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A Perfect Storm: Religion, Sex and Administrative Law

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Introduction

Agency regulations on sexual and reproductive health easily provoke religious conflict while failing to demonstrate convincing medical excellence.

This is a consequence of two agency characteristics – political partisanship and agencies' claims to superior expertise – intersecting with U.S. churches' commitments respecting sexual morality. More and more, U.S. cultural and political norms respecting sex and reproduction diverge from those held by traditional religions. Furthermore, the two political parties are increasingly committed to starkly opposed views of sexual and reproductive health, and the place of religion in the nation's life. Consequently, the agency charged with rulemaking on sexual and reproductive health – the Department of Health and Human Services ("HHS") – regularly issues poorly crafted policies that incite charges of religious establishment or the violation of the free exercise of religion.

This article will consider two of the most prominent policies. First, it will consider the Trump administration's decision to fund primarily those youth sex education programs committed to avoidance or delay of sexual intercourse versus programs instructing teens about reducing the risks of sex by means of contraception. The sex education programs endorsed by the Trump Administration are called Sexual Risk Avoidance ("SRA") by their creators, but were formerly known as "abstinence" education. These are distinguished from programs involving contraception, which the administration calls Sexual Risk Reduction programs. ("SRR"), but proponents call Comprehensive Sex Education ("CSE"). This article will use the terms for both programs preferred by their supporters, thus SRA for the first, and CSE for the latter.

This article will also consider the Obama administration's rule requiring religious institutions to offer health insurance guaranteeing free contraception. This is usually called the "contraception mandate," although the HHS Secretary and the Food and Drug Administration ("FDA") have acknowledged that some of the required drugs and devices can terminate already-formed human embryos, and are thus more accurately understood to be abortifacients.[1]

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[1] *See* Kelly Wallace, *Health and Human Services Secretary Kathleen Sebelius Tells iVillage "Historic" New Guidelines Cover Contraception, Not Abortion*, iVILLAGE (Aug 2, 2011) http://pages.citebite.com/n1r2c8f2s7bhb; *How does Plan B One-Step work?*, *Frequently Asked Questions*, PLAN B ONE-STEP, https://www.planbonestep.com/faq.aspx (last visited Oct. 30, 2018); STEVEN GALSON, FOOD AND DRUG ADMIN., Plan B Approved Labeling (2006), http:// www.accessdata.fda.gov/drugsatfda_docs/nda/2006/021045s011_Plan_B_PRNTLBL.pdf.

Both the SRA grant program and the contraceptive mandate are products of an openly partisan HHS, respectively Republican and Democrat. Both parties' presidential nominees were visibly intertwined with activists staunchly committed to one side or the other of America's culture wars over sex. Both parties and their nominees were also associated with one or the other side of a more recently emerging culture war over the place of religion in American life.

This storm of politics, religion, and health policy is not conducive to Americans' well-being. It also fails to engage the disturbing gap between the health outcomes of different socioeconomic and racial groups. In order to satisfy their constituencies, partisan HHS administrations overstate, obfuscate, or even sometimes mis-state the science respecting aspects of sexual and reproductive health.[2] On the right, this is also an attempt to avoid charges that an agency policy constitutes religious establishment. On the left, it is an attempt to create the appearance of a state interest so "compelling" that it can legally overcome any claim that the policy is causing a burden on the free exercise of religion.

This pattern is not inevitable. Even as HHS will surely continue to be a partisan enterprise, it can deliver better rules on sexual and reproductive health. It can report the pros and the cons of a chosen policy, and acknowledge both the full range of available evidence and the values underlying its choices. It can consult with experts on both sides of a plan. It can openly acknowledge the limited efficacy of any single government effort tackling an entrenched public health problem. And it can seek in advance both guidance and assurances from religious bodies to avoid unnecessary establishment or free exercise storms.

Religious institutions, too, can and should play a smarter role. They need to explain the weight of their teachings on sexual morality, and the relationship between these teachings and their institutions' missions. They also need to construct a well-supported argument about the link between their teachings and positive health outcomes.

In order to propose a way forward toward better sexual and reproductive health regulation, which also avoids undercutting or crossing swords with religion, this article will proceed as follows:

Part I will paint with a broad brush the current state of sexual and reproductive health problems in the US, focusing a bit upon younger Americans to whom SRA programs are addressed. It will highlight disparities according to race and socioeconomic conditions when these obtain. These are troubling on their face, but particularly troubling today at a time of perceived heightened racial and socioeconomic class tension in the US.

Regarding Ella, see WATSON PHARM., INC., FDA APPROVED PATIENT LABELING INFORMATION ELLA ("EL-UH") (ULIPRISTAL ACETATE) TABLET(2010), http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf.

[2] FUTURE OF SEX EDUC., RECONNECTING SCIENCE AND ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH POLICY MAKING (2014), http://www.futureofsexed.org/documents/FoSE-ResearchBrief-10-6-14.pdf.

Part II will set forth the controversies, first over the Trump administration's SRA grants, and second, concerning the Obama administration's contraception mandate. It will describe each agency action, and the partisan fabric of each administration's HHS. Then it will highlight each administration's claim to possessing high quality expertise on the subject matter at issue, and conclude with a description of the religious controversy that each agency action provoked.

Part III will critique the scientific arguments HHS deployed to support SRA funding and the contraceptive mandate. It will also identify the factors in both actions which give rise, respectively, to establishment and free exercise challenges, and suggest ways in which both HHS and religious actors might incrementally improve sexual and reproductive health policy while avoiding wasteful and unnecessary clashes with religion.

Part I. The sexual and reproductive health of Americans

It is commonly noted how surprising the disproportion is between the size and strength of the American economy and healthcare system, and the sexual and reproductive health of U.S. citizens. This is especially true regarding our poorest citizens.

A 2015 article regarding pregnancy, birth, and abortion rates among U.S. teens 15-19 shows the U.S. with the highest teen pregnancy rates among countries possessing complete data: the U.S. has more than double the rates of France, Israel, Portugal, Norway, and Spain.[3] The same study shows that U.S. adolescent birth rates are also the highest among all such countries. Recent surveys further demonstrate that teen birth rates[4] are disproportionately high among poorer and minority girls.

Younger Americans are also suffering alarming rates of sexually transmitted infections ("STIs"). A 2015 report from the Centers for Disease Control reported that some incidences of STIs are rising "at [an] alarming rate."[5] Americans between fifteen and twenty-four years old account for nearly two-thirds of the most common infections.[6] And while this same age group accounts "for only one quarter of the sexually experienced population, they contract nearly half of the 19 million new STIs

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[3] Gilda Sedgh, et al., *Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends,* 56 J. of Adolescent Health 223, 226 (2015).,

[4] Melissa Schettini Kearney & Phillip B. Levine, *Income Inequality and Early Nonmarital Childbearing: An Economic Exploration of the "Culture of Despair"*, NAT'L BUREAU OF ECON. RES. WORKING PAPER 17157, at 24-25 (2011), https://www.nber.org/papers/w17157.pdf;*see also* : Melissa Schettini Kearney & Philip B. Levine, *Explaining Recent Trends in the U.S. Teen Birth Rate*, NAT'L BUREAU OF ECON. RES. WORKING PAPER 17964, at 3, 8-9, 23 (2012);Melissa Schettini Kearney & Philip B. Levine, *Why is the Teen Birth Rate in the United States so High and why Does it Matter?* NAT'L BUREAU OF ECON. RES. WORKING PAPER 17965, at 2 (2012).

[5] Centers for Disease Control and Prevention, U.S. DEP'T OF HEALTH & HUMAN SERVICES, REPORTED CASES OF STDS ON THE RISE IN THE U.S. (Nov. 17, 2015), https://www.cdc.gov/nchhstp/newsroom/2015/std-surveillance-report-press-release.html.

[6] Press Release, U.S. Ctrs. for Disease Control and Prevention, *Reported STDs at Unprecedented High in the U.S.*, (Oct. 19, 2016), https://www.cdc.gov/nchhstp/newsroom/2016/std-surveillance-report-2015-press-release.html.

diagnosed each year.".[7] In the most recently reported year (2016), rates of chlamydia, gonorrhea, and even syphilis had increased by as much as seventeen percent over 2015.[8] Chlamydia, gonorrhea, and HPV can lead to infertility.[9] Like teen births, teen STIs are concentrated among the poor and racial minorities.[10]

The overall non-marital birth rate (as a percentage of all births) in the U.S. has hovered near forty percent for many years,[11] but has recently dipped to slightly below this.[12] This phenomenon, too, is concentrated among poorer Americans. It is predictive, on average, of educational, emotional, and economic difficulties for affected children.[13]

Some have tied the loss of one or both parents, and/or the presence of complicated household relations (step-siblings; unrelated partners of a parent), to an "epidemic of loneliness" and even addiction affecting especially young people.[14]

Abortion rates, while declining from their precipitous 1980s rates, remain high, with the Centers for Disease Control reporting that there is nearly one abortion for every five live births.[15] The Guttmacher Institute, with access to more complete data, reports that there is

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[7] Helen B. Chin et al., *The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services*, 42 AM. J. PREVENTIVE MED. 272, 273 (2012).

[8] U.S. Ctrs. for Disease Control and Prevention, *2016 Sexually Transmitted Diseases Surveillance* (last visited Sept. 26, 2017), https://www.cdc.gov/std/stats16/natoverview.htm.

[9] U.S. Ctrs. for Disease Control and Prevention, *STDs and Infertility* (last updated Oct. 6, 2017) https://www.cdc.gov/std/infertility/default.htm; Nigel Pereira et al., *Human Papillomavirus Infection, Infertility and Assisted Reproductive Outcomes*, 2015 J. PATHOGENS, at 2-3, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4644557/.

[10] *See* Guy Harling et al., *Socioeconomic Disparities in Sexually Transmitted Infections Among Young Adults in the United States: Examining the Interaction Between Income and Race/Ethnicity*, 40 SEXUALLY TRANSMITTED DISEASES 575, 575 (2013); Chin, *supra* note 7, at 273.

[11] Joyce A Martin et al., *Births: Final Data for 2015*, 66 NAT'L VITAL STAT. REP., Jan. 5, 2017, at 8-9, https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf.

[12] LYMAN STONE, INST. FOR FAM. STUD, DECADES-LONG RISE IN NONMARITAL CHILDBEARING REVERSES (2018)..

[13] U.S. CTRS FOR DISEASE CONTROL, DATABANK INDICATOR: BIRTHS TO UNMARRIED WOMEN, CHILD TRENDS (2018),; Mary Parke, *Are Married Parents Really Better for Children? What Research Says about the Effects of Family Structure on Child Well-Being*, CTR. FOR L. & SOC. POL'Y (2003), https://www.clasp.org/sites/default/files/public/resources-and-publications/states/0086.pdf; Kimberly Howard & Richard V. Reeves, *The Marriage Effect: Money or Parenting?*, BROOKINGS (Sept. 4, 2014), https://www.brookings.edu/research/the-marriage-effect-money-or-parenting/.

[14] David A. Sbarra, *Divorce and Health: Current Trends and Future Directions*, 77 PSYCHOSOM. MED. 227 (2015),; Eirik Evenhouse & Siobhan Reilly, *A Sibling Study of Stepchild Well-Being*, 39 J. HUM. RESOURCES 248, 256, 270 (2004); Felice J. Freyer, *"Loneliness Kills": Former Surgeon General Sounds Alarm on Emotional Well-Being,* BOS. GLOBE (Jan. 16, 2018), https://www.bostonglobe.com/metro/2018/01/16/former-surgeon-general-sounds-alarm-hidden-toll-loneliness/GweBtw1woQyll1Tl8CYpVL/story.html; Vanessa Hemovich & William D. Crano, *Family Structure and Adolescent Drug Use: An Exploration of Single Parent Families*, 44 SUBST. USE MISUSE 2099 (2009).

[15] *CDCs Abortion Surveillance System FAQs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (last reviewed Nov. 16, 2017).

one abortion for every four live births.[16] Guttmacher also reports that by age forty-five, one in four American women will experience an abortion.[17] Some studies associate abortion with the later possibility of premature births or other pregnancy complications.[18] Abortion, too, is concentrated among poor women and women of color.[19]

Obviously, sexual and reproductive health outcomes for Americans are shaped by many factors other than government-directed benefits (e.g. contraception) and messages (e.g. sex education). At the same time, however, these policies might touch thousands or even millions of Americans. They can influence public discourse and set the stage for future research and discoveries. The dollars involved are not overwhelming but are likely still to be amounts that no other single source could match. If these messages, programs, or benefits are more in the nature of a political gesture than a health care benefit, it would be a profound waste of dollars. It would also be a waste for the government to defend hundreds of lawsuits claiming violation of one or the other religion clause of the First Amendment,[20] or the Religious Freedom Restoration Act ("RFRA"),[21] if these suits might be avoided with better preparation.

In the next section, I will describe two HHS actions, with special attention to their partisan backgrounds and their overblown reliance upon claims of agency expertise. I will also describe how each of them provoked a claim that HHS had violated the proper relationship between religion and the state.

Part II. Sexual Risk Avoidance Grants and the Contraception Mandate

A. Abstinence or "Sexual Risk Avoidance" Curricula

1. Historical and conceptual background

Since the 1980s, when President Ronald Reagan's HHS supported school sex-education curricula promoting abstinence until marriage, there has been a dispute between supporters of SRA and supporters of CSE. Without covering the possible permutations of each program, it suffices to say that SRA programs promote students' remaining sexually abstinent until marriage or at least delaying sex until they are older. Generally, SRA does not teach about how

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[16] GUTTMACHER INSTITUTE, INDUCED ABORTION IN THE UNITED STATES: JANUARY 2018 FACT SHEET, (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[17] *Id.*

[18] Gabriele Saccone et al., *Prior **U**terine **E**vacuation of **P**regnancy **A**s **I**ndependent **R**isk **F**actor for **P**reterm **B**irth: **A** **S**ystematic **R**eview and **M**eta-**A**nalysis*, 214 AM. J. OBSTETRICS & GYNECOLOGY *572, 573* (2016); Rosanne Freak-Poll et al., *Previous Abortion and Risk of Pre-Term Birth: A Population Study*, 22 J. MATERNAL-FETAL & NEONATAL MED. 1, 2–5 (2009); Pierre-Yves Ancel et al., *Very and Moderate Preterm Births: Are the Risk Factors Different?*, 106 BRIT. J. OBSTETRICS & GYNAECOLOGY 1162, 1162, 1164 (1999) (prematurity).

[19] THE GUTTMACHER INSTITUTE, FACT SHEET: INDUCED ABORTION IN THE UNITED STATES: JANUARY 2018 FACT SHEET, GUTTMACHER INST. (Jan. 2018), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[20] U.S. CONST. amend. I ("Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof. . . .").

[21] 42 U.S.C. §§ 2000bb-2000 bb—4.

to use various forms of contraception, although they might teach about the health risks and failure rates of some forms.

CSE programs, on the other hand, may or may not teach that abstinence is the only 100%-sure method to avoid STIs and pregnancy, but always teach about various methods of contraception.

Proponents of both programs would undoubtedly add that there is much more to each of them. Both programs stress gaining information about healthy relationships, as well as about the risks of pregnancy and STIs. Both seek to build youth strength to make what each considers healthy decisions. Both teach about avoiding negative peer pressure and violence. But the nub of the dispute between the competing methods concerns the weight to be assigned to the message to avoid sex, and whether or not to teach contraception given that that some teens will become sexually involved.

