NOS. 14-1418, -1453, -1505, 15-35, -105, -119, & -191

In the Supreme Court of the United States

DAVID A. ZUBIK, *et al.*,
Petitioners,
v.
SYLVIA BURWELL, *et al.*,
Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Third, Fifth, Tenth and D.C. Circuits

BRIEF FOR *AMICUS CURIAE* MICHAEL J. NEW, PH.D., ASSOCIATE SCHOLAR, CHARLOTTE LOZIER INSTITUTE, IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

Michael J. New, Ph.D., is an Associate Scholar at the Charlotte Lozier Institute, which studies federal and state policies and their impact on women's health and on child and family well-being. The Lozier Institute is the education and policy arm of the Susan B. Anthony List.

Dr. New received a Ph.D. in Statistics from Stanford University, an M.S. in Statistics from Stanford University, a B.A. in Government from Dartmouth College, and a B.A. in Economics Modified with Mathematics from Dartmouth College. Dr. New has served as a post-doctoral fellow at the Harvard-MIT data center and a lecturer at the University of Massachusetts, Boston. Dr. New is also a Fellow with the Witherspoon Institute, Princeton, New Jersey and a Visiting Associate Professor of Economics at Ave Maria University.

Dr. New's interest in this case stems from his work for the Charlotte Lozier Institute and his academic research into the social impact of abortion legislation. Dr. New has published academic articles in peer-

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[1] No counsel for a party authored this brief in whole or part. The Charlotte Lozier Institute, where *Amicus* serves as an Associate Scholar, paid for the preparation and submission of this brief. No one other than the Charlotte Lozier Institute, *Amicus Curiae*, or Counsel for *Amicus Curiae* made a monetary contribution to the preparation or submission of this brief. The Clerk has received from counsel for Respondents and on behalf of all Petitioners consents to the filing of *amicus curiae* briefs in support of either party or of neither party.

reviewed journals. Four of those articles have examined the impact of state-level abortion legislation.

SUMMARY OF THE ARGUMENT

(1) *Contraception Mandates Do Not Reduce Rates of Unintended Pregnancy or Abortion.*

Between the years 1995 and 2010 more than half the states imposed mandates requiring that at least some health insurance programs cover various contraceptives. These states are geographically, demographically, and ideologically diverse. As such, this allows for powerful and incisive analysis of the impact of these contraceptive mandates. There is enough public health data to compare public health outcomes both before and after specific mandates took effect. There is also enough data to meaningfully compare public health outcomes in states that have contraceptive mandates to public health outcomes in those states that do not have such mandates in effect.

Amicus Dr. New conducted statistical analysis of these data and reached three findings.[2]

First, in comparing public health outcomes in states with contraceptive mandates to public health outcomes in states that did not have mandates, regression analysis conducted by Dr. New showed that the presence of a contraceptive mandate failed to have a

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[2] *See* Michael J. New, *Analyzing the Impact of State Level Contraception Mandates on Public Health Outcomes*, 13 Ave Maria L. Rev. 345, 353–68 (2015), *available at* http://lr.avemarialaw.edu/Content/articles/vXIII.i2.new.final.0809.pdf [hereinafter New, *Impact of State Level Contraception Mandates*].

statistically significant impact on either the state unintended pregnancy rate or the state abortion rate.[3]

Second, in comparing public health metrics both before and after the contraceptive mandate took effect, regression analysis conducted by Dr. New showed once again that the enactment of a contraceptive mandate failed to result in a statistically significant reduction in either the unintended pregnancy rate or the abortion rate.[4]

Third, Dr. New conducted specific analysis of five states that had a stronger contraception mandate than the others and found that the enactment of these stronger mandates failed to result in statistically significant reductions in either abortion rates or unintended pregnancy rates. Additionally, Dr. New found no evidence that these stronger mandates had a greater impact on either unintended pregnancy rates or abortion rates than the weaker contraceptive mandates.[5]

In summary, Dr. New conducted a comprehensive review of the public health data from nearly all 50 states that allows for analysis of the impact of contraceptive mandates that were in effect in more than half the states at the time of the analysis. The data indicate that these mandates do not lower rates of unintended pregnancy or abortion.

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[3] *See id.* at 361–63.

[4] *See id.* at 363–66.

[5] *See id.* at 366–68.

A federal contraception mandate will be no more effective than state mandates have been in reducing rates of unintended pregnancy or abortion.

