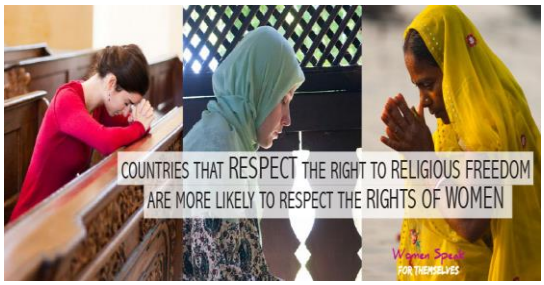
Women Speak FOR THEMSELVES

The U.S. Department of Health and Human Services ("HHS") all along has claimed that the Contraception and Emergency Contraceptives (ECs) Mandate is all about women's *freedom* and *health*. In order, however, to get from point "A" (forcing "free"[1] contraception and ECs coverage into all insurance policies) to point "B" (improved women's health and freedom), you have to show quite a few things that HHS never shows. The following five points (along with some crazy-useful footnotes!) show not only how HHS fails in its essential argument, but how thoughtless and demeaning some of their additional arguments appear.

1) **The HHS Mandate is ineffective, even counterproductive.**
   a. The Mandate only affects employed women and the daughters of employed persons, who largely already have access to contraception.[2] It is poor women who have the very high rates of unintended pregnancy and abortion that the Mandate claims to target. The government already provides this latter group free contraception.



   b. Increased access to contraceptives may drive unintended pregnancy & abortion up, not down. Nonmarital pregnancies, for example, increase in the long term when access to contraception increases, which studies suggest is due to "risk compensation" – the belief that one is insured against the risk of pregnancy.[3] Encouraging this false sense of security may end up achieving the opposite of what the Mandate intends.

2) **HHS has no meaningful data to support its claims that free contraception causes improved women's health.**
   a. The HHS has not demonstrated any causal link between either greater *access* to contraception and fewer unintended pregnancies and abortions,[4] nor between greater *usage* of contraception and fewer unintended pregnancies.[5] It simply assumes that

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[1] There is no free lunch, or free contraception; somehow, insurance companies will make customers pay.
[2] See *Inst. of Med., Clinical Preventive Services for Women: Closing the G*ap (2011) at 108.
[3] Peter Arcidiacono et al., *Habit Persistence And Teen Sex: Could Increased Access To Contraception Have Unintended Consequences For Teen Pregnancies?* (2005), http://public.econ.duke.edu/~psarcidi/addic ted13.pdf. For increased abortions among teens with increased access to contraceptives, see Jose Luis Duenas et al., *Trends in the Use of Contraceptive Methods and Voluntary Interruption of Pregnancy in the Spanish Population during 1997-2007.*
[4] It claims to have demonstrated the access-use linkage by referring to page 19 of the 2011 Institute of Medicine report, *Clinical Preventive Services for Women: Closing the Gap*. The sources cited there, however, consider cost as a factor affecting both men and women, or preventive health care generally, not contraception or ECs.
[5] This causation is nearly impossible to prove for reasons ranging from the slipperiness of the conception of "unintended" to the fact that nearly 50% of unintended pregnancies occur in women already using contraception. (For latter statistic see *Guttmacher Inst., Facts on Unintended Pregnancy in the United States*, 4 (2012), www.guttmacher.org/pubs/FBUnintended-Pregnancy-US.html.) Accordingly, the HHS Brief does not attempt to

what works on an individual level will work on a societal level, but data and experience contradict this assumption. On a national level, unintended pregnancies have risen along with increased access to contraceptives through various public programs.[6]

b. The Institute of Medicine report[7] that the HHS relies upon to supports its claims, never demonstrates a causal link between greater access to contraception and fewer unintended pregnancies and abortions. HHS' briefs in the lower courts and in the Supreme Court suffer the same problem. Without this proven causation, the Mandate's claims are merely speculative.
c. The Mandate is an overreach of the HHS' scope of authority. Even if increased access to contraceptives reduces unintended pregnancies, the HHS brief supporting the mandate provides no evidence of resulting *health benefits* for women,[8] which is what the HHS is authorized to address according to the Affordable Care Act.
d. The Mandate addresses a false need for low-cost access to contraceptives. According to a Center for Disease Control study, among the (only) 11% of sexually active women who do not use contraception, cost is not even a "frequently cited reason" for nonuse.[9]
e. The Mandate doesn't do anything to reduce the actual healthcare cost differential between men and women, which is associated with maternity costs, not contraceptive costs.[10] If leveling the healthcare playing field were really its goal, it would make more sense to provide assistance with maternity or children's healthcare costs, which are substantially more expensive for women than the relatively low cost of contraceptives.

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establish the causation but merely assumes it.

[6] See 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." During this same period, according to the Center for Disease Control, the number of women who had "ever used" birth control rose from 90% to 99%.) See also Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities*: 2006, 84 Contraception 478 (2011). In this Guttmacher Institute study, Finer and Zolna show that unintended pregnancies also rose during 2006-2008, despite the fact that women were accessing increasingly effective methods of birth control.

