraception uptake among poorer populations worldwide indicate instead that cost and lack of access are not terribly important factors. The percentage of women reporting cost barriers as a reason for not using contraception ranged from a high of 4% to a low of 0.6%. Access barriers were reported by a high of 0.5% of women to a low of 0.3% of women, while health concerns or opposition to the use of contraception accounted for the largest share of reasons.[249] Harvard University development economist Lant Pritchett writes that surveys of poorer women who "do not want a child and are not using contraception" about why they are not using it, include:

> [A]nswers like that they dislike the side effects, that they are no longer fecund, they are sexually inactive, that they have religious objections, that their husband is out of the country for a year. That is, many women give reasons suggesting they do not want contraception and only a few cite access or price as reasons for their "unmet need" status attributed to them.

He concluded: "The lesson that actual implementation of family planning programs has consistently found is that getting uptake is hard, not just slapping it out there."[250]

In light of all of this material, how does the Report make the case for a causal relationship between cost and effective usage of contraception so as to cause the rate of unintended pregnancies in the United States to decline? It devotes one paragraph on page 109—in the contraception section—to the question, and a few paragraphs earlier in the Report, where the Report is considering the *general* question of cost and access to health care, not contraception particularly. The page 109 reference states that cost-sharing requirements can result in less use of preventive and primary care services, *particularly for low income populations*, citing a 2003 Hudman

248. Jones et al., *supra* note 222, at 297–98 (detailing in Table 3 percentage of women obtaining abortions who had not been using contraceptive method in month of conception, by reported reasons for nonuse.)

249. WORLD BANK, UNMET NEED FOR CONTRACEPTION 1, 3–4 (2010).

250. Berk Ozler, *Is There an "Unmet Need" for Birth Control*, WORLDBANK BLOGS (Apr. 7, 2011 7:37), http://blogs.worldbank.org/impactevaluations/is-there-an-unmet-need-for-birth-control-0.

and O'Malley article about cost-sharing and low income populations.[251] This source is little help to the government's case. First, as already discussed, neither the Report nor the Mandate is about health insurance for low income populations, but for employed women and the daughters of the employed. Consequently, an article about the effect of cost sharing on low income populations is not relevant. Looking more closely at Hudman and O'Malley, one further finds that this piece acknowledges that not all studies find a relationship between cost sharing and access to primary and preventive services.[252] Finally, Hudman and O'Malley never make particular findings about contraception as a preventive service.

The second article cited on page 109 of the report is claimed to prove that "[e]ven small increments in cost sharing have been shown to reduce the use of preventive services, such as mammograms."[253] First, it should be noted that this article was specifically about mammograms only, not contraception, so it cannot provide any information or guidance about cost sharing and contraception. Second, the article studied only women using Medicare, and measured only "enrollees . . . between the ages of 65 and 69." As 65 is a common retirement age, and an age at which women are generally infertile, this study considered few if any women affected by the Mandate.

The most relevant study cited by the Report in this section claims to demonstrate that eliminating co-pays increases women's resort to LARCs versus other methods of contraception.[254] This study does not claim to show that more women overall will resort to contraception *usage* when contraception is free, nor that more women will remain faithful to LARCs over more than a few years—despite women's regular dissatisfaction with such methods[255]—only that more will consider using LARCs over other methods. But if government enthusiastically supported an increased resort to LARCs, as already suggested above, this might well reduce unintended pregnancy rates over time. The physical, emotional, and moral hazards of such a strategy are not considered in the Report.

Also regarding the relationship between cost and access, an earlier section of the Report treats this question with respect to preventive health care generally, not with specific reference to contraceptives.[256] First, it cites a Kaiser Family Foundation study for the claim that women are more

251. IOM 2011 REPORT, *supra* note 10, at 109 (citing JULIE HUDMAN & MOLLY O'MALLEY, HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE PREMIUMS AND COST-SHARING: FINDINGS FROM THE RESEARCH ON LOW-INCOME POPULATIONS 1 (2003), *available at* http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost-Sharing-Findings-from-the-Research-on-Low-Income-Populations-Policy-Brief.pdf).