(2) *If the purpose of the Government in enforcing the Mandate is to reduce rates of unintended pregnancy, the Government cannot even demonstrate a generalized interest in enforcing the Mandate in any case, much less a "marginal interest" in enforcing the Mandate in these cases, as RFRA requires the Government to do.*

In *Hobby Lobby* this Court explained that under the Religious Freedom Restoration Act (RFRA) the Government must "'demonstrate that the compelling interest test is satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened.'" *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (quoting *Gonzales v. O Centro Espírita Beneficente Uniao do Vegetal*, 546 U.S. 418, 430–31 (2006) (quoting 42 U.S.C. § 2000bb–1(b))). Under this standard the Court will "'scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants'—in other words . . . [,] look to the marginal interest in enforcing the contraceptive mandate in these cases." *Id.* (quoting *O Centro*, 546 U.S. at 431.)

In one of its rulemaking documents the Government stated that "by reducing the number of unintended pregnancies, contraceptives reduce the number of women seeking abortions."[6] However, application of the

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[6] 78 Fed. Reg. 39870, 39872 (July 2, 2013). In making that statement the Government cited to a page in a section titled

RFRA standard set forth in *Hobby Lobby* devastates any interest the Government might assert for the Mandate in reducing unintended pregnancy or abortion. Dr. New demonstrates that contraception mandates do not reduce rates of unintended pregnancy or abortion. If the purpose for the Mandate is to reduce rates of unintended pregnancy or abortion, then the Government cannot demonstrate even a generalized interest in enforcing the Mandate in any case, much less a "marginal interest in enforcing the contraceptive mandate in these cases," *Burwell*, 134 S. Ct. at 2779, as RFRA requires the Government to do.

ARGUMENT

A comprehensive analysis conducted by *Amicus* Dr. New of state level public health data from nearly all 50 States found that state level contraceptive mandates produced no discernible reduction in rates of unintended pregnancy or abortion. A federal mandate will be no more effective than state level mandates have been at reducing rates of unintended pregnancy or abortion. If the purpose of the Mandate is to reduce rates of unintended pregnancy or abortion, then the Government cannot demonstrate even a generalized interest in enforcing the Mandate in any case, much less a "marginal interest" in enforcing the Mandate against the parties in these cases, as the RFRA standard requires the Government to do.

"Preventing Unintended Pregnancy and Promoting Healthy Birth Spacing" (capitalization altered) in an Institute of Medicine Report. *See id.* at n.14 (citing Institute of Medicine, Clinical Prevention Services for Women: Closing the Gaps 105 (2011) [hereinafter IOM Report]).

I. Contraception Mandates Do Not Reduce Rates of Unintended Pregnancy or Abortion.

A comprehensive analysis conducted by *Amicus* Dr. New of state level public health data from nearly all 50 States found that state level contraceptive mandates produced no discernible reduction in rates of unintended pregnancy or abortion. A federal mandate will be no more effective than state level mandates have been at reducing rates of unintended pregnancy or abortion.

A. Comprehensive Analysis of State Level Public Health Data from Nearly All 50 States Found that State Level Contraceptive Mandates Produced No Discernible Reduction in Rates of Unintended Pregnancy or Abortion.

Between the years 1995 and 2010 more than half the states imposed mandates requiring that at least some health insurance programs cover various contraceptives.[7] These states are geographically, demographically, and ideologically diverse. As such, this allows for powerful and incisive analysis of the impact of these contraceptive mandates. There is enough public health data to compare public health outcomes both before and after specific mandates took effect. There is also enough data to meaningfully

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[7] *See* New, *Impact of State Level Contraception Mandates*, at 356–358 (Table 1) (citing Insurance Coverage for Contraception Laws, Nat'l Conf. of St. Legislatures, http://www.ncsl.org/research/health/insurance-coverage-for-contraception-state-laws.aspx (last updated Feb. 2012) [hereinafter Insurance Coverage for Contraception Laws]).

compare public health outcomes in states that have contraceptive mandates to public health outcomes in those states that do not have such mandates in effect.

Dr. New conducted a comprehensive analysis of these state level contraception mandates on a range of public health outcomes. Dr. New utilized data from nearly all 50 states. Dr. New published his methodology and findings in his 2015 academic article *Analyzing the Impact of State Level Contraception Mandates on Public Health Outcomes*.[8] This brief draws heavily upon that work by Dr. New.