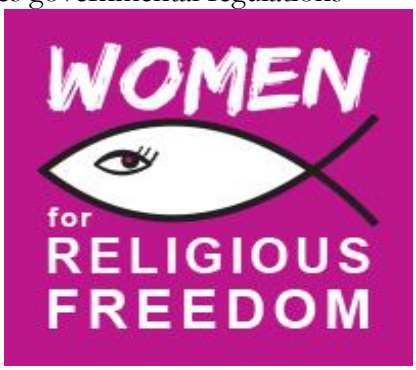
[7] See *supra* note 3. The IOM report cites two studies, one by Santelli and Melnikas, the other by the Guttmacher Institute. Santelli and Melnikas show only a correlation, not causation; see John S. Santelli & Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," 31 *Ann. Rev. Pub. Health* 371 (2010). The Guttmacher report does not attempt to demonstrate a causal link between increased contraception usage and decreased unintended pregnancies; rather, it states that "the decline in unintended pregnancy in the U.S. seems to have stalled," even with "nearly universal" use of contraceptives. See Heather D. Boonstra et al. (Guttmacher Inst.), Abortion In Women's Lives (2006), http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf at 32.

[8] See Brief for Petitioner at 47*, Sebelius v. Hobby Lobby Stores, Inc* ., (U.S. Sup. Ct., Jan. 10, 2014), at 46, 48.

[9] William D. Mosher & Jo Jones, U.S. Dep't of Health and Human Servs., *Use of Contraception in the U.S.: 1982-2008* (2010), at 5, 6, 9 and 14.

[10] Ctrs. for Medicare & Medicaid Servs., National Health Care Spending by Gender and Age, 2004 Highlights (2004), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/2004GenderandAgeHighlights.pdf.

3) **The mandate is unconstitutional.**
   a. Even if the data cited did support HHS' argument, it fails three legal standards:
      i. The Religious Freedom Restoration Act requires governmental regulations that burden the free exercise of religion to advance a "compelling state interest,"[11] but the HHS mandate fails to provide any evidence of such interest. The material above in point 2 demonstrates this.
         1. Also, the HHS tacitly admits as much by its willingness to grant vast exceptions to the mandate.[12] Just how compelling is the interest if so many organizations can opt out?



      ii. Secondly, First Amendment jurisprudence dictates that if the government is to limit First Amendment freedoms, it must "specifically identify an 'actual problem' in need of solving," then show that the burden is "actually necessary."[13] The HHS hasn't demonstrated either an actual problem or the necessity of the burden on religious individuals and organizations.
      iii. Finally, the Affordable Care Act authorizes the HHS to make regulations promoting women's health,[14] not children's health, but HHS' Supreme Court argument for the Mandate rests on claims of promoting child health (purportedly preventing health complications from unintended or too closely-spaced pregnancies etc.).[15] But even this argument is absurd on its face – how can it claim that preventing or destroying embryonic lives (via some contraceptives and ECs' post-fertilization action) help children?

4) **The Mandate is misleading and irresponsible regarding women's health.**
   a. It hides the risks of contraception and certain contraceptive devices. The World Health Organization has labeled certain hormonal oral contraceptives as "known carcinogens,"[16] Depo-Provera is linked with doubling HIV infection rates,[17] and IUD usage is associated with various adverse health effects.[18] The Mandate ignores these dangers and hides health risks from women.

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[11] 42 U.S.C. § 2000bb-1(b) (2012).
[12] According to *Church of Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520 (1993), a law that permits numerous exemptions (as does the HHS mandate) cannot be said to "protect[] an interest 'of the highest order'... when it leaves appreciable damage to that supposedly vital interest unprohibited." (At 547, Scalia, A., concurring in part and concurring in judgment, quoting Florida Star v. B. J. F., 491 U.S. 524, 541-42 (1989)
[13] *Brown v. Entertainment Merchants Association*, 131 S. Ct. 2729 (2011), at 2738.
[14] 42 U.S.C. § 300gg-13(a)(4) (2006)
[15] Brief for Petitioner at 47, *Sebelius v. Hobby Lobby Stores, Inc.*, No. 13-356 (U.S. Sup. Ct., Jan. 10, 2014) (citing IOM Report at 103).
[16] World Health Org., *Carcinogenicity of Combined Hormonal Contraceptives and Combined Menopausal Treatment* (2005), http://www.who.int/reproductivehealth/topics/ageing/cocs_hrt_statement.pdf; Steven A. Narod et al., *Oral Contraceptives and the Risk of Breast Cancer in BRCA1 and BRCA2 Mutation Car*riers, 94 J. Nat'l Cancer Inst. 1773 (2002).
[17] Renee Heffron et al., *Use of Hormonal Contraceptives and risk of HIV-1 Transmission: A Prospective Cohort Study*, 12 Lancet Infec. Dis. 19 (2012).
[18] Tessa Madden, *Risk of Bacterial Vaginosis in Users of the Intrauterine Device: A Longitudinal Study*, 39 Sex. Trans. Diseases 217 (2012).

b. In a 2012 study, STIs were shown to have increased along with increased access to emergency contraceptives and certain long acting reversible contraceptives.[19] The HHS needs to be up-front about the risks involved in increased usage of contraceptives.

5) **The Mandate is demeaning to women**, suggesting that childbearing women are unable to contribute to society on the same level as men.
   a. An HHS brief explained its purpose as ensuring that women are "able to contribute to the same degree as men as healthy and productive members of society,"[20] which is to be achieved by preventing pregnancies. This fails to promote gender equality on several levels. First, it is monumentally insulting to mothers, who are certainly contributing to society at "the same degree as men." But it also assumes that the sterile male is the norm to which women should aspire, disregarding entirely the unique contributions of women *qua* women in society.

[19] 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.
[20] Defendant's Memo., *Hobby Lobby Stores, Inc. v. Sebelius* , 870 F. Supp.2d 1278 (W.D. Okla. 2012) at 25-26.