Congress first funded abstinence education in 1981 with the Adolescent Family Life Act ("AFLA"), designed to encourage chastity and "self discipline." [22]

More federal funds were appropriated in response to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as "welfare reform."[23] Qualifying abstinence-only education was defined to include eight elements, including, *inter alia,* "teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; … abstinence from sexual activity outside marriage as the expected standard for all school-age children; … that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects; … [and] that bearing outof wedlock children is likely to have harmful consequences for the child, the parents and society."[24] In 2000, Congress began funding Community-Based Abstinence Education (CBAE) grants; [25]abstinence education funding under President Bush ultimately reached 176 million dollars by 2007.[26]

The Obama administration quickly cut off funding for CBAE while increasing funding for CSE. In December 2009, President Obama signed an appropriations act including zero federal

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[22] Pub. L. No. 97-35, § 955(a), 95 Stat. 578 (1981) (codified as amended at 42 U.S.C. § 300z (2006).
[23] Pub. L. No. 104-193, § 912, 110 Stat. 2150 (1996).
[24] 42 U.S.C. § 710 (b)(2).
[25] See Advocates for Youth, *The History of Federal Abstinence-Only Funding*, http://www.advocatesforyouth.org/publications/publications-a-z/429-the-history-of-federal-abstinence-only-funding ; Carmen Solomon-Fears, Congressional Research Service, *Scientific Evaluations Of Approaches To Prevent Teen Pregnancy* 1, 5 (2007) (explaining that CBAE funding was included in annual appropriations for the Department of Health and Human Services (HHS) starting in fiscal year 2001 and listing the appropriations bills containing CBAE funding), http://www.policyarchive.org/handle/10207/4497. Prior to 2005, the CBAE program was known as the Special Projects of Regional and National Significance (SPRANS) program.
[26] Kathrin F. Stranger-Hall and David W. Hall, *Abstinence-Only Education and Teen Pregnancy Rates: Why We need Comprehensive Sex Education in the U.S.,* 6 PLoS One, e24658 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/.

dollars for abstinence-only education, and $110 million to a Teen Pregnancy Prevention ("TPP") initiative funding CSE-type programs.[27] Shortly afterwards, by means of the Patient Protection and Affordable Care Act ("ACA"), some abstinence education dollars were again made available to states through 2014.[28] The ACA also funded "personal responsibility education," ("PREP") a program that places substantial emphasis on both abstinence and contraception.[29]

Teen pregnancy rates had been declining since the early 1990s, and continued to decline after the creation of the PREP and TPP Programs. Teen births declined 64% between 1991 and 2015, and 46% from 2007 to 2015.[30] The Centers for Disease Control attributed the declines to "more teens abstaining from sexual activity, and more teens who are sexually active using birth control than in previous years."[31]

There is an important caveat here, however. Because there is a strong correlation between declining teen births and higher ages at marriage,[32] a great deal of the current decline in teen births is due to dramatically fewer teens getting married today. The average age at first marriage in the U.S. is 27 for females and 29 for males. In 1957, at the height of teen births in the U.S. (96 births per 1,000 15-19 year olds), only about 14% of these births were to unmarried women, for a rate of 13.5 nonmarital teen births per 1,000 births.[33] In 2016, nine in ten births to teens were nonmarital, for a total of 18 nonmarital births among 1,000 teen women 15-19 years old.[34]

Our current rate of nonmarital teen births is still far lower today than it was in the 1990s, however. In 1994, the most recent historical peak, there were 59 teen births per 1,000 girls aged 15-19, but 71% of the births were nonmarital for a rate of 42 nonmarital teen births per 1,000.[35] Thus, current rates represent a decline from our modern high, but do not represent a decline in nonmarital teen parenting over the last 60 years.

The TPP programs received mixed evaluations. The Sexuality Information and Education Council of the U.S. (SIECUS), which exists to advocate for comprehensive sex

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[27] *See* Teenage Pregnancy Prevention: Statistics and Programs, Congressional Research Service, (January 15, 2016) (RS20301), https://fas.org/sgp/crs/misc/RS20301.pdf.
[28] *Id.*
[29] See supra n. 27, at 14.
[30] Brady E. Hamilton and T.J. Mathews, *Continued Declines in Teen Births in the United States* (NCHS Data Brief, No. 259, Sept. 2016), https://www.cdc.gov/nchs/data/databriefs/db259.pdf.
[31] U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, ABOUT TEEN PREGNANCY: TEEN PREGNANCY IN THE UNITED STATES (2017), https://www.cdc.gov/teenpregnancy/about/index.htm. *See also* Laura Lindberg et al., *Understanding the Decline in Adolescent Fertility in the United States, 2007–2012*, J. ADOLESCENT HEALTH 1, 1, 4–5 (2016).
[32] *See* PHILIP N. COHEN, MARRIAGE PROMOTION AND THE MYTH OF TEEN PREGNANCY, (2015), https://familyinequality.wordpress.com/2015/04/27/marriage-promotion-and-the-myth-of-teen-pregnancy/.
[33] STEPHANIE VENTURA et al,, BIRTHS TO TEENAGERS IN THE UNITED STATES, 1940–2000, 49 1, 10 (Sept. 25, 2001).
[34] Dept. of Health and Human Serv., Office of Adolescent Health, *Trends in Teen Pregnancy and Childbearing* (June 2, 2016), https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/trends/index.html.
[35] *See* Ventura, *supra* note 33, at 4, 10.

education,[36] claims that 4 of the 10 Obama-era Teen Pregnancy programs had a "positive impact,"[37] acknowledging that "when you're sort of looking at this in line with other public health evaluations, that's actually a pretty good percentage."[38]

The Obama administration's HHS concluded that[39] eight of the programs had some type of effect on outcomes for teens. Depending upon the program in question, the following outcomes were noted: some teens were significantly less likely to report sex without contraception nine months after the program; some were less likely to have vaginal intercourse without a condom 6 months after the program; some females, but not males, were less likely to have vaginal intercourse than peers in schools without programs several years after the program; some students at the beginning of 7th or 9th grades were less likely to have or initiate sex, or to have sex without using birth control.

Ascend, the leading organization opposing CSE, however, summarized the published conclusions of the TPP programs differently,[40] noting that 80 percent of students "fared no better or even worse than those who did not receive [such] programs." It also highlighted: programs wherein teens suffered greater risks than students in the control group; the fact that the federal programs had reached only 1 percent of the population, and the fact that declines in teen pregnancy had been proceeding for two decades prior to the invention of the TPP. It also pointed to a 28 percent increase in abstinence among teens since 2010.[41]

2. **The Trump Administration's SRA Programs**

In July 2017–claiming insufficient efficacy for dollars spent–President Trump's HHS cut short eighty-one federal grants for TPP programs t hat would have otherwise lasted until 2020. HHS claimed[42] that of the 37 of 41 TPP programs that reported results, 73 percent had no impact or a negative impact, and very few of the positive results were sustained over time. Regarding the programs that had replicated previously funded models, it stated that 78 percent of them had no impact or negative impacts, that only three had mixed impacts (i.e.

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[36] Sexuality Educ. & Info. Council of the U.S., https://siecus.org/about-siecus/ (2018).
[37] Jordan Smith, *Donald Trump's Embrace of Abstinence –Only Sex Ed is an Absurd Twist on a Failed Policy*, THE INTERCEPT (Apr. 2, 2018), https://theintercept.com/2018/04/02/donald-trumps-embrace-of-abstinence-only-sex-ed-is-an-absurd-twist-on-a-failed-policy/.
[38] *Id.*
[39] OFFICE OF ADOLESCENT HEALTH, RESULTS FROM THE OAH TEEN PREGNANCY PREVENTION PROGRAM (2016); OFFICE OF ADOLESCENT HEALTH, SUMMARY OF FINDINGS FROM THE TPP PROGRAM GRANTEES (FY2010–2014) (2016). A special issue of the American Journal of Public Health explores the impacts of the Teen Pregnancy Prevention Program. Amy Feldman Farb & Amy Margolis, *The Teen Pregnancy Prevention Program (2010–2015): Synthesis of Impact Findings*, 106 AM. J. PUB. HEALTH S9, S13 (2016), https://youth.gov/federal-links/reports-oah-teen-pregnancy-prevention-program-evaluation-findings.
[40] Press Release, Ascend, Ascend Applauds HHS in Ending the Ineffective Teen Pregnancy Prevention (TPP) Program.
[41] *Id.*
[42] Press Release, HHS.gov Office of the Assistant Secretary for Health, Teen Pregnancy Prevention Program Facts: False Claims vs. The Facts (Aug. 28, 2017).

both positive and negative), and that only one had a sustained positive effect. It concluded that the reported effects stood in "stark contrast to the promised results."[43]

HHS' report further stated that the TPP programs could not claim responsibility for the drop in teen birth rates that had begun in 1992, long before their existence, and because the programs had only served between .2 and 1 percent of the US population.

The agency attributed an important role instead, in the decline of teen pregnancy, to teens waiting to have sex, citing the CDC's 2015 data[44] showing that the percentage of teens that have never had sex increased from 45.9 in 1991 to 58.8 in 2015. The same data shows that the percentage of teens that have never had sex increased from 53.2 in 2013 to 58.8 in 2015. Additionally, the data showed that more than half of teens have not had sex by 11th grade, and 42 percent haven't had sex by 12th grade, up from 33 percent in 1991 for 11th graders and up from 27 percent for 12th graders since 1991.

HHS also noted that TPP programs had not assisted with the epidemic of STIs, which disproportionately affect teenagers and those in their early 20s, and have reached record highs.[45]

Many commentators slammed the Trump administration's early cutoff. Some states and contraception interest groups sued the administration, arguing that the program was terminated unlawfully under the terms of the Administrative Procedure Act.[46] At the time of this writing, HHS is losing most of these lawsuits.[47]

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[43] *Id.*

[44] *Id.*

[45] CDC (2017, September). CDC (2015, Nov). STD Surveillance, 2016. Atlanta: USDHHS. NCHHSTP. Accessed 10-11-2017 at https://www.cdc.gov/std/stats16/default.htm. ("During 2015–2016, rates of reported chlamydia increased in all regions of the United States. . . . In 2016, 468,514 gonorrhea cases were reported for a rate of 145.8 cases per 100,000 population, an increase of 18.5% from 2015. . . . During 2015–2016, the P&S syphilis rate increased among both men and women in every region of the country; overall, the rate increased 14.7% among men and 35.7% among women.");
Press Release, HHS.gov Office of the Assistant Secretary for Health, Teen Pregnancy Prevention Program Facts: False Claims vs. The Facts (Aug. 28, 2017) ("Although young adults (age 15-24) only account for about 25% of the sexually active population, the newest data shows that they account for nearly 2/3 of all reported cases of chlamydia and gonorrhea."); Press Release, Centers for Disease Control and Prevention, Reported Cases of STDS on the Rise in the U.S. (Nov. 17, 2015) (" 'America's worsening STD epidemic is a clear call for better diagnosis, treatment, and prevention,' said Jonathan Mermin, M.D., director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention."). The press release also stated: "Reported cases of three nationally notifiable STDs – chlamydia, gonorrhea, and syphilis – have increased for the first time since 2006." *Id.*

[46] *See, e.g.*, Complaint for Declaratory and Injunctive Relief at 3, *King County v. Azar II*, Civil Action No. 2:18-cv-00242 (W.D. Wash. Feb 15, 2018).

[47] *See, e.g.*, *King County v. Azar*, 320 F. Supp. 3d 1167, 1177–78 (W.D. Wash. 2018). *See also* Jennifer Hansler, *HHS loses another court battle over pregnancy prevention grant funding*, CNN POLITICS (June 4, 2018), https://www.cnn.com/2018/06/02/politics/hhs-teen-pregnancy-program-dc-district-court/index.html.

Leading medical associations on record supporting CSE also reacted negatively. The president of the American College of Obstetricians and Gynecologists ("ACOG"), called the program "vital," and labeled the administration's decision, a "step backward for ensuring healthy moms and healthy babies."[48]

Some Democratic Senators wrote to President Trump calling the move "short-sighted," and a risk to the wellbeing of "women and our most vulnerable youth." They lauded the TPP as a "pioneering example of evidence-based policymaking," importantly responsible for decline in teen pregnancy rates since 2010. They disparaged HHS' scientific bona fides.[49]

A spokesperson for the well-regarded Mathematica Policy Research (commissioned by both Republican and Democratic administrations to evaluate government programs) opined that: "The evidence shows that these programs are showing promising results on a range of outcomes."[50] She added that while some programs might have had positive outcomes on only one program goal — for example, knowledge about pregnancy and STDs, or attitudes toward contraceptives — and may "not necessarily have an impact now" — such knowledge might later "influen[ce] subsequent sexual behaviors," noting that longer term research is needed.[51]

While HHS is currently losing its bid to defund ongoing TPP projects, it has proceeded to invite grant applications to develop and implement SRA programs. In November 2017, HHS launched a ten million dollar research project[52] in consultation with Mathematica, to develop and implement SRA, TPP and PREP Programs. The announcement referred potential grantees to materials for measuring efficacy developed in part by renowned evaluator Doug Kirby, who has also played an important role in Democratic administrations.[53]

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[48] Heidi Pryzbyla, *Notes, emails reveal Trump appointees' war to end HHS teen pregnancy program*, NBC NEWS (Mar. 20, 2018), https://www.nbcnews.com/politics/politics-news/notes-emails-reveal-trump-appointees-war-end-hhs-teen-pregnancy-n857686.

[49] Letter from Democratic Senators, United States Senate, to Thomas E. Price, M.D., Secretary, Health and Human Services (July 21, 2017), https://www.help.senate.gov/imo/media/doc/071817%20Teen%20Pregnancy%20Program%20letter%20FINAL.pdf.

[50] Elizabeth Chuck, *Trump Administration Abruptly Cuts Funding to Teen Pregnancy Programs*, NBC NEWS (Aug. 25, 2017), https://www.nbcnews.com/news/us-news/trump-administration-abruptly-cuts-funding-teen-pregnancy-prevention-programs-n795321.

[51] *Id.*

[52] Press Release, HHS Office of the Assistant Sec'y for Health & Admin. for Children & Families, HHS Announces New Efforts to Improve Teen Pregnancy Prevention & Sexual Risk Avoidance Programs (Nov. 3, 2017), https://www.acf.hhs.gov/media/press/hhs-announces-new-efforts-to-improve-teen-pregnancy-prevention-sexual-risk-avoidance-programs-0.
HHS, Administration for Children and Families, *HHS Announces New Efforts to Improve Teen Pregnancy Prevention and Sexual Risk Avoidance Programs*, Nov. 3, 2017, https://www.acf.hhs.gov/media/press/hhs-announces-new-efforts-to-improve-teen-pregnancy-prevention-sexual-risk-avoidance-programs-0.

[53] *See* Dep't. of Health and Human Services, *Announcement of Availability of Funds for Phase I Replicating Programs (Tier 1) Effective in the Promotion of Healthy Adolescence and the Reduction of Teenage Pregnancy and*

In April 2018, HHS issued two funding opportunity announcements, for a total of 61 million dollars, for Tier I programs "Effective in the Promotion of Healthy Adolescence and the Reduction of Teenage Pregnancy and Associated Risk Behaviors"[54] and for Tier II programs.[55] Tier I programs are required to replicate a "risk avoidance" or "risk reduction" model targeted to an at-risk community, and to contain one of the following sets of elements. Either set one: "(1) enhance knowledge of physical development and sexual risks and personal relationships, (2) support personal attitudes and beliefs that value sexual risk avoidance, (3) acknowledge and address common rationalizations for sexual activity, (4) improve perception of and independence from negative peer and social norms, (5) build personal competencies and self-efficacy to avoid sexual risk, (6) strengthen personal intention and commitment to avoid sexual activity, (7) identify and reduce the opportunities for sexual activity, (8) strengthen future goals and opportunities, and (9) partner with parents."[56]

Or set two elements: "(1) involved multiple people with different backgrounds; (2) assessed relevant needs and assets of the target group; (3) used a logic model approach to develop the curriculum that specified the health goals, behaviors affecting the health goals, risk and protective factors affecting those behaviors, and activities addressing the risk and protective factors; (4) designed activities consistent with community values and available resources; and (5) pilot tested the project; that the contents of the curriculum (6) focused on clear health goals; (7) focused narrowly on specific behaviors leading to the health goals, gave clear messages about the behaviors, and addressed situations that might lead to them and how to avoid them; (8) addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors; (9) created a safe social environment for youth to participate; (10) included multiple activities to change each of the selected risk and protective factors; (11) employed instructionally sound teaching methods that actively involved the participants, helped them personalize the information, and were designed to change risk and protective factors; (12) employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience; and (13) covered topics in a logical sequence; and that the implementation of the curriculum (14) secured at least minimal support from appropriate authorities, (15) selected educators with desired characteristics, trained them, and provided monitoring, supervision, and support; (16) if needed, implemented activities to recruit and retain youth and overcome barriers to their involvement; and (17) implemented virtually all activities with reasonable fidelity."[57]

Associated Risk Behaviors, , 3, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61741 (relying on Douglas Kirby, et al., *Tools to Assess the Characteristics of Effective Sex and STD/HIV Education Programs*, ETR AND HEALTHY TEEN NETWORK (2014), http://go.etr.org/17-characteristics

[54] Dep't. of Health and Human Services, *Announcement of Availability of Funds for Phase I Replicating Programs (Tier 1) Effective in the Promotion of Healthy Adolescence and the Reduction of Teenage Pregnancy and Associated Risk Behaviors*, , 1, 27, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61741

[55] *id.* at 3.