Dr. New analyzed the impact of the contraceptive mandates on state unintended pregnancy rates. The Guttmacher Institute began to release state level data on unintended pregnancy rates in 2002. As of 2014, when Dr. New conducted his analysis, Guttmacher had released state level data on unintended pregnancy rates for four years: 2002, 2004, 2006, and 2008.[9]

Dr. New also analyzed the impact of contraceptive mandates on state abortion rates. The state abortion rate can serve as a good proxy for the unintended pregnancy rate because a relatively high percentage of unintended pregnancies are aborted. State data on abortion rates came from two sources. The first data source is the Centers for Disease Control. The CDC has been releasing state level abortion data annually since

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[8] *See* New, *Impact of State Level Contraception Mandates*, at 347, 353–68.

[9] *See* Kathryn Kost, *Unintended Pregnancy Rates at the State Level: Estimates for 2002, 2004, 2006 and 2008*, Guttmacher Inst. 1, 4–5 (2013).

1969.[10] Because federal reporting requirements are weak, there are concerns about the reliability of CDC data. However, CDC abortion statistics are still used by many academic researchers. In this analysis Dr. New analyzed state abortion rate data from the CDC from 1991 to 2010.

Dr. New also obtained state level abortion data from the Guttmacher Institute. Guttmacher's method of collecting abortion data involves conducting a survey of abortion facilities. This data collection mechanism is more consistent and Guttmacher's data tend to be more reliable. Guttmacher does not, however, release state level abortion data every year. For his analysis, Dr. New had state abortion rate data from Guttmacher for only seven years: 1991, 1992, 1995, 1996, 2000, 2005, and 2007.

To capture the impact of these contraception mandates on various public health outcomes, Dr. New used regression analysis. Regression analysis is well suited to analyze the impact of these contraception mandates because there are a variety of economic, demographic, and policy factors that can impact both unintended pregnancy rates and abortion rates. Regression analysis can "hold constant" these other factors and allow a qualified researcher to examine the impact of contraceptive mandates on various public health outcomes.

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[10] *See* Charles A. Donovan & Nora Sullivan, Charlotte Lozier Inst., *Abortion Reporting Laws: Tears in the Fabric* 1, 4 (2012), *available at* http://www.lozierinstitute.org/wp-content/uploads/2012/12/American-Report-Series-ABORTION-REPORTING-LAWS.pdf.

Dr. New held constant economic variables, demographic variables, and policy variables. The economic variables that Dr. New held constant include the annual change in the state unemployment rate, annual state per capita personal income growth, and a measure of state per capita personal income. The demographic variables include the respective percentages of women 15-44 who identify as African American, Hispanic, Asian, and Native American. The demographic variables also include the respective percentages of women between the ages of 15-44 who are between 20-24, 25-29, 30-34, 35-39, and 40-44.

When Dr. New analyzed the impact of these contraception mandates on abortion rates, he also held constant two policy variables which have been shown to affect the incidence of abortion at the state level. One policy constant was whether a state funds therapeutic abortions through its state Medicaid program. There is a substantial body of peer-reviewed research which shows that subsidizing abortions through Medicaid increases state abortion rates.[11] The other policy constant was whether a state has an informed consent law which requires two separate trips to the abortion facility. There is academic research indicating that informed consent laws requiring two visits to the abortion facility lower the incidence of abortion.[12]

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[11] *See* Michael J. New, *Analyzing the Impact of U.S. Antiabortion Legislation in the Post-Casey Era: A Reassessment*, 14 St. Pol. & Pol'y Q. 228, 230, 250–51 (2014).

[12] *See id.* at 232, 254–54, 256–57.

Applying this methodology to these data Dr. New conducted three sets of analyses.

In the first set of analyses, Dr. New looked at how the presence of a contraceptive mandate affected various public health outcomes. In essence, Dr. New was comparing public health outcomes in states with contraceptive mandates to public health outcomes in states that did not have mandates. The regression analysis showed that the presence of a contraceptive mandate failed to have a statistically significant impact on either the state unintended pregnancy rate or the state abortion rate.[13]

In the second set of analyses, Dr. New looked at how the enactment of a contraceptive mandate affected various public health outcomes. In this set of analyses Dr. New was essentially able to compare public health metrics both before and after the contraceptive mandate took effect. Once again the regression analysis, which held constant a range of economic and demographic variables, found that the enactment of a contraceptive mandate failed to result in a statistically significant reduction in either the unintended pregnancy rate or the abortion rate.[14]

In the third set of analyses, Dr. New specifically analyzed five states that had a stronger contraception mandate than the others. Most state mandates only require that those health insurance plans that cover prescriptions or outpatient services cover

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[13] *See* New, *Impact of State Level Contraception Mandates*, at 361–63.