252. *Id.* at 1–2.

253. *Id.* at 19 (citing Amal N. Trivedi et al., *Effect of Cost Sharing on Screening Mammography in Medicare Health Plans*, 358 NEW ENG. J. MED. 375 (2008)).

254. *Id.* at 109.

255. *See supra* note 232 and accompanying text.

256. IOM 2011 REPORT, *supra* note 10, at 19–20.

likely than men to report cost barriers to accessing medical care.[257] But the study is inapposite; it asked men and women if they *or a family member* had delayed or forgone health care in the past year because of cost. Women reported, by a few percentage points more than men, that they or a family member (*male or female*) had done so.[258] The Report also cites other studies claiming that women delay various preventive care treatments due to costs,[259] but none consider contraception specifically.

### C. *Concluding Thoughts about the IOM Report*

This Article has expended more space on the question of the relationship between mandatory "free" contraception and women's health than did the IOM Report itself. This is indicative not only of the genuine complexity of the topic, and the inability to make simple cause and effect connections and predictions about it, but also of the possibility that the IOM did not so much conduct an investigation of the topic as they did draft a brief on behalf of a preordained position. The lone dissenter to the IOM Report—Dr. Anthony Lo Sasso—was likely accurate when he wrote:

> The 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.[260]

His conclusions are supported by the doubtful objectivity of the IOM process as indicated by the prior commitments of so many of the panel members and invited witnesses. These matters have been fully documented in a set of comments submitted to HHS in 2011,[261] but a few highlights include the following: At least nine of the sixteen panel members had close ties with the nation's largest provider of government-subsidized birth control, and the largest abortion provider, Planned Parenthood—serving as members or even chairs of boards of directors of various Planned Parenthood affiliates nationwide. They had recently donated over one hundred thousand dollars to that organization. Others founded or worked directly for other contraception and abortion advocacy groups. Invited witnesses included Planned Parenthood, the abor-

257. *Id.* at 19 ("Indeed, women are consistently more likely than men to report a wide range of cost-related barriers to receiving or delaying medical tests and treatments and to filling prescriptions for themselves and their families.").

258. HENRY J. KAISER FAMILY FOUND., IMPACT OF HEALTH REFORM ON WOMEN'S ACCESS TO COVERAGE AND CARE 3 (2010), *available at* http://www.kff.org/womenshealth/upload/7987.pdf.

259. IOM 2011 REPORT, *supra* note 10, at 19–20.

260. *Id.* at 207.

261. Letter from Anna Franzonello, Ams. United for Life, to Ctrs. for Medicare and Medicaid Servs. (Sept. 29, 2011), *available at* http://www.freedom2care.org/docLib/20110929_AmericansUnitedforLifepreventiveservicescomment.pdf.

tion advocacy groups the National Women's Law Center, and the Guttmacher Institute. There was no representative on the panel, or as a witness, from the leading private provider of health care to women in the United States: Catholic health care services.

In sum, the IOM Report did not prove any of the following: that it used a reliable and consistent measure of unintended pregnancy; that there is a relationship between contraceptive usage and unintended pregnancy or abortion rates; that unintended pregnancy causes poor health outcomes for women; that rates of contraceptive usage are driven by cost; or that increasing usage among the objects of the Report—employed women and the daughters of the employed—will affect rates of unintended pregnancy which are highest among women already provided with free or low-cost contraception from the government. The IOM Report also did not consider the several categories of well-developed literature bearing on the subject of the links between contraceptive usage and women's health: physical side-effects of contraception; and the social changes effected by dissociating sex from commitment and from parenting.

## IV. THE FEDERAL GOVERNMENT HAS NOT SATISFIED THE COMPELLING STATE INTEREST TEST FOR BURDENING THE FREE EXERCISE OF RELIGION

The Religious Freedom Restoration Act[262] forbids the federal government from substantially burdening the exercise of religion unless the burden: (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.[263] This obtains even if the "burden results from a rule of general applicability."[264] A compelling governmental interest analysis also applies to federal and state laws burdening free exercise which are not "neutral laws of general applicability," according to the jurisprudence interpreting the First Amendment of the U.S. Constitution.[265] This Article does not take up the matter of the Mandate's substantial burden on free exercise, nor does it address the question of its "neutrality" or "general applicability." It does, however, suggest that in whatever context—RFRA or the First Amendment—the federal government is required to show a "compelling governmental interest" in the Mandate, the government should fail, based upon its failure to demonstrate such an interest in the Report the government claims provides its evidentiary basis for the Mandate.