[56] *Id.* at 12

[57] *Id*. at 13 .

Follow-up language in the grant invitation makes it clear that even sexual risk reduction activities (CSE-type programs) must prioritize cessation of sex among teens who are engaged in it.[58]

Tier II funding,[59] will be awarded "to develop and test new and innovative strategies to prevent teen pregnancy by promoting healthy adolescence and addressing youth sexual risk holistically by enhancing protective factors in order to result in healthy decision making and future thriving. Projects will be funded to evaluate and test innovative strategies to reduce teen pregnancy, improve adolescent health and address youth sexual risk holistically by focusing on protective factors."[60] Tier I exists to replicate existing models containing a required set of factors, described above; Tier II is about creating new strategies. Like Tier I, Tier II projects need to communicate that teen sex is a risk behavior, and that teens should avoid risk entirely, or if already engaged in sex, cease.

Requirements for showing that a program has strong scientific promise are listed,[61] and include low sample attrition, "at least one sustained, statistically significant positive effect on an outcome that meaningfully reduces or avoids risk and is found for the entire relevant cohort (and not merely a subset of the cohort) . . . and no statistically significant negative effects or potentially negative effects for any of the studied cohort." It is also required that the "[s]tudy is conducted by an independent researcher not a part of the publishing company producing the program nor an author of the curriculum," and is "based on a site sample that is sufficient to provide adequate power for the research."[62] Furthermore, "Use of a skilled independent evaluator is required for all summative evaluations. Applicants should clearly describe the training, education, and experience of the proposed lead evaluator relevant to the proposed evaluation agenda. Applicants should discuss the capacity of their lead evaluator to design and implement evaluation(s) of the type(s) proposed within the evaluation agenda, the ability of the evaluator to quickly implement a summative evaluation and evidence of a selected institutional review board."[63]

In February 2018, Congress appropriated 75 million dollars for grants to states for 2018 and 2019, for the implementation of SRA education.[64] The education is required to address each of the following topics: "(A) The holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decision making, and a focus

[58] *Id*. at 14–16.
[59] Dep't. of Health and Human Services, Announcement of the Availability of Funds for Phase I New and Innovative Strategies (Tier 2) to Prevent Teenage Pregnancy and Promote Healthy Adolescence, , 3, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61742

[60] *Id*. at 3-4.
[61] *Id.* at 18.
[62] *Id*.
[63] *Id*. at 19–20.
[64] 42 U.S.C. § 710(a) (2018).

on the future; (B) The advantage of refraining from non-marital sexual activity in order to improve the future prospects and physical and emotional health of youth; (C) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity; (D) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families; (E) How other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex; [and] (F) How to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that even with consent teen sex remains a youth risk behavior."[65]

On contraception, the law provides that each state must ensure that "(A) any information provided on contraception is medically accurate and complete and ensures that students understand that contraception offers physical risk reduction, but not risk elimination; and (B) the education does not include demonstrations, simulations, or distribution of contraceptive devices."[66]

Critics of the new programs blended disdain for the administration's claimed ideology with accusations of its ignoring science and establishing religion.

Planned Parenthood's former research arm—now pro-choice sexual health advocacy and research organization, the Guttmacher Institute—stated that it is known "from a body of evidence that abstinence-only programs don't provide a full range of medically accurate and non-stigmatized education around contraception use."[67] It called the administration's move "reverting back to the failed practices that we wasted more than $2 billion on over the past three decades."[68] Continuing the anti-science theme, Guttmacher claimed that[69] there is "a wealth of evidence that abstinence-only programs do not work to deter or delay sex among young people." And in a "crisis" report Guttmacher issued, they called the effort "ideologically driven," and stated that the teen sex which is the object of the federal initiatives is "a natural and healthy part of being human."[70] Guttmacher continued, saying that sex—far from being inherently harmful to teens—"can offer pleasure and intimacy throughout one's life, not to mention the potential for having children."[71] Guttmacher labeled "controversial" HHS' statements that "abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems," and that "a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity."[72] Finally, they claimed that SRA education "require[s] unethical behavior from educators," and that it "perpetuate[s] inequities and discrimination, and

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[65] 42 U.S.C. § 710(b)(3) (2018).
[66] 42 U.S.C. § 710(b)(4) (2018).
[67] Jessie Hellmann, *Abstinence-only Education Making a Comeback Under Trump*, THE HILL (Mar. 3, 2018),
[68] *Id.*
[69] Jesseca Boyer, *New Name, Same Harm: Rebranding of Federal Abstinence-Only Programs*, 21 GUTTMACHER POL'Y REV., 11, 11 (2018).
[70] *Id.* at 11–12.
[71] *Id.*
[72] *Id.* at 12.

promote[s] stigma against marginalized individuals and toward sex more generally in society,"[73] on the grounds that it promotes gender stereotypes and ignores homosexual sex.[74] Previously, however, Guttmacher had acknowledged that teens having less sex played a role in reducing teen pregnancy rates.[75]

SIECUS, too, criticized SRA, calling the approach "failed" in part on its assertion that about 60 percent of adolescents will have sexual activity before the end of high school. The CDC's actual figure is about 40%[76].

The anti-science claim dominated the reactions reported by media and contraception interest groups. In a single article from the left leaning site *The Intercept*, the "anti-science" theme was repeated five separate times, concluding with the quotation of a university professor: "So, what we're doing is exactly the opposite of what science shows."[77]

3. Partisanship

The controlling staff of the Trump administration's HHS, like HHS staffs of prior administrations, is a partisan body**.** While he was not known as a cultural conservative before his 2015–16 campaign,[78] Donald Trump reached out to and significantly relied upon social conservatives during his presidential run. He met with Evangelical leaders,[79] issued a list of conservative judges whom he would appoint,[80] appointed a Pro-Life Coalition headed by the leader of perhaps the most visible pro-life group today (the Susan B. Anthony List), and

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[73] *Id.* at 13.

[74] *Id.* at 14.

[75] Heather D. Boonstra, *What is Behind the Declines in Teen Pregnancy Rates?*, 17 GUTTMACHER POL'Y REV., no. 3, 15, 16 (2014).

[76] CTRS. FOR DISEASE CONTROL AND PREVENTION, HIGH SCHOOL YOUTH RISK BEHAVIOR SURVEY, 2017 (2017), https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=XX (reporting that slightly less than forty percent of females and slightly more than forty percent of males reported "ever" having sexual intercourse during high school).

[77] Jordan Smith, *Donald Trump's Embrace of Abstinence-Only Sex Ed is an Absurd Twist on a Failed Policy*, THE INTERCEPT (April 2, 2018), https://theintercept.com/2018/04/02/donald-trumps-embrace-of-abstinence-only-sex-ed-is-an-absurd-twist-on-a-failed-policy/.

[78] *See* NBC News, *Trump in 1999: "I am Very Pro-Choice"*, NBC NEWS: MEET THE PRESS (October 24, 1999), https://www.nbcnews.com/meet-the-press/video/trump-in-1999-i-am-very-pro-choice-480297539914?v=railb (Donald Trump explaining his views on same-sex marriage, homosexuals in the military, and abortion); *see also* Melina Dekic, *How Many Times Has Trump Cheated on His Wives? Here's What We Know*, NEWSWEEK (Jan 12, 2018), https://www.newsweek.com/how-many-times-trump-cheated-wives-780550 (discussing allegations of public cheating scandals that Donald Trump has been involved in).

[79] Sarah McCammon, *Donald Trump Meets Evangelical Leaders In New York*, NAT'L PUB. RADIO: ALL THINGS CONSIDERED (June 21, 2016), https://www.npr.org/2016/06/21/482981933/donald-trump-meets-evangelical-leaders-in-new-york.

[80] Lawrence Hurey, *Trump's Supreme Court list: all conservative, some provocative*, REUTERS (May 19, 2016), https://www.reuters.com/article/us-usa-election-trump-court-list/trumps-supreme-court-list-all-conservative-some-provocative-idUSKCN0YA2XV.

promised to appoint pro-life judges and to sign certain pro-life legislation.[81] He also promised to repeal the ACA[82] with its mandate for religious employers to provide contraception to employees. Some of the groups to whom Trump reached out to during his run for the presidency generally support SRA education, including Evangelicals.[83]

Once elected, President Trump appointed two HHS leaders who support SRA education. One of whom is Valerie Huber M.Ed., Senior Policy Advisor for the Office of the Assistant Secretary for Health and Acting Deputy Assistant Secretary, Office of Population Affairs.[84] Dr. Huber has final authority over the Title X family planning program – a federal program providing free or low cost birth control to poor Americans. In February 2018, HHS announced the availability of 260 million Title X dollars for a "broad range of family planning methods and services" and new processes for "streamlin[ing]" applications. The announcement noted that Title X supports 4000 family planning sites nationwide, and serves four million women and men annually.[85]

Dr. Huber managed an abstinence-only sex education program at the Ohio Department of Health, then became President of the National Abstinence Education Association in 2007. The organization is now known as "Ascend," and describes itself as "champion[ing] youth to make healthy decisions in relationships and life by promoting well-being through a primary prevention strategy, and . . . represent[ing] and equip[ping] the Sexual Risk Avoidance (SRA) field."[86]

The prior Deputy Assistant Secretary for Population Affairs—with oversight of Title X programs—was Teresa Manning. She resigned in January 2017, but had worked for the policy arm of Focus on the Family, the Family Research Council, an organization founded by Evangelical leader Dr. James Dobson. When she was appointed, Ms. Manning's 2003 National Public Radio interview expressing skepticism about the long-run efficacy of contraception was widely quoted in the news.[87]

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[81] Letter from Donald Trump, President, U.S., to Pro-Life Leaders, (Sept. 2016) (available at: https://www.sba-list.org/wp-content/uploads/2016/09/Trump-Letter-on-ProLife-Coalition.pdf).
[82] Jacqueline Howard, *What could happen to birth control under President Trump*?, CNN (Jan. 13, 2017), https://www.cnn.com/2016/11/10/health/birth-control-trump/index.html.
[83] *See, e.g.*, Focus on the Family Issue Analysts, *Abstinence Education: Our Position* (2008), https://www.focusonthefamily.com/socialissues/family/abstinence-education/abstinence-education-our-position (an Evangelical Christian organization providing advice and inspiration respecting family life).
[84] U.S. DEP'T OF HEALTH & HUMAN SERV. OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, VALERIE HUBER (June 11, 2018), https://www.hhs.gov/ash/about-ash/leadership/valerie-huber/index.html.
[85] Press Release, Department of Health and Human Services, HHS announces the availability of $260 million to fund the Title X family planning program (Feb. 23, 2018) https://www.hhs.gov/about/news/2018/02/23/hhs-announces-availability-260-million-fund-title-x-family-planning-program.html.
[86] *See* ASCEND, https://weascend.org/ (last visited Nov. 2, 2018)
[87] Juliet Eilperin & Page W. Cunningham, *Antiabortion activist abruptly steps down as head of HHS's family planning division*, THE WASH. POST (Jan. 13, 2018), https://www.washingtonpost.com/news/powerpost/wp/2018/01/12/antiabortion-activist-to-step-down-as-head-of-hhss-family-planning-division/?utm_term=.2146a23fcb28.

1. Scientific Expertise

The Trump administration's HHS spoke of its SRA initiative in the language of "agency expertise" noting that all grantees are required to "use an evidenced based approach and/or effective strategies."[88] As detailed above, its conditions for assessing a program's strong scientific promise[89] include commonly accepted standards for reliability, including, *inter alia*, low sample attrition, a "sustained, statistically significant positive effect," an "outcome that meaningfully reduces or avoids risk and is found for the entire relevant cohort, . . . and no statistically significant negative effects or potentially negative effects for any of the studied cohort." It also required that the study be "conducted by an independent researcher not a part of the publishing company producing the program nor an author of the curriculum," and is "based on a site sample that is sufficient to provide adequate power for the research."[90] Furthermore, "[u]se of a skilled independent evaluator is required for all summative evaluations.[91]

HHS also announced a project to "develop a conceptual model to understand the pathways to sexual risk avoidance for prevention of teen pregnancy." This project would be led by respected Mathematica Policy Research, and would include "(1) a comprehensive and structured literature review of the theoretical foundation of sexual risk avoidance and the evidence on the effectiveness of program approaches, including public health messaging related to sexual and other risk behaviors; and (2) input from a set of experts on teen development and risk-taking behavior."[92]

In sum, the agency set out requirements for SRA programs which appear to demand a high level of evidence respecting efficacy from grantees. It also asserted in its detailed public critique of CSE programs[93] that these could not meet its evidence-based standards.

2. Religious Establishment?

It is well known that many religions have extensive theological and moral teachings concerning sex, including about premarital sex, the meaning and purpose of sex, and contraception. Many world-religions teach that non-marital sex is immoral, although only the

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[88] HHS, FAMILY AND YOUTH SERVICES BUREAU, SEXUAL RISK AVOIDANCE EDUCATION PROGRAM FACT SHEET (Feb. 17, 2017), https://www.acf.hhs.gov/fysb/resource/srae-facts.
[89] HHS, OFFICE OF THE ASSISTANT SEC'Y FOR HEALTH, OFFICE OF ADOLESCENT HEALTH, ANNOUNCEMENT OF THE AVAILABILITY OF FUNDS FOR PHASE I NEW AND INNOVATIVE STRATEGIES (TIER 2) TO PREVENT TEENAGE PREGNANCY AND PROMOTE HEALTHY ADOLESCENCE (June 29, 2018), https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61742.
[90] *Id*. at 18.
[91] *Id*. at 18–19.
[92] HHS, Adminis. For Children & Families, Office of Planning, Research & Evaluation, *Model on Risk Avoidance Theory and Research, Informing an Optimal Health Model*, 2017 – Overview (Feb. 13, 2018), https://www.acf.hhs.gov/opre/resource/model-on-risk-avoidance-theory-and-research-informing-an-optimal-health-model-2017-overview.
[93] *See* Office of the Assistant Secretary for Health, *supra* note 42.