[14] *See id.* at 363–66.

contraceptives.[15] However five states have contraceptive mandates that require all health insurance plans to cover contraceptives.[16] The results indicate that the enactment of these stronger mandates failed to result in statistically significant reductions in either abortion rates or unintended pregnancy rates. Additionally, the analysis provided no statistically significant evidence that these stronger mandates had a greater impact on either unintended pregnancy rates or abortion rates than the weaker contraceptive mandates.[17]

In summary, Dr. New conducted a comprehensive review of the public health data from nearly all 50 states that allows for analysis of the impact of contraceptive mandates that were in effect in more than half the states at the time of his analysis. The data indicate that these mandates do not lower rates of unintended pregnancy or abortion.

B. A Federal Contraception Mandate Will Be No More Effective than State Mandates Have Been in Reducing Rates of Unintended Pregnancy or Abortion.

A useful feature of our federalist system of government is that "the States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear."

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[15] *See* Insurance Coverage for Contraception Laws.

[16] *See* New, *Impact of State Level Contraception Mandates*, at 356–58 (Table 1), 366.

[17] *See id.* at 366–68.

United States v. Lopez, 115 S. Ct. 1624, 1641 (1995) (Kennedy, J., concurring). The States have experimented with contraceptive mandates and, in Dr. New's opinion, as set forth above, the results of that experiment are now clear—contraceptive mandates do not reduce rates of unintended pregnancy or abortion.

For at least two reasons, one positive and one negative, it is the opinion of Dr. New that a federal mandate will be no more effective than state mandates have been in reducing rates of unintended pregnancy or abortion.

First, positively, Dr. New has conducted an extensive review of literature regarding contraceptive use, availability, and cost. This literature review comports with his statistical findings regarding the inefficacy of state level contraceptive mandates. As with his statistical analysis, Dr. New's literature review is set out in his academic article *Analyzing the Impact of State Level Contraception Mandates on Public Health Outcomes*.[18]

Dr. New concludes that, overall, the academic research on contraceptive use and availability paints a clear picture. One, the availability of contraceptives has failed to reduce either unintended pregnancies or abortions.[19] This is true in both the United States and in foreign countries.[20] Two, increases in the use of contraceptives have also largely failed to lower either

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[18] *See id.* at 348–53.

[19] *See id.* at 350–52.

[20] *See id.*

unintended pregnancy rates or the incidence of abortion.[21] Three, specific government programs to improve access to contraceptives by reducing their cost or distributing them free of charge have also failed to reduce unintended pregnancies or abortions.[22] In Dr. New's opinion, overall, numerous policy efforts to improve the accessibility of contraception, both in the United States and around the world, have failed to achieve these public health benefits.

Second, negatively, the Institute of Medicine (IOM) Report relied upon by the Government contains no evidence that alters Dr. New's opinion regarding the inefficacy of contraception mandates.[23] Dr. New concedes that the IOM Report does provide evidence that unintended pregnancies have negative health consequences. However, the IOM Report contains no evidence undermining Dr. New's conclusion that contraception mandates do not reduce the rate of unintended pregnancy or abortion.

Dr. New analyzed the section of the IOM Report advocating for contraceptive coverage and found that the report cites only two studies which purportedly show public health benefits from increased

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[21] *See id.*

[22] *See id.* at 352–53.

[23] *See* IOM Report 102–10. "HHS adopted the IOM's recommendation entirely and the Labor and Treasury Departments adopted regulations to the same effect." Br. for Petitioners in Nos. 15-35, 15-105, 15-119 & 15-191 at 8, *East Texas Baptist University v. Burwell* (S. Ct. Jan. 4, 2016) (internal citations omitted).

contraceptive use.[24] According to Dr. New, both of those studies have methodological limitations.

The first study by Boonstra et al., (2006) is correct, in Dr. New's opinion, that increases in contraceptive use by unmarried women between 1982 and 2002 are *correlated* with declines in the abortion rate. However, the increase in contraceptive use among unmarried women started well before the early 1980s.[25] Additionally, during some periods of time—such as the 1970s—increasing contraception use in the United States was coupled with a sharply increasing abortion rate.[26] Finally, unintended pregnancy rates have been relatively stable over time and have actually increased since the mid-1990s—despite increases in contraceptive use.[27]

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[24] The section of the IOM Report addressing contraceptive coverage is found at pages 102–110 under the section heading "Preventing Unintended Pregnancy and Promoting Healthy Birth Spacing." The studies identified by Dr. New in that section and addressed herein are found at page 105.