The government's interest in the Mandate, as suggested by the Report, but also as specifically articulated by the Secretary of the responsible

262. 42 U.S.C. § 2000bb (2006). RFRA applies to laws passed by the federal government. *See* Gonzales v. O Centro Espirita Beneficiente Uniao do Vegetal, 546 U.S. 418, 419–20 (2006).

263. 42 U.S.C. § 2000bb-1(b).

264. *Id.* § 2000bb-1(a).

265. *See generally* Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520 (1993).

agency, HHS, is: to "increase access to contraceptives"[266] in order to benefit women's health. A recent U.S. Supreme Court decision engaged in an extended discussion of what a government must demonstrate in order to show that it possesses a "compelling interest" in promulgating a law. The case was the First Amendment free speech decision: *Brown v. Entertainment Merchants Association*.[267] There, the Supreme Court struck down California's law restricting minors' access to violent video games on the grounds that the state had failed the compelling governmental interest analysis. The decision strongly indicates that the shallow, disputed, and incomplete argument on behalf of the Mandate will not satisfy a compelling state interest test.

The standard announced by the Court in *Brown* was as follows: the state must "specifically identify an 'actual problem' in need of solving," and that the burden on the constitutional right is "actually necessary" to the solution.[268] It may not make a merely "predictive judgment" about a direct causal link based upon competing studies.[269] It may not rely upon "ambiguous proof."[270]

In *Brown*, California relied primarily upon the research of one Ph.D. "and a few other research psychologists whose studies purport to show a connection between exposure to violent video games and harmful effects on children."[271] The Court rejected these as proof of a compelling state interest due to the following defects: first, the state was required to "prove" that the thing it is regulating is the "cause" of the harm it is seeking to prevent.[272] Evidence of "correlation" (versus "causation") was insufficient. So, additionally, were studies with "significant, admitted flaws in methodology."[273] Further, even if causation could be shown, evidence that the "effects" are "small" and "indistinguishable" from effects produced by things *not* regulated, renders the legislation underinclusive—the Court used the expression "wildly underinclusive."[274] The Court continued: "[u]nderinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint."[275]

Further, if there is only a "modest gap" between the government's ultimate goal and the current situation on the ground, "the government

266. Press Release, Dep't of Health & Human Servs., *supra* note 4. ("This rule will provide women with greater access to contraception by requiring coverage and by prohibiting cost sharing.").

267. 131 S. Ct. 2729 (2011).

268. *Id.* at 2738.

269. *Id.*

270. *Id.* at 2739.

271. *Id.*

272. *Id.*

273. *Id.*

274. *Id.* at 2740.

275. *Id.*

does not have a compelling interest in each marginal percentage point by which its goals are advanced."[276] This last observation referred to a potential twenty percent gap between the video industry's practices regarding restraining minors' access to violent video games, and the California law's intention to require explicit parental or aunt or uncle approval.

Applying *Brown*'s summary of a "compelling governmental interest" analysis to the case at hand, it is not difficult to see how the federal government has failed, by a wide margin, to demonstrate such an interest with respect to the Mandate. There is, first, real empirical uncertainly about how to measure the "unintended pregnancy" the government wishes to prevent. Thus the state may not have identified an "actual problem" in need of solving.

Even, however, if the state had articulated a well-supported and consistent measure over time, of the meaning of unintended pregnancy, it did not show that the burden on religions' free exercise is "actually necessary" to solving the problem of unintended pregnancy. Rather, the government relied upon an intuitive or "predictive judgment" of a direct causal link between no-cost contraception and reduced rates of unintended pregnancy, and upon unsupported claims regarding causal links between unintended pregnancy and women's health outcomes. It seemed to rely upon the intuition that what is true on an individual scale—contraception can prevent a pregnancy—must be true on a social scale; but to do so it had to ignore a large and developed literature indicating that this has not been consistently true in the past, and that there are rational reasons—economic and psychological reasons, among others—why large scale contraceptive programs might produce different, even contrary results.