Roman Catholic Church teaches that it is immoral to use contraception. In light of this, it is not surprising that government action seeking to stop premarital sex, and largely avoiding the subject of contraception, would be subject to scrutiny on the grounds that it establishes religious ideas. Members of conservative administrations are familiar with this criticism. Dr Valerie Huber was quoted regarding the SRA approach: "Our critics like to pigeonhole this as a religious issue," "but the truth is that this has value for every student regardless of faith or moral framework - or lack thereof."[94]

More than a few legal scholars have worked to make the case that SRA programs establish religion.[95] According to the excellent summary by Professor John Taylor, it is frequently argued that "abstinence education is so ineffective that it can only be explained as an effort to promote a religious vision of sexual morality."[96] This perspective, he writes, "invites us to view debates about sex education as contests between pragmatic, scientific promoters of public health and ideologues who privilege (religious) values over science (and, perhaps, over common sense as well)."[97] Authors might even claim that the norm of premarital abstinence is wholly religious, because religious organizations vocally promote it, and because it is so widely rejected by nonreligious Americans.[98]The Supreme Court has held in two decisions, however, that an overlap between a religious teaching and a civil law or rule does not, without more, automatically spell "establishment."[99]

In the 1980 case of *Harris v. McRae*,[100] for example, the Court upheld the federal Hyde Amendment (denying federal funding for certain abortions) against an establishment challenge, stating that "it does not follow that a statute violates the Establishment Clause because it

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[94] Dr. Valerie Huber as quoted in Jordan Smith, *Donald Trump's Embrace of Abstinence – Only Sex Ed is an Absurd Twist on a Failed Policy,* THE INTERCEPT (April 2, 2018), https://theintercept.com/2018/04/02/donald-trumps-embrace-of-abstinence-only-sex-ed-is-an-absurd-twist-on-a-failed-policy/.

[95] *See e.g.*, Erica Woebse, *Eating Hot Peppers to Avoid HIV/AIDS: New Challenges to Failing Abstinence-Only Programs*, 20 WILLIAM & MARY J. OF WOMEN & THE LAW 709, 724 (2014); John E. Taylor, *Family Values, Courts, and Culture War: The Case of Abstinence-Only Sex Education*, 18 WM. & MARY BILL RTS. J. 1053, 1054 (2010); Julie Jones, *Money, Sex, and the Religious Right: A Constitutional Analysis of Federally Funded Abstinence-Only-Until-Marriage Sexuality Education*, 35 CREIGHTON L. REV. 1075, 1094–95 (2002); James McGrath, *Abstinence-Only Adolescent Education: Ineffective, Unpopular, and Unconstitutional*, 38 U.S.F. L. REV. 665, 689 (2004); Edward L. Rubin, *Sex, Politics, and Morality*, 47 WM. & MARY L. REV. 1, 46 (2005) ("Abstinence-only sex education is . . . a religious position . . . [and] [t]he preference for sexual abstinence is . . . just as clearly a religious position as prayer or creationism."); Gary J. Simson & Erika A. Sussman, *Keeping the Sex in Sex Education: The First Amendment's Religion Clauses and the Sex Education Debate*, 9 S. CAL. REV. L. & WOMEN'S STUD. 265, 284 (2000); Naomi Rivkind Shatz, Comment, *Unconstitutional Entanglements: The Religious Right, the Federal Government, and Abstinence Education in the Schools*, 19 YALE J. L. & FEMINISM 495, 520 (2008).

[96] John E. Taylor, *Family Values, Courts, and Culture War: The Case of Abstinence-Only Sex Education*, 18 WM. & MARY BILL RTS. J. 1053, 1055 (2010).

[97] *Id.* at 1055–56.

[98] *See* Naomi Rivkind Shatz, Comment, *Unconstitutional Entanglements: The Religious Right, the Federal Government, and Abstinence Education in the Schools*, 19 YALE J.L. & FEMINISM 495, 524–26 (2008).

[99] *See Harris v. McRae*, 448 U.S. 297, 320 (1980); *McGowan v. Maryland*, 366 U.S. 420, 444, 448–49, 452 (1961).

[100] 448 U.S. 297 (1980).

‘happens to coincide or harmonize with the tenets of some or all religions.”[101] And in its 1988 *Bowen v. Kendrick*[102] decision, the Court held that the federal government’s promotion of premarital sexual abstinence in its Adolescent Family Life Act programs was not an establishment of religion, even though some grants were used by religious organizations. The Court determined instead that AFLA was motivated primarily by a legitimate secular purpose: “the elimination or reduction of social and economic problems caused by underage sexuality, pregnancy and parenthood.”[103] Further, parents, and a myriad of secular groups were enlisted to assist with these problems, not just religious groups. [104] The Court opined that it was reasonable for Congress to recognize that “religious organizations can influence values and can have some influence on family life, including parents’ relations with their adolescent children.” [105] It also found nothing inherently religious about the activities of the program, stating that just because its approach “may coincide with the approach taken by certain religions,” the notion of self-discipline and abstinence are not intrinsically religious notions or practices.[106] The Court left open an invitation to the program’s challengers on remand, however, “to show that AFLA aid is flowing to grantees that can be considered ‘pervasively sectarian,’” or to show that the money was “used to fund ‘specifically religious activit[ies].’”[107] The challengers pursued such an inquiry, which eventually led to a settlement with the federal government requiring more oversight and transparency from religious grantees.[108]

I now turn to a second HHS action – this one during the Obama administration - wherein a sexual and reproductive health initiative triggered claims about partisanship, the quality of the science, and the proper relationship between religion and the state.

B. THE CONTRACEPTION MANDATE

1. The Mandate

The contraception mandate arose under the Obama Administration as a result of a “preventive services” provision within the Affordable Care Act,[109] which required group health plans and health insurance issuers offering group or individual health insurance coverage, to cover, without a co-pay, “preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.”[110] The Health Resources Services Administration (“HRSA”) is an office within HHS.

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[101] *Id.* at 319 (quoting *McGowan v. Maryland*, 366 U.S. 420, 442 (1961)).
[102] 487 U.S. 589 (1988).
[103] *Id.* at 602, citing § 300z(a), (b).
[104] *Id.* at 603.
[105] *Id.* at 607.
[106] *Id.* at 605.
[107] *Id.* at 621.
[108] *See* Rebekah Saul, Whatever Happened to the Adolescent Family Life Act? The Guttmacher Report on Public Policy 5, 10 (April, 1998), https://www.guttmacher.org/sites/default/files/article_files/gr010205.pdf.
[109] The Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
[110] 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.*

HRSA thereafter commissioned the Institute of Medicine ("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."[111] Today it is renamed the National Academy of Medicine. For purposes of discussing its role in the contraception mandate, however, I will continue to refer to it as the IOM, given how frequently this title was used during litigation over the mandate.

After empaneling a committee of sixteen persons and holding hearings throughout 2010 and 2011, the IOM issued its report in July 2011 entitled: *Clinical Preventive Services for Women: Closing the Gaps,* ("the IOM Report")[112] The report stated, among other recommendations, that "[t]he 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."[113]

HHS fully adopted the IOM report on this point, and issued a rule[114] requiring employers of a certain size to provide employees health insurance covering, without a co-pay, "[a]ll…[FDA] approved contraceptive methods," with a religious exemption for churches, associations of churches, and religious orders, but without an exemption for religious institutions such as hospitals, schools and social services.[115] The latter religious employers were given rather an "accommodation," requiring them to facilitate provision of the objectionable drugs and devices to their employees by cooperating with an insurer who would work with their insurance provider.[116] A revised accommodation was issued in August 2014, allowing an objecting religious employer to trigger the provision of contraceptives to its employees by notifying the government of its objection, and not its insurance company.[117] The government thereafter would notify the organization's insurers who are thereby authorized and obligated to pay for contraception for the religious employers' beneficiaries.[118] A failure to abide by the rule would subject these institutions to fines up to one hundred dollars per day per employee.[119]

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[111] IOM (INSTITUTE OF MEDICINE), CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAP (2011).
[112] *Id.*
[113] *Id.* at 109–10.
[114] Coverage of Certain Preventative Services Under the Affordable Care Act, 78 Fed. Reg. 39,874, 39,875 (July 2, 2013).; *See* 45 C.F.R. 147.131(b)(1) and (2)(i) (2012).
[115] Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39870-01, 39,870, 39,872-4 (July 2, 2013).
[116] Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 8456-01, 8456–76 (Feb. 6, 2013); 78 Fed. Reg. at 39,871 (July 2, 2013).
[117] 29 C.F.R. 2590.715- 2713A(b)(1)(ii)(B) and (c)(1); 45 C.F.R. § 147.131(c)(1); *See* 79 Fed. Reg. 51,092 (Aug. 27, 2014).
[118] *See* 26 C.F.R. §§ 54.9815-2713AT(b)(2), (c) (2017); 29 C.F.R. §§ 2590.715-2713A(b)(1)(ii)(B), (b)(2), (c); 45 C.F.R. §§ 147.131(c)(1)(ii), (c)(2)(i).
[119] *See* 26 U. S. C. § 4980D (2015).

On the face of the regulation, it is plain that HHS drew a line between churches on the one hand, and religious charitable, educational, and social service institutions on the other, on the basis of its belief that the latter institutions are not equally religious if they serve and hire nonbelievers, or have purposes (e.g. health care, charity, etc.) other than the inculcation of a particular faith.

Over 300 plaintiffs in one hundred lawsuits challenged the mandate on religious freedom grounds. A Christian for-profit corporation, Hobby Lobby Stores, Inc., challenged only the mandate's requirement to provide FDA-approved drugs and devices that the FDA and then-Secretary of HHS, Kathleen Sebelius, had acknowledged might act to destroy an embryo, versus to prevent conception.[120] This case was decided by the Supreme Court in *Burwell v. Hobby Lobby Stores, Inc.*,[121] which held that the regulations substantially burdened the exercise of religion under the Religious Freedom Restoration Act,[122] while the government had failed to show that the mandate constituted the least restrictive means of serving a compelling governmental interest.

2. Partisanship

Interest groups and elected officials robustly committed to contraception and/or abortion were quite active in producing the contraception mandate, most particularly the Planned Parenthood Federation of America ("PPFA") and its prior research affiliate, the Alan Guttmacher Institute.[123] PPFA enjoyed a close relationship with President Obama, HHS Secretary Sebelius (in her prior role as the Governor of Kansas), and a large percentage of the members of the IOM committee that drafted the recommendation.

PPFA received approximately 350 million dollars triennially[124] from HHS throughout the Obama presidency, and was during that same period a large contributor to President Obama's

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[120] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2775 (2014). Plan B is a drug that prevents contraception. *See How Does Plan B One-Step Work?*, PLANBONESTEP.COM, https://www.planbonestep.com/faq.aspx (last visited Oct. 29, 2018); Food & Drug Admin., Plan B Approved Labeling (2006), available at http:// www.accessdata.fda.gov/drugsatfda_docs/nda/2006/021045s011_Plan_B_PRNTLBL.pdf. Ella i+s another drug that prevents contraception. *See* Watson Pharm., Inc., Ella Labeling Information (2010), available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf.

[121] *Hobby Lobby Stroes, Inc.*, 134 S. Ct. at 2759.

[122] Pub. L. No. 103-141, § 6(c), 107 Stat. 1488, 1489 (1993). 42 U.S.C. § 2000bb *et seq*.

[123] Alan Guttmacher was the President of the PPFA in the late 1960s and early 1970s. Originally called the Center for Family Planning Program Development, what became known as the Guttmacher Institute was part of PPFA's corporate structure in the late 1960s. It remained a special affiliate of PPFA, receiving funding therefrom, until its affiliate status was ended in 2007. Today, the positions of PPFA and the Guttmacher Institute on contraception and abortion remain identical. *See* Gutttmacher Institute: Frequently Asked Questions, https://www.guttmacher.org/guttmacher-institute-faq#6 (last visited Oct. 29, 2018).

[124] Letter from Marcia Crosse, Director, Health Care, US Government Accountability Office, *Response to Congressional Requesters: Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012* (Mar. 20, 2015), http://www.gao.gov/assets/670/669140.pdf.

reelection campaign.[125] PPFA also proved to be the most tireless and vocal interest-group supporter of the mandate, as against the religious freedom claims of hundreds of largely Christian institutions. President Obama became the first sitting President ever to speak personally at a PPFA meeting. There, he referred to himself as "a president who's going to be right there with you, fighting every step of the way."[126]

In 2010, President Obama proposed a budget cutting off all funding for the abstinence programs funded by the Bush administration, and redirecting all funding to CSE programs of the kind supported by PPFA, Guttmacher and SIECUS.[127]

In 2016, when some states were seeking to re-orient family planning funding to agencies other than PPFA, President Obama quickly oversaw the issuance of a regulation[128] that did not mention PPFA by name, but was carefully drafted to forbid states – on the threat of cutting off their federal Medicaid funding – from refusing to grant abortion-providing family planning agencies from receiving state-allocated Title X family planning funds.[129] At this time, PPFA was suffering a severe reputational blow due to undercover sting videos showing PPFA officials in several states agreeing to sell fetal body parts to companies (falsely) claiming to specialize in this business.[130] Whether or not PPFA was engaged in illegal behavior under federal or state laws, the videos led many state legislatures to consider cutting off PPFA funding.

The Secretary of HHS, under whom the IOM panel was commissioned, Kathleen Sebelius, was also exceptionally close to PPFA. She enjoyed their support during her time as Governor of Kansas. At that time, Planned Parenthood of Kansas and Mid-Missouri threw a tribute party to Governor Sebelius, celebrating her as one of the "champions of our cause."[131]

The language of the IOM Report closely reflected a recommendation made by PPFA's former research affiliate, the Guttmacher Institute, one of the few witnesses selected by the IOM panel to testify before it. In a 2011 article published in its *Policy Review*, Guttmacher

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[125] Press Release, *Planned Parenthood: Obama Reelection, Minnesota Triumphs are "Resounding Victory for Women, by Women"* (Nov. 7, 2012), available at http://plannedparenthoodadvocate.typepad.com/blog/2012/11/planned-…-minnesota-triumphs-are-resounding-victory-for-women-by-women.html

[126] Associated Press, *Obama tells Planned Parenthood: abortion foes want return to 1950*s, The Associated Press, last updated Dec. 20, 2015, http://www.foxnews.com/politics/2013/04/26/obama-tells-planned-parenthood-abortion-foes-want-return-to-150s.html.

[127] *See* Teenage Pregnancy Prevention, *supra* note 27, at 18.

[128] 42 C.F.R. Part 59.3(b), 81 F.R. 91852-01, 91852, 91853 (2016) ("Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients"); *see also* Stephanie Armour, *States Warned Over Ending Medicaid Funds for Planned Parenthood*, THE WALL STREET J., August 12, 2015, http://www.wsj.com/articles/hhs-warns-states-of-possible-violation-in-ending-medicaid-funds-for-planned-parenthood-1439392786?ru=yahoo?mod=yahoo_itp.

[129] 42 C.F.R. Part 59.3(b), 81 F.R. 91852-01, 91852, 91853.

[130] See e.g. Brianna Ehley, *Court rules Arkansas can block Medicaid funding from Planned Parenthood*, POLITICO, (Aug. 16, 2017, 12:53 PM), https://www.politico.com/story/2017/08/16/planned-parenthood-medicaid-funding-arkansas-241706.

[131] *Real Issues*, (Planned Parenthood of Kansas and Mid-Missouri), Summer 2007, reprinted at **http://operationrescue.org/pdfs/PP%20NL%20Summer07.pdf.**

proposed "The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing." Planned Parenthood's materials endorsed the same outcome. [132]

The experts empaneled by the IOM to produce its "preventive health care services" recommendations were also committed to a particular outcome concerning contraception and abortion. At least nine out of sixteen members of the panel had close ties with either PPFA, or another prominent contraception and abortion advocacy organization. They served as members or even board chairs of various Planned Parenthood affiliates nationwide.[133] These committee members included the following: Dr. Paula Johnson, who had served for many years on the board of the Planned Parenthood League of Massachusetts and chaired its board from 1997-1998;[134] Dr. Magda Peck who served as chair and vice-chair of the Board of Directors Planned Parenthood of Nebraska Council Bluffs (now Planned Parenthood of the Heartland) from 2006-2009;[135] Dr. Carol Weisman who was a member of the Affiliate Medical Committee of Planned Parenthood of Maryland from 1993-1997 and a member of the Board of Directors of Planned Parenthood of Maryland from 1978-1984;[136] and Dr. Francisco Garcia who worked with the International Planned Parenthood Federation.[137] Other Committee members closely associated with contraception and abortion advocacy organizations included: Dr. Paula Johnson who served on the board of the Center for Reproductive Rights, an organization with the mission of expanding abortion access;[138] Dr. Claire Brindis, a co-founder of the Bixby Center for Global and Reproductive Health, which provides abortion training and initiatives designed to expand abortion services. Dr. Brindis also chaired the Population, Family Planning and Reproductive Health Section (PRSH) of the American Public Health Association.[139] Dr. Angela Diaz, another Committee member, served as a Board Member for the Physicians for

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[132] Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 GUTTMACHER POL'Y REV., no. 1, 7, 10, 15 (2011); see, e.g., *Birth Control Matters: Making Prescription Birth Control Affordable for America's Women*, PLANNED PARENTHOOD OF THE GREAT NORTHWEST, Winter 2011, https://www.plannedparenthood.org/files/1214/0519/4964/Focus_Winter_2011_web.pdf

[133] See Letter from Anna Franzonello, Ams. United for Life, to Ctrs. for Medicare and Medicaid Servs. (Oct. 21, 2014).