[25] *See* William D. Mosher and William Pratt, *Contraceptive Use in the United States 1973-1988*, Advance Data No. 182, National Center for Health Statistics (1990).

[26] *See id.* at 4; Sonya B. Gamble et al., *Abortion Surveillance – United States 2005*, Morbidity and Mortality Weekly Report 57 (Nov. 14, 2008).

[27] *See* Jo Jones, William Mosher, and Kimberly Daniels, *Current Contraceptive Use in the United States 2006-2010 and Changes in Patterns of Use Since 1995*, National Health Statistics Reports No. 60, National Center for Health Statistics (2012).

Dr. New found that the IOM Report also cites Santelli and Melnikas (2010) to argue that increased contraception use played a large role in the significant decline in the teen pregnancy rate. However, a considerable body of evidence shows that teen sexual activity has been declining since the early 1990s.[28] Furthermore, a subsequent analysis of teen pregnancy rates shows that teen pregnancies have continued to decline even though the percentage of sexually active teens using no contraceptives actually increased between 2009 and 2013.[29]

The IOM Report was subjected to dissent from the day it was published.[30] Dr. New's review of the IOM

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[28] *See* Dep't of Health & Human Servs., Centers for Disease Control and Prevention, *Youth Risk Behavior Surveillance-United States, 2009*, 59 Morbidity and Mortality Weekly Report at 33 (June 4, 2010), http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf; U.S. Dep't of Health and Human Servs., Centers for Disease Control and Prevention, National Center for Health Statistics, *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006-2010 National Survey of Family Growth*, Vital Health Statistics at 4 (Oct. 2011), http://www.cdc.gov/nchs/data/series/sr_23/sr23_031.pdf.

[29] *See* Sarah Kliff, *The Mystery of the Falling Teen Birthrate*, Vox.com (Jan. 21, 2015), http://www.vox.com/2014/8/20/5987845/the-mystery-of-the-falling-teen-birth-rate.

[30] *See* IOM Report, Appendix D, Dissent and Response (setting forth the dissenting opinion of committee member Anthony Lo Sasso stating that "the committee process for evaluation of the evidence lacked transparency and was largely subject to the preferences of the committee's composition" as well as that "the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy").

Report does nothing to weaken his findings, grounded in statistical analysis and theoretical conclusions stemming from a review of literature, that contraceptive mandates do not reduce rates of unintended pregnancy or abortion.

II. If the Purpose Is to Reduce Rates of Unintended Pregnancy, the Government Cannot Demonstrate a Generalized Interest in Enforcing the Mandate in any Case, Much Less a "Marginal Interest" in Enforcing the Mandate in These Cases.

In *Hobby Lobby* this Court explained that under the Religious Freedom Restoration Act (RFRA) the Government must "'demonstrate that the compelling interest test is satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened.'" *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (quoting *Gonzales v. O Centro Espírita Beneficente Uniao do Vegetal*, 546 U.S. 418, 430–31 (2006) (quoting 42 U.S.C. § 2000bb–1(b))). Under this standard the Court will "'scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants'—in other words . . . [,] look to the marginal interest in enforcing the contraceptive mandate in these cases." *Id.* (quoting *O Centro*, 546 U.S. at 431.)

In one of its rulemaking documents the Government stated that "by reducing the number of unintended pregnancies, contraceptives reduce the number of

women seeking abortions."[31] However, application of the RFRA standard as set forth in *Hobby Lobby* devastates any interest the Government might assert for the Mandate in reducing unintended pregnancy or abortion. Dr. New demonstrates that contraception mandates do not reduce rates of unintended pregnancy or abortion. If the purpose for the Mandate is to reduce rates of unintended pregnancy or abortion, then the Government cannot demonstrate even a generalized interest in enforcing the Mandate in any case, much less a "marginal interest in enforcing the contraceptive mandate in these cases," *Burwell*, 134 S. Ct. at 2779, as RFRA requires the Government to do.

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[31] 78 Fed. Reg. 39870, 39872 (July 2, 2013). In making that statement the Government cited to a page in a section titled "Preventing Unintended Pregnancy and Promoting Healthy Birth Spacing" (capitalization altered) in the IOM Report. *See id.* at n.14 (citing IOM Report at 105).

CONCLUSION

The Court should protect religious freedom by ruling in favor of the Petitioners.

Respectfully submitted,

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