The government's proffer falls far short of the *Brown* standard. Like California in the *Brown* case, HHS here rested its finding on a relatively few studies. It didn't acknowledge let alone explore "competing studies"; its findings are a tiny drop in the ocean of the relevant literature and they are sometimes even strenuously contradicted by competing studies. This is exactly the kind of "ambiguous proof" the *Brown* Court rejected. Additionally, on the matter of "ambiguous proof," versus "prov[ing]" that the thing it is regulating is the "cause" of the harm it is seeking to prevent, the Report gave evidence only of "correlation" versus "causation," respecting the relationship between contraception and unintended pregnancy, *and* any relationships between unintended pregnancy and women's health. This is, according to *Brown*, insufficient de jure.

Finally, respecting the *Brown* requirement that any "causal" effects are more than "small," and not "indistinguishable" from effects produced by things which are *not* regulated—i.e., that the regulation is fatally underinclusive—it is easy to see from the evidence set forth above that laws addressing many *un*regulated things might have a greater effect upon women's decisions to use contraception and use it effectively—or to avoid

276. *Id.* at 2741 n.9.

smoking, drinking, depression, and violence during and after a pregnancy—than a law reducing its cost to zero. These include: making contraception safer in order to address women's fears about its safety; supporting research on male contraception; supporting fertility education, so more women and girls will know when they are likely to become pregnant (and in the case of the first three suggestions, assuming the government could overcome the objection that "unintended pregnancy" is not significantly related to women's health); and stepping up preventive education for women—especially in their late adolescence and early twenties—concerning smoking, drinking, depression, and domestic violence, etc. Some of these proposals get at the causes of women's health problems. Others answer the concerns raised by women and girls in interviews about why they are among the few who choose not to use contraception.

Regarding this "few," it should also be noted that there is here, in the case of the Mandate, a far smaller gap than the twenty percent gap called too "modest" in the *Brown* opinion to justify sweeping regulations to attempt to close the gap to zero. In the words of the *Brown* Court: "Even if the sale of violent video games to minors could be deterred further by increasing regulation, the government does not have a compelling interest in each marginal percentage point by which its goals are advanced."[277] As applied to the Mandate then, one might say that "even if contraceptive usage by women at risk of unintended pregnancy could be deterred further by increasing regulation, the government does not have a compelling interest in each marginal percentage point by which its goals are advanced." Yet, given that even one hundred percent contraception usage by "at risk women," would leave between four and fourteen percent of users pregnant each year due to use or method failure, the gap between eighty-nine percent usage and one hundred percent usage may not really be amenable at all to government "help" or mandates. Only some sort of state-monitored sterilization or LARCs program pressing *usage*, not mere *access* to contraception—a program undoubtedly falling hardest on those who are poor and a minority, and at greatest risk for unintended pregnancy—would make more than a few percentage points difference at all. It would seem that *Griswold v. Connecticut*[278] and *Eisenstadt v. Baird*[279] would at the very least, forbid this type of governmental invasion of individuals' and couples' constitutionally delineated right to decide about contraception. More to the point, however, this is not what the Mandate does. The Mandate fails the *Brown* test. The government cannot demonstrate that increasing access to contraception will produce lowered rates of unintended pregnancy among the women affected by the Mandate, or that,

277. *See id.*

278. 381 U.S. 479 (1965).

279. 405 U.S. 438 (1972).

even if it could, their health would thereby be improved. The Mandate fails the *Brown* test regarding a "compelling governmental interest."

## V. CONCLUDING THOUGHTS ON THE MANDATE, AND ON WOMEN AND RELIGIOUS FREEDOM

The practical effect of the HHS Mandate would be to render less visible the last and still visible objectors to the contraceptive project. These churches would be forced to sign on de facto if not theologically to the project. The Mandate would not only render their teachings more private—as they could no longer be shared *in practice* with employees or students, or clients, or patients—but it would de jure characterize their teachings as violations of women's freedom and equality.