[134] *Annual Report FY: 2013*, PLANNED PARENTHOOD OF MASSACHUSETTS (2013), https://www.plannedparenthood.org/files/5814/0995/1649/9_PPLM_FY13_AnnualReport_FINAL.pdf.

[135] Magda Peck Executive Profile, BLOOMBERG, https://www.bloomberg.com/research/stocks/private/person.asp?personId=60438776&privcapId=51867329&previousCapId=51867329&previousTitle=Planned%252520Parenthood%252520Of%252520Nebraska-Council%252520Bluffs%252520Iowa%252520Inc (last visited Oct. 30, 2018).

[136] Carol S. Weisman, *Curriculum Vitae*, PENN. STATE AT HERSHEY, (Oct. 10), http://www.pennstatehershey.org/c/document_library/get_file?folderId=229089&name=DLFE-25907.pdf

[137] Francisco Garcia M.D., *Biography*, U.S. PREVENTIVE TASK FORCE (Oct. 2018), https://www.uspreventiveservicestaskforce.org/Page/Biography/Francisco-Garcia.

[138] Paula Johnson, *CV*, WELLESLEY COLLEGE (Oct. 2015), https://www.wellesley.edu/sites/default/files/assets/departments/news/files/paula_johnson_cv.pdf.

[139] Claire Brindis, *Biography*, BIXBY CENTER, https://bixbycenter.ucsf.edu/claire-brindis-drph (last visited Oct. 30, 2018).

Reproductive Choice and Health.[140] And Dr. Alina Salganicoff had worked as a trainer and counselor for CHOICE, "a Philadelphia-based, reproductive health care advocacy organization."[141]

The IOM Committee as thus constituted thereafter selected a disproportionate number of very like-minded organizations to be among the few witnesses invited testify before it. These included, *inter alia*, contraception and/or abortion advocates PPFA, the Guttmacher Institute, [142] the National Women's Law Center's Health and Reproductive Rights Center, the National Women's Health Network, and the National Campaign to Prevent Teen and Unplanned Pregnancy.[143] No religious health care provider or association was selected to testify, including the Catholic Health Association, which is the group representing the hospitals providing the largest amount of private healthcare for women and men in the United States, treating one out of every six U.S. patients admitted to a U.S. hospital.[144]

The mandate's campaign purposes were described by Michael Wear, a close advisor to President Obama during his 8 years in office. Wear revealed in his memoirs—*Reclaiming Hope: Lessons Learned in the Obama White House about the Future of Faith in America*[145]—that senior presidential campaign staff urged the president in an Oval Office meeting to choose "the path of most resistance" to the claims of even sympathetic religious nonprofit plaintiffs fighting the mandate—like the Little Sisters of the Poor (a group of nuns caring without charge for the elderly poor).[146] Staff members advised the president that this strategy would amplify the perception that the president was the clear champion of women—as opposed to his Republican opponent Mitt Romney.

This strategy worked in concert with another dynamic characterizing both the Obama administration and the Obama re-election campaign: their claims to champion the sexual expression interests of women against religions and religious institutions. For example, an administration spokesperson stated that the contraception mandate better represented Catholic women's interest than the Catholic Church's own teachings respecting

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[140] *Board of Directors*, PHYSICIANS FOR REPRODUCTIVE HEALTH, https://prh.org/board-of-directors/ (last visited Oct. 30, 2018).

[141] Alina Salganicoff, *Biography*, CTR. FOR HEALTH JOURNALISM, https://www.centerforhealthjournalism.org/resources/sources/alina-salganicoff (last visited Nov. 1, 2018).

[142] *Testimony of Guttmacher Institute*, Submitted to the Committee on Preventive Services for Women, Institute of Medicine, GUTTMACHER INSTITUTE, Jan. 12, 2011.

[143] *See*IOM, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS: APPENDIX B: AGENDAS OF PUBLIC MEETINGS HELD BY THE COMMITTEE ON PREVENTIVE SERVICES FOR WOMEN (2011), , http://www.nap.edu/read/13181/chapter/12.

[144] *2018 U.S. Catholic Health Care: The nation's largest group of not-for-profit health care providers*, CATHOLIC HEALTH ASS'N OF THE U.S., https://www.chausa.org/docs/default-source/default-document-library/cha_2018_miniprofile7aa087f4dff26ff58685ff00005b1bf3.pdf?sfvrsn=2 (last visited Nov. 1, 2018).

[145] MICHAEL R. WEAR, RECLAIMING HOPE: LESSONS LEARNED IN THE OBAMA WHITE HOUSE ABOUT THE FUTURE OF FAITH IN AMERICA (2017), ___.

[146] *Our Mission Statement*, LITTLE SISTERS OF THE POOR, http://www.littlesistersofthepoorwashingtondc.org/who-we-are/ (last visited Nov. 1, 2018).

contraception.[147] The president personally contacted the single woman publicly challenging a Catholic university's refusal to provide her free birth control, in order to support her in her public spat with radio host Rush Limbaugh.[148] And the administration imposed a rule requiring access to contraception and abortion onto an anti-trafficking law, effectively excluding Catholic providers whom it had deemed more competent than other recipients.[149]

The campaign took a very aggressive stance on the mandate. One of its campaign websites (*Tumblr*) falsely claimed that Romney wished to allow employers to make decisions for women about their health care, even to the point of holding specific conversations with female employees about their use of contraception, and whether their preferences aligned with their employers'.[150] It also strongly suggested that without the mandate, employees would need an employer's explicit and written permission even to personally decide to buy or use contraception.[151]

The campaign also developed an e-postcards called "misleading" by the *Washington Post*'s factchecker.[152] The cards urged women to "vote like your lady parts depend on it. . . . Because they kinda do,"[153] and invented a "letter to home" from a young, single adult, asking her parents for "$18,000 to help pay for my birth control?"- referring to the claim that Republican candidate Mitt Romney would repeal the health care law and the mandate. Meanwhile, the IOM Report had acknowledged that contraceptive coverage was at that time "standard practice for most private insurance," with nine of ten employer-based insurance plans already including it.[154]

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[147] *See* Becky Bowers, *White House official says 98 percent of Catholic women have used contraception*, POLITIFACT (Feb. 6, 2012, 4:09 P.M.), https://www.politifact.com/truth-o-meter/statements/2012/feb/06/cecilia-munoz/white-house-official-says-98-catholic-women-have-u/.

[148] M.J. Lee, *Obama calls student dissed by Rush*, POLITICO, (Mar. 2, 2012, 1:24 P.M.), https://www.politico.com/story/2012/03/obama-calls-student-dissed-by-rush-073549.

[149] *See* Jerry Markon, *Abortion, birth control access at issue in dispute over denial of grant to Catholic group*, THE WASH. POST (Nov. 11, 2011), https://www.washingtonpost.com/politics/abortion-birth-control-access-at-issue-in-dispute-over-denial-of-grant-to-catholic-group/2011/11/11/gIQA36sYDN_story.html?noredirect=on&utm_term=.7b72ab7c4b94.; and 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) (Determining that the Catholic "proposal for assisting human trafficking victims" provided the "best value").

[150] Michael Brendan Dougherty, *The Obama Campaign Just Told Some Massive Lies in the Fight Over Contraception*, BUS. INSIDER (Mar. 1, 2012, 2:11 P.M.), http://www.businessinsider.com/the-obama-campaign-just-told-some-massive-lies-in-the-fight-over-contraception-2012-3.

[151] *Id.*

[152] Josh Hicks, *Misleading messages from the Obama campaign on the contraceptive mandate*, WASH POST. (Oct. 5, 2012), https://www.washingtonpost.com/blogs/fact-checker/post/misleading-messages-from-obama-campaign-on-contraceptive-mandate/2012/10/04/ebb2148c-0cdf-11e2-bd1a-b868e65d57eb_blog.html.

[153] Daniel Halpern, *Obama Campaign: "Vote Like Your Lady Parts Depend on it. Because they kinda do,"* THE WEEKLY STANDARD, (Oct. 2, 2012); Hicks, *supra* note 152.

[154] IOM Report, *supra* note 111, at 108.

Secretary Sebelius and other presidential surrogates spoke frequently on the matter of the mandate during the course of the campaign, in person and in print, making regular claims about its "health benefits," and the "prohibitive" expense of contraception.[155] The campaign also ran ads through its last weeks, conflating women's "health issues" entirely with contraception and abortion, and highlighting Romney's opposition to requiring religious institutions to comply with the mandate.[156] The melding of women's health and contraception was also accomplished by the choice of the leading public face of the mandate, Sandra Fluke, to be the featured speaker at "women's night" at the Democratic National Convention, re-nominating Barack Obama for President.[157] Ms. Fluke thereafter transitioned into full-time work within the Obama campaign, travelling across the United States and speaking continually about the mandate.

3. Scientific Expertise

From the beginning of its commission to the IOM, HHS and leading press characterized the mandate as a matter of straightforward scientific fact. They characterized the IOM as "nonpartisan," and "expert[]"[158] . HHS claimed that the mandate would "remov[e] the barriers to economic advancement and political and social integration" that have "plagued certain disadvantaged groups, including women."[159] It would ensure that women are "able to contribute to the same degree as men as healthy and productive members of society."[160]

Courts of appeals upholding the regulations against constitutional attack regularly accepted these characterizations of both the IOM report and the mandate.[161] And in *Burwell v. Hobby Lobby Stores, Inc.*[162] Justice Kennedy's concurrence — which provided the 5th crucial vote — used IOM language to conclude that HHS was serving a "compelling interest" by providing coverage "necessary to protect the health of female employees," "significantly more costly than for a male employee," and necessary for "many medical conditions for which pregnancy is contraindicated."[163]

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[155] Michelle Bauman, *USA today editorial clashes with Sebelius on HHS Mandate*, CATHOLIC NEWS AGENCY (Feb. 7, 2012), https://www.catholicnewsagency.com/news/usa-today-editorial-clashes-with-sebelius-on-hhs-mandate.

[156] Jon Greenberg, *Barack Obama says Mitt Romney opposes contraception mandate and would cut Planned Parenthood funding*, POLITIFACT, (Aug. 8, 2012), http://www.politifact.com/truth-o-meter/statements/2012/aug/08/barack-obama/obama-slams-romney-on-contraception-and-planned-pa/.

[157] Wall Street Journal, *DNC 2012 – Sandra Fluke Address the DNC*, YOUTUBE, https://www.youtube.com/watch?v=cfNimwxSTU4.

[158] Robert Pear, Panel Recommends Coverage for Contraception, The New York Times, July 19, 2011, https://www.nytimes.com/2011/07/20/health/policy/20health.html.; Brief for the Petitioners, Sebelius v. Hobby Lobby Stores, Inc., et al. (U.S. Supreme Court No. 13–354), 5,

[159] Brief for the Petioners at 49, *Sebelius v. Hobby Lobby Stores, Inc*., et al., 134 S.Ct. 2751 (2014) (No. 13-354).

[160] Priests for Life v. The U.S. Department of Health and Human Services, Def. Mem. at 25-26 (filed October 17, 2013).

[161] *See e.g.*, Priests for Life v. The U.S. Department of Health and Human Services, 772 F. 3d 229, 238 (2014).

[162] Burwell v. Hobby Lobby., 134 S. Ct. 2751 (2014) (Kennedy, J, concurring).

[163] *Id.*, at 2785–86.

The dissenting opinion of Justices Ginsburg, Sotomayor, Breyer and Kagan in *Hobby Lobby* also assumed the IOM report's accuracy and expertise, and referred to the IOM Committee as "independent experts."[164] On the basis of the Committee's claims about "cost-related barriers," the contraindications for pregnancy among women with "congenital heart diseases, pulmonary hypertension and Marfan Syndrome," and the claimed health effects of unintended pregnancy,[165] the dissenting Justices easily found that the state had shown a compelling state interest sufficient to override the free exercise claims of the religious corporations.

When challengers won suits against the mandate, several Supreme Court Justices and opposing interest groups claimed that science had lost. Justice Sotomayor's concurrence in *Zubik v. Burwell*[166], for example — after the Court refused to impose the mandate on objecting religious organizations due to outstanding questions about the state's use of "least restrictive means" — assumed the correctness of HHS' characterization of birth control as preventive medical care.[167] Planned Parenthood's action arm reminded subscribers that the "nonpartisan" IOM recommended free birth control because it is "fundamental" to the health of women and their families, concluding that "[m]edical research has demonstrated this fact for decades."[168]

Finally, when the Trump administration overturned the mandate and proposed a new rule in October 2017, [169] lawsuits were immediately filed by several states' attorney generals, claiming that the reversal constituted an establishment of religion.[170] At the time of this writing, two federal judges have issued preliminary injunctions blocking the rule on the basis of administrative procedure failures, while one has upheld the rule.[171]

Judges in these cases regularly grant credibility to the IOM but not to the scientific sources cited in the Trump administration's new rule. They might, for example, refer to the IOM as a "diverse committee of experts."[172] Further, when California's attorney general prevailed over HHS's new rule on the grounds of the Administrative Procedure Act, the court cited the

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[164] *Id*. at 2788–89 (Ginsburg, J., dissenting).
[165] *Id*. at 2789.
[166] *Id*.
[167] *Id.* at 1561 (Sotomayor, J., concurring).
[168] Planned Parenthood Action Fund, 7 Facts You Need to Know About Birth Control Coverage, https://www.plannedparenthoodaction.org/issues/birth-control/facts-birth-control-coverage.
[169] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the ACA, 82 Fed. Reg. 47792, 47807-08 (proposed Oct. 13, 2017); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the ACA, 82 Fed. Reg. 47838, 47849 (proposed Oct. 13, 2017).
[170] *See*, *e.g. State of California v. Health and Human Services*, 17 Civ. 05783 (HSG) (N.D. CA Dec. 21, 2017), https://www.courthousenews.com/wp-content/uploads/2017/12/Contraception-Mandate-TRO-ORDER.pdf; *Commonwealth of Pennsylvania v. Donald Trump*, Civil Action No. 17-4540 (E.D. PA Dec. 15, 2017), https://www.courthousenews.com/wp-content/uploads/2017/12/Beetlestone-order.pdf.
[171] Nate Raymond, *Judge rejects Massachusetts challenge to Trump birth control rules*, REUTERS (March 12, 2018), https://www.reuters.com/article/us-usa-trump-healthcare/judge-rejects-massachusetts-challenge-to-trump-birth-control-rules-idUSKCN1GO2M4.
[172] *State of California v. HHS* at 3.

"potentially dire public health and fiscal consequences" of allowing some religious employers to opt out.[173] Moreover, Pennsylvania's injunction of the new rule cited the possibility of medical harm to the Commonwealth's female residents.[174]

4. A Free Exercise Violation?

From its first iteration of the contraceptive mandate, HHS drew lines between churches and religious institutions such as charities, hospitals and schools.[175] It refused exemption to religious organizations that did not primarily hire and serve co-believers, and exist primarily for the purpose of inculcating religious values. But the bulk of religious charities, schools and health care institutions make their services available to all human beings in need, without regard to creed. The revised regulations continued to require such institutions to ensure free contraception to employees by means of their health insurance benefits. [176]

The US Conference of Catholic Bishops ("USCCB") claimed that later version of the mandate "continues to define 'religious employer' in a way that, by the government's own admission, excludes (and therefore subjects to the mandate) a wide array of employers that are undeniably religious. Generally the nonprofit religious organizations that fall on the 'non-exempt' side of this religious gerrymander include those organizations that contribute most visibly to the common good through the provision of health, educational, and social services."[177]

In the words of First Amendment Professor Rick Garnett: "The mandate reflected a view that religious freedom is really just about a freedom to worship on the Sabbath and believe in the privacy of your home. . . . But for many people in the Christian tradition, faith is something that's lived on Monday, not just practiced on Sunday; what happens in soup kitchens and adoption agencies doesn't really count as religious exercise."[178]

A coalition of religious leaders, including Mormons, Catholics, Evangelicals, Baptists, Orthodox Christians, Jews, and members of the Society for Krishna Consciousness, issued a statement saying, "[w]e believe the doctrines of our respective faiths require something of us beyond the walls of our churches, synagogues, temples, and other places of worship. Those

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[173] *Id*. at 27.
[174] *Commonwealth of Pennsylvania v. Trump*, at 37.
[175] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and ACA, 77 Fed. Reg. 8725, 8727 (Feb. 15, 2012).
[176] *Id.* at 8728.
[177] USCCB, *News Releases: USCCB Says Administration Mandate Violates First Amendment Freedoms of Religious Organizations and Others* (March 20, 2013), http://www.usccb.org/news/2013/13-054.cfm.
[178] Heidi Schlumpf, *Contraception mandate: women's health or religious liberty issue?*, NATIONAL CATHOLIC REPORTER (Oct. 18, 2017), https://www.ncronline.org/news/people/contraception-mandate-womens-health-or-religious-liberty-issue.

faith convictions manifest themselves through our daily interactions among family, neighbors, strangers and institutions."[179]

> An observation by a representative of the USCCB later observed that:
> The HHS's 'religious employer exemption' is 'so extremely narrow that it protects almost no one. . . .'" "Jesus himself, or the Good Samaritan of his famous parable, would not qualify as 'religious enough' for the exemption, since they insisted on helping people who did not share their view of God.[180]

> A representative of Evangelical educational institutions, wrote that:

> [F]ull time administrators and faculty at our institution share the Christian faith of the institution. Obviously our administrators and faculty do share the deeply held religious convictions of their employers, contrary to the Department's view. Ironically, churches, on the other hand, some of which do not hire only Christians, remain exempt in this scheme. This exposes why this is not a coherent criterion -- rather, the religious mission of the organization should drive the distinction.[181]

Information surfaced, during discovery in one of the many lawsuits filed against the mandate, that HHS wished to ensure that religious charities, schools and hospitals were covered by the mandate, without serious reflection upon their religious character. To wit, before HHS actually considered comments submitted to it by religious institutions—that is, before the official comment period had ended—Secretary Sebelius delivered a speech at Harvard University stating that HHS had already concluded that such religious institutions would not be considered for exemption, interestingly focusing upon Catholic institutions. She stated:

> [B]y August 1st of this year, every employer *will be covered by the law* with one exception. Churches and church dioceses as employers are exempted from this benefit. But, Catholic hospitals, Catholic universities, other religious entities, *will be providing* coverage to their employees starting August 1st. . . . . [A]s of August 1st, 2013, every employee who doesn't work directly for a church or a diocese will be included in the benefit package.[182]

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[179] Standing Together for Religious Freedom: An Open Letter to All Americans, reprinted in Matthew Brown, *Coalition of religious groups signs open letter for religious liberty*, DESERET NEWS, (July 8, 2013), https://www.deseretnews.com/article/865582788/Religious-groups-including-LDS-Church-sign-open-letter-against-birth-control-mandate.html.

[180] News Release, US Conference of Catholic Bishops, Cardinal DiNardo Issues Respect Life Month Statement (Sept. 26, 2011) (on file with author).http://www.usccb.org/news/2011/11-180.cfm.

[181] Brief of Wheaton College at 50, Wheaton Coll. v. Burwell, 791 F.3d 792 (7th Cir. 2015)

[182] *See* Kathleen Sebelius, U.S. Sec'y of Health and Human Serv., Remarks at The Forum at Harvard Sch. of Pub. Health (Apr. 8, 2013)
(transcript available at http://theforum.sph.harvard.edu/events/conversation-kathleen-sebelius)(emphasis added).

PART III. Promoting Sexual and Reproductive Health Without Sacrificing the Guarantees of the First Amendment or the Religious Freedom Restoration Act

Outside of the arena of human sexuality, federal medical information and advice is regularly communicated in a nuanced fashion. HHS agencies like the Centers for Disease Control and the National Institutes of Health discuss new reports or findings alongside caveats and or calls for further research to overcome the limitations of what is available.[183]

But when sex meets administrative policy and intersects religious positions, the agency's scientific case is rarely nuanced. As will be discussed below, this almost certainly reflects a mix of partisanship with the desire to avoid establishment or free exercise claims by characterizing the agency rule as 100% "science." Additionally, religious actors often fail to respond to the government's blunt pronouncements in ways that adequately state or defend their position. In this section, I will critique HHS' claimed scientific arguments for both SRA funding and the contraception mandate. I will then suggest ways in which HHS could more credibly develop and present its sexual and reproductive health policy. Finally, I will discuss the charges of establishment or the violation of free exercise, and suggest ways for HHS to avoid the charges, and for religious actors to clarify their positions before government and the public.

A. The Science Behind the Policies – Not as Expert as it Needs to Be

1. SRA Education and "Expertise"

When announcing its substitution of SRA for CSE funding, HHS recited its critique of CSE in well-known scientific terms. HHS also required SRA grantees to structure and evaluate their programs according to a substantial array of rigorous scientific criteria, including criteria authored by an evaluator of sex education programs used by the Obama administration.[184] HHS additionally stressed the logical argument in favor of SRA programs: that only sexual abstinence guarantees freedom from pregnancy and STIs, with the latter representing a very significant problem for teenagers in the 21st century. HHS pointed to data from the 1990s to today indicating that asking high school students to abstain from or delay sex is not an impossible ideal. The drop in high school students' sexual activity beginning in the early 1990s is quite dramatic, recently, dropping to near 40%.[185] And HHS noted that SRA programs are far more than "just say no" instructions. They contain numerous components designed to address

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[183] *See, e.g.,* National Institutes of Health, *Coffee Drinkers Have Lower Risk of Death*, NIH Research Matters (June 4, 2012), https://www.nih.gov/news-events/nih-research-matters/coffee-drinkers-have-lower-risk-death (reporting on the health effects of coffee while noting that all of coffee's effects are difficult to "tease out" due to its complex contents, effect differentials by sex, and the inability to prove causality).

[184] *See* Dept. of Health and Human Services, *supra* note 53, at 12-14; see also Kirby, *supra* note 53, at 9.

[185] *See* CDC, *supra* note 76, at tbl.133.

broader sets of psychological, emotional and practical factors affecting a young person's decisions about sex.[186]

This is a scientific presentation on the part of the state. Still, HHS failed to present a more balanced empirical picture about SRA and CSE, and left a number of subjects and questions unaddressed, which have a bearing on the matter of improving sexual and reproductive health. The following description of leading evaluations of CSE and SRA education indicates what more HHS could have done, while appreciating the difficulty of speaking briefly but accurately about the efficacy of various forms of sex education in an article of this size.

First, HHS should have strengthened its case by pointing out that it is generally agreed (though there are of course dissenters who support teens exploring sex[187]) that it would be ideal for teenagers to avoid sex given the public expense, and the harms to both parents and children of very youthful parenting,[188] including very high rates of teen STIs. It is also generally agreed that individuals with fewer sex partners are less likely to divorce,[189] while an earlier sexual debut predicts more partners.[190] HHS might also have pointed out that because the vast majority of contraceptives don't protect against STIs, *and* people are resistant to using two forms of contraception simultaneously (i.e. including a condom), abstinence is an important way to help teens avoid fueling the current STI epidemic. Finally, HHS might have pointed to literature about the psychological harms, and later relationship instability possibly associated with adolescent sexual involvement.[191]

Second, HHS should have noted plainly that there are many measurement problems associated with evaluating sex education programs, whether SRA or CSE. There are questions of sample size, the socioemographics of individuals and their communities, the use of self-reported results, the presence or absence of a control group, variations in program designs and consistency of attendance, and the timing of the evaluation, post-program. Researchers admit that the topic and the research is controversial and "intertwined with ideologies, inadequate

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[186] FAMILY & YOUTH SERV. BUREAU, *Sexual Risk Avoidance Education Program Fact Sheet*, HHS (Feb. 17, 2017) https://www.acf.hhs.gov/fysb/resource/srae-facts.
[187] *See* Hellman, *supra* note 67.
[188] Helen B. Chin, *The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services*, 42 Am. J. Prev. Med. 272, 273 (2012).
[189] Nicholas H. Wolfinger, *Counterintuitive Trends in the Link Between Premarital Sex and Marital Stability*, INST. FOR FAMILY STUDIES BLOG (June 6, 2016) https://ifstudies.org/blog/counterintuitive-trends-in-the-link-between-premarital-sex-and-marital-stability.
[190] *See e.g.,* John Santelli, et al., *Multiple Sexual Partners Among U.S. Adolescents and Young Adults*, 6 Family Planning Perspectives 271, 273 (1998), https://www.guttmacher.org/sites/default/files/article_files/3027198.pdf.
[191] *See e.g.,* K.Paige Harden, *Does True Love Wait? Age of First Sexual Experience Predicts Romantic Outcomes in Adulthood,* ASS'N FOR PSYCHOL. SCIENCE, (Oct. 17, 2012), https://www.psychologicalscience.org/news/releases/does-true-love-wait-age-of-first-sexual-experience-predicts-romantic-outcomes-in-adulthood.html; *see generally* Denise D. Hallfours et al., *Which Comes First in Adolescence – Sex and Drugs or Depression*? 29 AM. J. OF PREVENTIVE MEDICINE 163 (2005)

research, and misunderstandings of such efforts."[192] There are also sharp differences about the proper goals. What should matter? Abstinence until marriage? Delayed intercourse? Fewer sexual partners? Knowledge and/or attitudes about sex, STIs, pregnancy, or contraception? Avoiding pregnancy or STIs?

Third, regarding the literature that *has* attempted to evaluate either or both SRA and CSE programs, HHS should have pointed out that while some studies conflict, others have overlapping conclusions sufficient to draw at least a few reliable conclusions about both types of programs. More than a few conclude that some SRA programs have some effects, although usually not large effects, for varying periods of time, post-program. This was acknowledged regarding programs funded by the Obama administration[193] and from evaluations of earlier programs.[194] It is also acknowledged in several well-regarded peer-reviewed articles considering particular programs or existing studies.[195]

But HHS should acknowledge these effects differ *widely* among particular programs. Some effects are quite gender specific.[196] Some work possibly because of levels of parent participation.[197] Some have short-term effects but no apparent longer-term ones. Some show differences mainly in knowledge and attitudes. Effects might also differ depending upon age,[198] or upon whether the students have had prior sexual experience.[199] There might also be

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[192] Thomas E. Smith et al., *Evaluating Effectiveness of Abstinence Education*, 14 J. OF EVIDENCE-INFORMED SOCIAL WORK 360, 365 (2017).

[193] U.S. DEP'T OF HEALTH & HUM. SERV., RESULTS FROM THE OAH TEEN PREGNANCY PREVENTION PROGRAM https://www.hhs.gov/ash/oah/sites/default/files/tpp-cohort-1/tpp-results-factsheet.pdf (last visited October 10, 2018); U.S. DEP'T OF HEALTH & HUM. SERV., TPP PROGRAM GRANTEES (FY2010-2014), https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/about/tpp-cohort-1/index.html (last visited May 11, 2017); special issue of American Journal of Public Health explores impacts of Teen Pregnancy Prevention Program. Russell P. Cole, *The Teen Pregnancy Prevention Program (2010-2015): Synthesis of Impact Findings*, 106 AM. J. OF PUB. HEALTH S9 (2016); *see also* Jennifer Manlove et al, *Programs to Improve Adolescent Sexual and Reproductive Health in the U.S.: A Review of the Evidence*, 6 ADOLESCENT HEALTH, MED. AND THERAPEUTICS 47 (2015).

[194] *See e.g.* STAN E. WEED AND IRENE H. ERICKSON, THE INSTITUTE FOR RESEARCH AND EVALUATION, RE-EXAMINING THE EVIDENCE: SCHOOL-BASED COMPREHENSIVE SEX EDUCATION IN THE UNITED STATES (Sept. 12, 2017), https://www.comprehensivesexualityeducation.org/wp-content/uploads/Reexamining_the_Evidence-CSE_in_USA_6-1-18FINAL.pdf)

[195] *See e.g.* Thomas E. Smith, et al., *Evaluating Effectiveness of Abstinence Education*, 14 J. OF EVIDENCE-INFORMED SOCIAL WORK 360 (2017); Peter S. Bearman & Hannah Bruckner, *Promising the Future: Virginity Pledges and First Intercourse*, 106 AM. J. OF SOCIOLOGY, 859, 860-62 (2001); Michael D. Resnick et al., *Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health*, 278 J. OF THE AM. MEDICAL ASS'N, 823 (1997); ELAINE BORAWSKI, ET AL., CTR. FOR HEALTH PROMOTION RESEARCH, DEP'T. OF EPIDEMIOLOGY AND Q3 BIOSTATISTICS, CASE WESTERN RESERVE UNIV. SCH. OF MED., EVALUATION OF THE TEEN PREGNANCY PREVENTION PROGRAMS FUNDED THROUGH THE WELLNESS BLOCK GRANT (1999–2000); Marion Howard & Judith Blamey McCabe, *Helping Teenagers Postpone Sexual Involvement,* 22 FAM. PLAN. PERSPECTIVES 21, 21 (1990); Stephen R. Jorgensen et al., *Project Taking Charge: Six Month Follow Up of a Pregnancy Prevention Program for Early Adolescents*, 42 FAM. RELATIONS 401, 404 (1993).

[196] *See generally* Monica Silva, *The Effectiveness of School-Based Sex Education Programs in the Promotion of Abstinent Behavior: A Meta-Analysis, 17* HEALTH EDUC. RESEARCH 471 (2002).

[197] *Id.*

[198] Smith et al., supra note 194, at 361; Chin et al., supra n. 7, at 288–89.

[199] Smith, T. E., Steen, J. A., Schwendinger, A., Spaulding-Givens, J., & Brooks, R. G., *Gender*

differences among programs conducted in school, or in a clinic,[200] or depending upon the use of a "parent-youth" relationship model.[201]

When summarizing program evaluations, HHS should have highlighted articles achieving respect from *both* SRA advocates *and* opponents[202] such as the article[203] concluding that one particular SRA program demonstrated a significant reduction in the numbers of young people (mean age 12.2) who had sex, and reductions in sexual activity and frequency of (33% versus 48% in the control group) when measured two years after the program's conclusion. Some other articles show modest but promising outcomes as well. [204]

On the other hand, HHS should have frankly grappled with studies concluding that some SRA programs are ineffective respecting most or all outcomes. Some studies even claim to show that SRA education produces reverse effects, i.e. worse outcomes on measures ranging from pregnancy to STI rates to use of contraception.[205] More commonly, however, negative articles find few to no effects.

For example, in a widely-cited 2007 review of SRA programs during the Bush Administration, conducted by one of the most prominent evaluators of sex education, the Mathematica Policy Institute,[206] the authors followed students from four to six years after their enrollment in SRA education. The students were young (grades 3-8), racially and ethnically diverse, and mostly poorer. The programs were mandatory or voluntary. There was a control group. The study found that "youth in the program group were no more likely than control group to have abstained from sex and, among those who reported having had sex, they had similar numbers of sexual partners and had initiated sex at the same mean age." But they were

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differences in adolescent attitudes and receptivity to sexual abstinence education, 27 Children & Schools 45, 46 (2005). Borawski, E. A. et al., *Effectiveness of abstinence-only intervention in middle school teens,* 29 American Journal of Health Behavior*,* 423, 431 (2005); Chin, supra note 190, at 288–89.