This is troubling on its face, as it denigrates in substance a long held teaching of a religion espoused by about one quarter of American citizens. But things might also be worse. It might turn out that the government's efforts to advance women—by advancing the contraceptive project—harm women, in the various ways this Article suggests. This is possible because there is a rational and empirically supported possibility that women's freedom—including freedom from unwanted pregnancies, addictions, violence, and depression—is better achieved when women and men practice the virtues and disciplines expressed in the Christian and other churches' conscientious objection to the Mandate. This subject is too large to take up in an already lengthy Article. It should only be remarked here that the churches opposing the Mandate hold, and teach women and men to maintain, an understanding of the sacredness of sexual intercourse, and its intrinsic connection with the procreating of new, vulnerable, human life. These teachings are the natural precursors to fewer uncommitted sexual encounters, fewer unintended and nonmarital pregnancies, and fewer abortions. There is a great deal of evidence, in fact, indicating that women in particular benefit physically, mentally, and otherwise, from practicing the personal and religious disciplines flowing from these teachings. Consequently, there are good reasons to believe that their health will flourish in situations wherein the free exercise of religion is strongly protected. Not only do women, on average, practice their faiths more than men,[280] but among practicing Catholics and Christians generally, data shows that there is less nonmarital sex (a chief indicator of unintended pregnancy), more marriage, less cohabitation (thus less domestic abuse), and less excess drinking and depression.[281] Finally, across na-

280. *The Stronger Sex—Spiritually Speaking*, PEW FORUM ON RELIGIOUS AND PUB. LIFE (Feb. 26, 2009), http://www.pewforum.org/The-Stronger-Sex—Spiritually-Speaking.aspx.

281. *See, e.g.*, BYRON R. JOHNSON ET AL., CTR. FOR RESEARCH ON RELIGION AND URBAN CIVIL SOC'Y, ASSESSING THE EFFECTIVENESS OF FAITH-BASED ORGANIZATIONS: A SYSTEMATIC REVIEW OF THE LITERATURE (2002), *available at* www.manhattan-institute.org/pdf/crrucs_objective_hope.pdf; Achaempong Y. Amoeateng & Stephen J. Bahr, *Religion, Family, and Drug Abuse*, 29 SOC. PERSP. 53 (1986); Diane R. Brown &

tions, countries giving religious freedom a wider berth tend also to better respect women's equality.[282]

All of this is in addition to the practical observation that women would lose a great deal of health care if religious health care institutions were forced to go out of business due to the Mandate. The Catholic health care system in the United States alone accounts for one in six hospital patients, one in eight hospitals, 19 million emergency room visits and 101 million outpatient visit.[283] Studies show that this system provides "significantly better quality performance" than investor-owned systems and secular not-for-profit systems.[284]

Why then call it "women's freedom" when religion—a source of support and conviction, not to mention healthy relationships and healthcare, for women—is shackled? At the very least, the religious voice, the religious project where sex and marriage and parenting are concerned, ought to be allowed to continue to shine its light. Religion's thick, intuitive, and longstanding rationales for keeping in mind the links between sex and new life can help restore balance to our national discourse about sex and marriage and parenting. Not only women, but society itself, would be better off if the religious witness were allowed to live.

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282. *See* Brian J. Grim, *Religious Freedom and Socio-Economic Well-Being*, *in* FREEDOM IN THE WORLD 42 (Paula A. Marshall ed., 2008).

283. CATHOLIC HEALTH ASS'N, CATHOLIC HEALTH CARE IN THE UNITED STATES 2 (2013), *available at* http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=7830.

284. DAVID FOSTER, CTR. FOR HEALTHCARE IMPROVEMENT, DIFFERENCES IN HEALTH SYSTEM QUALITY PERFORMANCE BY OWNERSHIP 2 (2010), *available at* http://www.100tophospitals.com/assets/100TOPSystemOwnership.pdf.