[200] *See* Stan E. Weed and Irene H. Erickson, *Re-Examining the Evidence: School-Based Comprehensive Sex Education in the United States, The Institute for Research and Evaluation* (Sept. 12, 2017), 21, 23, https://www.comprehensivesexualityeducation.org/cse-report/ (recommending non-school settings).

[201] Jennifer Manlove, Heather Fish and Kristin Anderson Moore, *Programs to improve adolescent sexual and reproductive health in the US: a review of the evidence*, 6 Adolesc. Health Med. Ther. 47, 47, 62–63, (2015). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4396579/

[202] *See, e.g.,* Henry J. Kaiser Family Foundation, *Abstinence Education Programs: Definition, Funding and Impact on Teen Sexual Behavior* (June 1, 2018) https://www.kff.org/womens-health-policy/fact-sheet/abstinence-education-programs-definition-funding-and-impact-on-teen-sexual-behavior/#footnote-258222-12 (praising study cited in *infra* note 205).

[203] Jemmott JB III, Jemmott LS, Fong GT, *Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescent,* 164 Arch Pediatr Adolesc Med 152, 153 (2010).

[204] Christine M. Markham et al., *Behavioral and Psychosocial Effects of Two Middle School Sexual health Education Programs at Tenth-Grade Follow-Up*, 54 J. of Adolesc. Health 151, 157–158 (2014), https://www.jahonline.org/article/S1054-139X(13)00739-8/fulltext; Chin, supra note 190 at 288.

[205] Stanger-Hall, K. F., & Hall, D. W., *Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S.*, 6 PLoS One, e24658 (2011), doi:10.1371/journal.pone.0024658.

[206] Christopher Trenholm et al., *Impacts Of Four Title V, Section 510 Abstinence Education Programs*, Final Report (2007), http://www.mathematica-mpr .com/publications/PDFs/impactabstinence.pdf.

no more likely to have engaged in unprotected sex than the control group.[207] Among the program group it discerned "no overall impact on knowledge of unprotected sex risks and the consequences of STDs."[208]

Looking more closely at one of the four programs evaluated, this study found that it did show a modest positive impact for sexual abstinence in the last 12 months.[209] The report also noted that another program seemed to lead to a statistically significant increased knowledge of the risks of STDs and pregnancy.[210]

Mathematica observed further that a teen's religiosity predicted for remaining abstinent and having fewer partners,[211] though it would not go so far as to claim causality. It also pointed to the possible positive effect of peer influence, but noted that peer groups often dispersed in high school.[212]

Interestingly, this report, like many others, noted that many SRA programs are targeted to very young students (elementary and middle school), such that it could not opine about the effects of SRA education in high school, or of SRA education continued from elementary through high school.[213]

Fourth, HHS should have addressed directly the biggest fear of CSE proponents about SRA education: whether it might diminish the use of contraception by young people who *do* choose to become sexually active, leading possibly to STIs and pregnancy. Many studies suggest that this should not be a concern,[214] or even that SRA students had *less* unprotected sex,[215] but a few studies demonstrate the opposite.[216]

Fifth, HHS should have acknowledged how frequently researchers claim *better* outcomes following CSE versus SRA programs. One study flatly concluded that CSE, but not SRA programs, are capable of reducing pregnancy rates. This same article also noted, however, that

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[207] *Id.* at xvii.
[208] *Id.* at xviii.
[209] *Id.* at xxii.
[210] *Id*. at xxiii.
[211] *Id*. at app. D, pp. 9-10 tbl.D.4.
[212] *Id*. at xxiv.
[213] *Id*. at 61.
[214] Chin, *supra* note 190, at 289; John B. Jemmott, III, et. al., *Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 months: A Randomized Controlled Trial With Young Adolescents*, 164(2) ARCH PEDIATR ADOLESC MED 152, 152-53 (2010).
[215] Christine M. Markham, et al., *Behavioral and Psychosocial Effects of Two Middle School Sexual health Education Programs at Tenth-Grade Follow-Up*, 54 J. OF ADOLESC. HEALTH 151, 155 (2014), https://www.jahonline.org/article/S1054-139X(13)00739-8/fulltext.
[216] Anthony Paik, et. al., *Broken Promises: Abstinence Pledging and Sexual and Reproductive Health*, 78(2) J. OF MARRIAGE FAM. 546, 546-47 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4806393/.

neither program appeared to affect STI rates,[217] and stated that fears of CSE opponents that CSE increased rates of sexual activity were not founded.[218]

An article by perhaps the most prominent sex-education researcher, Douglas Kirby, concluded that while some few SRA programs delayed the initiation of sex—though not significantly—a much larger percentage of CSE programs both delayed sex and increased contraception use among youth.[219]

Sixth, HHS should have noted that even conservative voices claiming the benefits of SRA admit that the effects of sex education on delaying sexual debut seem to differ according to a child's sex, age and race. It also appears that protective effects wane as adolescents age, and are very small by age 19.[220]

Seventh and finally, HHS should have noted that there is significant literature concluding that *neither* type of sex education program is worth the struggle and money that contestants expend. One large 2016 study of sex education programs in Africa, Latin America and Europe—covering 55 thousand participants, and relying only upon randomized control trials and objective measures—concluded that such programs had no measurable effects whatsoever on non-marital pregnancy rates.[221] The exception? A program offering poorer students incentives to stay in school using cash payments or free school uniforms, which reduced both STI and pregnancy rates.

In his widely-hailed book *Forbidden Fruit: Sex and Religion in the Lives of American Teenagers*[222] sociologist Mark Regnerus included a sub-chapter entitled: "The Irrelevant Sex Education Debate." There, he claims that what motivates sexual decision-making is the "plausibility structure" of "like-minded family, friends, and authorities who [ ] teach and enable comprehensive religious perspectives about sexuality to compete more effectively against ubiquitous sexually permissive scripts."[223]

And in his comprehensive study of 20th century sex education in the U.S., historian Jeffrey Moran, questions the entire idea that students will simply "respond rationally to information given them."[224] He suggests instead that the "critical question is not whether

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[217] Pamela K. Kohler, et. al., *Abstinence-Only and Comprehensive Sex Eduation and the Initiation of Sexual Activity and Teen Pregnancy*, 42 J. OF ADOLESC. HEALTH 344, 344 (2008).
[218] *Id.*
[219] Douglas B. Kirby, *The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior*, 5 SEXUALITY RES. & SOC. POL'Y 18, 18 (2008).
[220] Samuel W. Sturgeon, *The Relationship Between Family Structure and Adolescent Sexual Activity*, THE HERITAGE FOUNDATION: FAMILY FACTS: SPECIAL REPORT, 10 (2008).
[221] Amanda J. Mason-Jones, et al., *School-based interventions for preventing HIV, sexually transmitted infections, and pregnancy in adolescents*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS, 11 (2016), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006417.pub3/epdf/full.
[222] MARK D. REGNERUS, FORBIDDEN FRUIT: SEX AND RELIGION IN THE LIVES OF AMERICAN TEENAGERS 58 (2009).
[223] *Id.* at 203.
[224] JEFFREY P. MORAN, TEACHING SEX: THE SHAPING OF ADOLESCENCE IN THE 20TH CENTURY [pincite] (2000).

students understand the mechanics of the condom but whether their vision of their own life is such that preventing pregnancy or avoiding disease is important enough for the condom to seem relevant."[225] He proposes that only education that touches on their most important relationships and their hopes for the future can begin to influence their incremental choices about sex and parenting.

More than a few scholars, in fact, suggest that factors other than the type of sex education matter much more to teen outcomes—factors such as family structure or function or educational opportunities. There is some evidence, for example, that family structure, the teen pregnancy histories of mothers or sisters, and the degree of parental support[226] play a role in teen pregnancies. And regarding education, scholars are paying close attention to the role played by educational opportunities in influencing young people to avoid a teen pregnancy.[227] Agencies might demonstrate convincing and proper humility in the face of the many factors affecting teen pregnancy, in fact, by offering to work across federal agencies dealing with the entire array of factors involved.

1. Contraception and Expertise

The IOM Report made a variety of arguments[228] that seem intuitively true on their face and were repeated constantly by Obama administration officials during his re-election campaign and in the mandate litigation. In other words, it seem intuitively true that women and not men pay the cost of most contraception such that its coverage and cost would be gender equity questions. It seemed intuitively true that contraception would reduce unintended pregnancies, and non-marital pregnancies, and rates of abortion. It also seems true that long-acting methods could be more expensive albeit more effective, but beyond the reach of women with less money.

In other words, given the wide appeal of contraception and arguments which were logical on their face, it was not at all difficult for HHS to present a brief argument (8 pages of a 236 page report) with relatively few footnoted sources written by groups and individuals friendly to the notion of a contraception mandate. Yet even a brief reflection upon the creation of the IOM Report, and upon the few sources it relied upon, reveals the one-sidedness of the

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[225] *Id.* at 220.
[226] Richard W. Blum, et al., *The Effects of Race/Ethnicity, Income, and Family Structure on Adolescent Risk Behavior*s, 90 AM. J OF PUB. HEALTH 1879, 1881–83 (2000) (but not at individual level); Erin Calhoun Davis and Lisa V. Friel, *Adolescent Sexuality: Disentangling the Effects of Family Structure and Family Context*, 63 J. OF MARRIAGE AND FAMILY 669, 670 (2001); Kristin Mmari, et al., *The Influence of the Family on Adolescent Sexual Experience: A Comparison between Baltimore and Johannesburg*, 11 PLoS ONE 2 (2016), *available at* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0166032; Patricia L. East, et al., *Association Between Adolescent Pregnancy and a Family History of Teenage* Births, 39 PERSP. ON SEXUAL AND REPROD. HEALTH 108, 108 (2007) ("Compared with young women with no family history of teenage births, young women whose sister had had a teenage birth and those whose sister and mother both had had teenage births were significantly more likely to experience a teenage pregnancy").
[227] *See* Stone, *supra* note 12.
[228] IOM REPORT, *supra* note 112, at 102–10.

mandate. Regarding the former, I have already described above the biases of a large fraction of the appointed IOM Committee, and the exclusion of religious health care witnesses in favor of activists supporting maximum contraception and abortion availability. Regarding the latter—the sources and arguments relied upon in the IOM Report—I have critiqued their inadequacy extensively in prior writing,[229] but will summarize their shortcomings briefly here.

The Report's leading claims included: that women's higher health care costs are attributable to contraception such that sexual equality along economic lines demands free contraception; that there is an unmet demand for contraception due to its cost; that there is an unmet demand for contraception among women with health problems rendering pregnancy especially dangerous; that making contraception free would increase its usage or lead directly to usage of different, more effective means of contraception; that contraception has caused a reduction in unintended pregnancy rates; that unintended pregnancy itself poses health risks to women; and that contraception leads directly to declining abortion rates.[230]

But a careful review of each medical source referenced in the contraception chapter of the IOM report, combined with a wider review of medical literature produced by widely accepted expert sources (e.g. the Centers for Disease Control, the World Health Organization, the Guttmacher Institute, prior IOM reports, and leading medical journals), reveals a different picture.

First, women's higher health care costs do not appear to be due to the cost of contraception. The IOM Report provided no sources at all to substantiate this claim; federal Medicaid and Medicare research that the IOM ignored attributes the higher health care costs of women in their child-bearing years to maternity care, not contraception.[231]

Second, regarding cost as a barrier, the Centers for Disease Control data, which is cited in the IOM Report, doesn't include "cost" on its list of "frequently cited reasons for nonuse," of contraception among the 11% of sexually-active women not using it.[232] Furthermore, in a Guttmacher source the IOM overlooked, only 7.9% of the total sample of women seeking abortions listed cost as a barrier to contraceptive usage[233]; the study's authors did not inquire whether these women were eligible for one of the many state programs providing free or low cost contraception.[234] The lack of urgency for the mandate from a cost perspective was eventually disclosed in a 2017 Guttmacher Institute report showing that after three years of

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[229] Helen M. Alvare, *No Compelling Interest: The "Birth Control" Mandate and Religious Freedom*, 58 VILLANOVA L. REV. 379, 379 (2013).

[230] IOM REPORT, *supra* note 112, at 103–09.

[231] ALVARE, *supra* note 231, at 425–430; CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. PERSONAL HEALTH CARE SPENDING BY AGE AND GENDER, 2012 HIGHLIGHTS (2012).

[232] IOM REPORT at 103; WILLIAM D. MOSHER & JO JONES, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, USE OF CONTRACEPTION IN THE U.S.: 1982-2008 6, 14 (2010).

[233] RACHEL K. JONES ET AL., CONTRACEPTIVE USE AMONG U.S. WOMEN HAVING ABORTIONS IN 2000-2001, PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 294, 297–98 (2002).

[234] ELAYNE J. HEISLER, ET AL., FEDERAL SUPPORT FOR REPRODUCTIVE HEALTH SERVICES: FREQUENTLY ASKED QUESTIONS, CONGRESSIONAL RESEARCH SERVICE, No. 7-5700, (last Visited Aug. 24, 2016), https://fas.org/sgp/crs/misc/R44130.pdf.

free contraception provided under the mandate, sexually active women had not increased their use of contraception at all, nor had they switched to methods which may be more effective and longer-acting, but more expensive up-front.[235] Furthermore, the Centers for Disease Control has very recently reported that slightly *fewer* sexually active women ages 15-44 are using contraception today than before the mandate was promulgated: 79.7 percent before and 79.2 percent after.[236]

Third, medical evidence undercuts the argument that contraception is especially necessary for women with certain health conditions contraindicating for pregnancy. The IOM Report specified the conditions of pulmonary hypertension, cyanotic heart disease, and Marfan Syndrome. But in the case of each of these health problems, the relevant specialist medical associations instead recommended that women *avoid* the more prescription hormonal methods the Report promotes, and use instead nonprescription barrier methods, or even natural methods of family planning, given the dangers that hormones pose to women with these conditions.[237] These types of risks are acknowledged in a chart published by the Obama-era HHS, detailing health conditions contraindicating for various forms of contraception. It is a long list.[238]

Fourth, although it seemed that it must be facially true that contraception would reduce unintended pregnancy rates, the IOM and others had previously acknowledged that this had not occurred over time periods when the use, availability, and even funding of contraception had increased. The IOM did not allude to this in its report. For example, in a different IOM report issued just one year earlier than the preventive services report, the IOM had written that "[t]he 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

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[235] *New Study Finds Little Change in Patterns of U.S. Contraceptive Use From 2012 to 2015*, THE GUTTMACHER INSTITUTE (March 13, 2017), https://www.guttmacher.org/news-release/2017/new-study-finds-little-change-patterns-us-contraceptive-use-2012-2015.

[236] CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS, KEY STATISTICS FROM THE NATIONAL SURVEY OF FAMILY GROWTH- C LISTING, https://www.cdc.gov/nchs/nsfg/key_statistics/c.htm#everused(last visited Nov. 5, 2018).

[237] *See, e.g.*, HEART DISEASE & PREGNANCY, PATIENT INFORMATION: MARFAN SYNDROME,http://www.heartdiseaseandpregnancy.com/pat_mar_mom.html (last visited Nov. 5, 2018); THE ADULT CONGENITAL HEART ASSOCIATION, HEART MATTERS, ACHA Q AND A: BIRTH CONTROL FOR WOMEN WITH CONGENITAL HEART DISEASE(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), https://www.phaonlineuniv.org/files/Birth%20Control%20and%20Hormonal%20Therapy%20in%20PAH.pdf (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 . . . .").

[238] CENTERS FOR DISEASE CONTROL, SUMMARY CHART OF U.S. MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (2017),https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf (last visited Nov. 5, 2018)

other countries."[239] This contradicted the Report's general claim that "greater use of contraception within the population produces lower unintended pregnancy . . . rates nationally."[240] IOM also did not discuss research by Guttmacher Institute and others showing that unintended pregnancy rates are the highest among the group of women who already receive free contraception–poor women.[241] Furthermore, according to both Guttmacher and federal sources, unintended pregnancy rates sometimes rise during periods of time when rates of contraception usage among women are also increasing.[242] And rises in unintended pregnancy rates have also occurred during the period of time when the IOM reported that twenty-eight states passed laws similar to the mandate.[243]

It is well known to academics following the subject of unintended pregnancy that it is not by any means a simple function of available contraception; it is rather affected by everything from rates of poverty and cohabitation, to age at first marriage, use and method failures of contraception, and the state of public mores associated with non-marital sex, pregnancy and birth. Furthermore, there are also frequently explored sex and marriage "marketplace" effects when contraception is widely available. In such a context, it might appear to participants that sex is seemingly "insured" against the risk of pregnancy, and thus less "weighty" or significant. Rates of non-marital sex sometimes increase.[244]

Fifth, neither the IOM report nor a great deal of additional literature supports the claim that unintended pregnancy itself causes health risks to women, which contraception could help avoid. The IOM report also failed to treat at any length the possible health risks posed by contraception itself.

On the matter of health risks, the IOM report claimed that unintended pregnancy causes violence against women, smoking, and drinking. But not only did the report fail to cite studies containing causal claims, it also overlooked evidence that strongly suggests that a third factor,

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[239] INST. OF MED., WOMEN'S HEALTH RESEARCH: PROGRESS, PITFALLS, AND PROMISE 143 (2010).
[240] IOM REPORT at 105.
[241] *See* LAWRENCE B. FINER AND MIA R. ZOLNA, UNINTENDED PREGNANCY IN THE UNITED STATES: INCIDENCE AND DISPARITIES: 2006, CONTRACEPTION 478 (Nov. 2011).
[242] *See, e.g.*, 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."); JO JONES, WILLIAM MOSHER & KIMBERLY DANIELS, *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, in NATIONAL HEALTH STATISTICS REPORTS 1, 11 (2012), https://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf.
[243] IOM Report, *supra* note 111, at 108.
[244] *See, e.g.*, John S. Santelli & Andrea J. Melnikas, *Teen Fertility in Transition: Recent and Historic Trends in the United States*, 31 ANN. REV. PUB. HEALTH 371, 377, 380, C-1 (2010); 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, 280, 288–300 (1996); Peter Arcidiacono, Ahmed Khwaja & Lijing Ouyang*, Habit Persistence And Teen Sex: Could Increased Access To Contraception Have Unintended Consequences For Teen Pregnancies*? 30 J. BUS. & ECON. STAT. 312, 312, 323 (2012); and Jonathan Klick & Thomas Stratmann, *The Effect of Abortion Legalization on Sexual Behavior: Evidence from Sexually Transmitted Diseases*, 32 J. LEGAL STUD. 407, 410 (2003).

women's "risk taking" proclivity, leads *both* to unintended pregnancy *and* to smoking, drinking, violence and, depression.[245]

Furthermore, contraception itself poses risks to women's health. There is substantial evidence linking some forms of contraception—usually hormonal—with various adverse health outcomes for women.[246] This is not to suggest alarm about contraceptive drugs and devices, which are used by millions of women without significant complaint. It is to observe, however, that in a report devoted to women's health, large scale studies linking contraception with increased rates of sexually transmitted infections, depression, greater HIV transmission, blood clots and certain cancers, would appear to merit more attention.[247] On the matter of the risks of contraceptives themselves, the Report said only that "[f]or women with certain medical conditions or risk factors, some contraceptive methods may be contraindicated," and that there are "[s]ide effects," which are "generally considered minimal."[248] A CDC informational chart available to the public during the Obama administration indicates many of these risks.[249]

The fact that contraception poses some health risks may be why U.S. Preventive Services Task Force—the highest governmental medical expertise in the United States respecting necessary "preventive care"—has not, even to this time, recommended contraception as preventive health care for women.[250] Contraception's absence from this list, for nearly 60 years following its invention, was not discussed by the IOM Report.

Sixth and finally, the Report does not cite to literature showing that contraception inevitably leads to declining abortion rates. The Report based its claim upon a Guttmacher study[251] reporting a rise in the rate of unmarried women using contraception during the period 1982 to 2002, and a decline for abortion over the latter portion of this period. But this study does not address population level effects, only effects upon unmarried women and only for 20 years. It variously claimed that more contraception "accompanied" or "contributed" to diminished abortion rates. It does not mention or control for the other factors affecting abortion rates at that time such as the economy, mores, and changes in relationship and family structures, to name just a few. This same study also admits that early widespread adoption of contraception has often been accompanied by an increase in abortion rates. For example,

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[245] *Id*. at 411–14.
[246] *Id*. at 416–20.
[247] 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 Carriers*, 94 J. NAT'L CANCER INST. 1773, 1778 (2002); Natasha Singer, *Health Concerns over Popular Contraceptives*, N.Y. TIMES, Sept. 26, 2009, at B1, https://www.nytimes.com/2009/09/26/health/26contracept.html.
[248] IOM Report, *supra* note 111, at 105.
[249] U.S. CENTERS FOR DISEASE CONTROL, A SUMMARY CHART OF U.S. MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (2017), https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf.
[250] U.S. PREVENTIVE SERVICES TASK FORCE, PUBLISHED RECOMMENDATIONS, https://www.uspreventiveservicestaskforce.org/BrowseRec/Index (current as of October 2018).
[251] HEATHER D. BOONSTRA ET AL., "ABORTION IN WOMEN'S LIVES", Guttmacher Inst. 1, 17-18 (2006).

between 1970 and 1982, during which time access to contraception was rising because of the invention of the federal Title X program, abortion rates were climbing. Furthermore, since the rates of abortion began falling in the early 1990s, they have occasionally ticked up during a few years between 2000 and 2010 when the Report claims contraception use was rising.[255] Again, the relationship between contraception and abortion is far more complex and unpredictable than the IOM Report's treatment allows.

2. Elevating the Expert Case

Given the above evaluations of the evidence underlying the SRA grants and the contraception mandate, it is not difficult to prescribe how HHS might improve the quality of its sexual and reproductive health recommendations in order to meet accepted standards of scientific credibility regarding efficacious programs.

First, on matters upon which there are competing, credible position HHS should consult the necessary variety of experts, and transparently report their identity and affiliations.

When reporting the evidence supporting a particular policy, the agency should be precise. It should be precise about the balance of the evidence and its level of credibility, and it should provide details about the potential efficacy of each funded program regarding each desired goal: e.g. some advance one goal, some another; some work better with girls, or junior high students, etc. This is to say that HHS should also be frank about what success looks like. If programs are deemed successful because they "increase knowledge" about STI transmission, this is fine, but should not be confused with evidence that a program appears to lead to reduced STIs, which is the more important result.

HHS should also demonstrate modesty about the role that *any* of its initiatives might play, especially in an area like sexual behavior where improvements have usually been modest or non-existent. Numerous other factors matter. And even a program funded with tens of millions of dollars will reach only a tiny subset of American teens. There is also the fact that HHS efforts are far from the entire universe of efforts regarding teen pregnancy. States might cooperate with HHS, or agree to its funding limitations, but they can also pursue their own initiatives, which might differ considerably, or even take an *opposite* view to that of HHS.

B. Avoiding Both Establishment and the Burdening of Free Exercise

1. Establishment

It seems obvious on its face, and in the mind of the Supreme Court that it is not an establishment of religion to encourage sexual abstinence or delay. There are sound medical and

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[255] See LAURIE D. ELAM-EVANS, ET AL., (CDC) Abortion Surveillance-United States, 2000, 52 MORBIDITY AND MORTALITY WEEKLY REP. NO. SS-12, 17 (2003); STEPHANIE J. VENTURA ET AL., (CDC) Estimated Rates of Pregnancy Outcomes for the U.S., 1990-2008, 9 (June 20, 2012).

emotional reasons for teens to avoid sexual entanglements.[256] The majority of high school students today do so. The Supreme Court, as detailed *supra*,[252] has clearly indicated that the fact of agreement between a religious precept and a civil law is not intrinsically suspicious, including where abstinence education is concerned. President Obama's HHS funded several abstinence programs, and reported that several demonstrated positive outcomes.

But it is also certainly the case that abstinence is a "value" as so helpfully articulated by Professor John Taylor,[253] just as, for some proponents of CSE, a teen's choice to be sexually active while using contraception is a value. Agencies can and should acknowledge this, and discuss how easily – even inaccurately – observers might always conflate the notion of a value with a religious precept. Nearly all laws and policies express a value; in fact they regularly take sides on competing values. One need not be a smart lawyer to find an overlap between almost any value and some religious precept. That cannot be the test for a religious establishment.

Religious actors also have a role to play in helping to avoid establishment claims. First, they can demonstrate transparency in avoiding teaching religion with government money. This might involve advance assurances, and agreements to monitor and report upon the carrying out of the government program. For its part, the agency should assure the public that it will ensure against religious training with federal money.

Religions might also wish to speak about a stance they take on a particular sexual or reproductive matter, in "natural law" terms, i.e. what can be know from reason about human nature and wellbeing. Too often, during the many years of the mandate controversy, religious institutions framed their objection strictly as a violation of the rights of a religious institution's *leadership's*, i.e. their right to refuse to facilitate behavior violating their religion. This framing is not likely to elicit sympathy or understanding. It suggests that the religion's primary concern is the moral purity of its leadership, and that (in the case of the mandate) the women using contraception are judged immoral.[254] It also leaves wide open the belief that non-Catholic women employees or students are suffering a loss because of religious principles they do not share. Instead, an attractive and credible argument would begin with a natural law claim about human flourishing in sexual and reproductive relationships, supported by well-regarded literature, before segueing into how a theological teaching affirms and illuminates the empirical claim. For example, the religion might say: "Contraception has ushered in a time when sex has

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[256] Fletcher GJO, et al., *Pair-Bonding, Romantic Love, and Evolution: The Curious Case of Homo sapiens*, 10 PERSPECTIVES ON PSYCHOLOGICAL SCIENCE 20, 29 (2015); Johnson ZV and Young LJ, "Neurobiological mechanisms of social attachment and pair-bonding," 3 CURR. OPIN. BEHAV. SCI. 38, at 5 (2015); Hinde K, Muth C, Maninger N, et al., *Challenges to the Pair Bond: Neural and Hormonal Effects of Separation and Reunion in a Monogamous Primate*, 10 FRONTIERS IN BEHAVIORAL NEUROSCIENCE 221, at 2 (2016).

[252] *See* Bowen v. Kendrick, 487 U.S. 589, 605 (1988).

[253] John E. Taylor, *Family Values, Courts, and Culture War: The Case of Abstinence-Only Education*, 18 WM. & MARY BILL RTS. J. 1053, 1074 (2010).

[254] *See* Douglas Nejaime and Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L. J. 2516, 2576-78 (2015) (claiming that religious refusals to facilitate what they consider immoral behavior harmfully affect individuals' dignity).

lost much of its weight and beauty, because contraception severs sex from tomorrow. This is evident in everything from the spate of 'college hookup' books, to the #MeToo movement. Our faith teaches that the dignity of both sexes, and relationships between men and women, are better served when sex is not severed in mind or body from concepts like marriage, kin, future and children. We believe that this perspective supports the wellbeing of all human persons, not just Catholics."

2. Free Exercise

Both administrative agencies and religious actors could do a better job avoiding free exercise controversies. It is more than obvious that religious positions on sexual and reproductive matters will clash from time to time with HHS' policies. It is also apparent that religions will continue to operate health care, education, charitable and other entities providing services and overseeing employees, which entities will be affected by HHS policies. Finally, there is persistent evidence that religion can be an ally in the work of promoting sexual and reproductive health, given some associations between religious identity and healthy sexual behavior.[255] Given the increasing frequency of such clashes, it therefore seems prudent for HHS to hear from religious institutional leaders before finalizing sexual and reproductive health policies.

First, religions need to give an expert account of how their stances work for human wellbeing. It is no secret that many believe that irrationality is a constitutive part of religion – that religion is simply a matter of blind faith.[256] If a religion holds, rather, that its teachings on human sexuality are both rational *and* affirmed or illuminated by religious doctrine, it needs to paint this picture, both for regulators
contemplating a possible exemption, and/or a judge evaluating a free exercise claim.

Second, and closely related to the first, religions need help agencies to understand their claim that a particular governmental mandate constitutes a burden on their religious freedom. During the years'-long struggle over the contraception mandate, HHS claimed that no religious actor could suffer a legally cognizable burden on religion from being required merely to notify the government or an employer of its objection, in order to trigger a third party's attaching free contraception to the employer's insurance benefit. [257] An advance consultation between the religious actor and HHS about the "theology of cooperation with immoral acts" could help clarify this point in advance.

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[255] *See e.g.,* Brenna C. LeJeune, et al., *Religiosity and Sexual Involvement Within Adolescent Romantic Couples*, 52 J. RELIG. HEALTH 804, 804 (2013); Sharon Scales Rostosky, *The Impact of Religiosity on Adolescent Sexual Behavior: A Review of the Evidence*, 19 J. OF ADOLESC. RESEARCH 677, 682-83 (2004).
[256] *See e.g.,* Stephen T. Asma, *What Religion Gives Us (That Science Can't),* N.Y. TIMES, June 3, 2018, https://www.nytimes.com/2018/06/03/opinion/why-we-need-religion.html?action=click&pgtype=Homepage&version=Moth-Visible&moduleDetail=inside-nyt-region-4&module=inside-nyt-region®ion=inside-nyt-region&WT.nav=inside-nyt-region (arguing that although religion is irrational, it might still have uses).
[257] University of Notre Dame v. Burwell, 786 F. 3d 606, 616 (7th Cir. 2015).

In other words, religious employers need to explain their "theology of cooperation." They could also give a better explanation of how requirements respecting matters as seemingly far removed from the central activities of a religious institution as "what the health insurance policy covers," might interfere with the mission of their institutions, which, after all, hire and serve nonbelievers.

Catholic charitable or health care or educational institutions, for example, would need to explain in words that nonbelievers could understand matters such as Pope Benedict XVI's admonition that "the Church cannot neglect the service of charity any more than she can neglect the Sacraments and the Word."[258] Pope Francis continued this theme on several occasions issuing pointed reminders that Catholic services are never to be mere "NGOs" (nongovernmental organizations) or humanitarian agencies separated from their essential missions of revealing Christ to the world. In his words: "The church is not a shop, she is not a humanitarian agency, the Church is not an NGO. The church is sent to bring Christ and his Gospel to All. She does not bring herself…the Church carries Jesus and should be like Mary when she went to visit Elizabeth." [259] These traits apply whether or the institution hires and/or serves some non-Catholics.

In other words, religions have to craft better explanations and HHS has to provide a forum for receiving these, in order for the agency to decide about whether to impose or refrain from imposing a particular requirement on religious actors.

IV. Conclusion

Sexual and reproductive health has become a partisan battle, waged often by HHS against religious bodies or interest groups favoring, respectively, a closer or more distant relationship between religion and American society.

The agency charged with promoting America's sexual and reproductive health regularly crafts its policies and messaging on this subject in order to depict a virtually airtight empirical case on behalf of its position. This lack of nuance does Americans no favors. We continue to experience very high rates of STIs, abortions, and non-marital births, with effects concentrated in already-disadvantaged populations. Both HHS and religious bodies have tools at their disposal to ameliorate the current mess. This article proposes several, for both parties involved.

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[258] POPE BENEDICT XVII, GOD IS LOVE: DEUS CARITAS EST, ¶ 22 (Libreria Editrice Vaticana, 2006).
[259] POPE FRANCIS, *Francis: "The Church is not an NGO,"* Zenit.org (June 11, 2013), https://zenit.org/articles/francis-the-church-is-not-an-ngo/.