Is Contraceptive Coverage Costless?*

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How did we end up with the HHS[1] contraceptive/abortifacient mandate? Is the logic of this rule-making sound? Is what HHS Secretary Kathleen Sebelius did even legal? In my four decades as a professional federal regulatory bureaucrat, I worked on several dozen rule-makings implementing major new laws. This one simply doesn't stand up to close scrutiny.

Oversimplifying greatly, with many footnotes omitted, the Administrative Procedures Act http://en.wikipedia.org/wiki/Administrative_Procedure_Act (5 U.S.C. 500 *et seq)* generally requires that an agency demonstrate its legal authority to promulgate a proposed rule. It must demonstrate that it has met every condition in the authorizing statute. It must also articulate a rational basis for its decision in language clear enough for a reviewing judge to understand (in the event that it is challenged by an affected party).

With these requirements in mind, let's examine the written decision that brought us this HHS mandate. We'll first quickly sketch out the chain of argument by which HHS arrives at the mandate. In this article, I'll then return for a close examination of the first point.

The Reasoning behind the HHS Contraception Mandate

Boiled down to its essentials, the argument made to support this mandate consists of only three points. (1) "Preventive" contraceptive care reduces overall costs (the argument considers both direct healthcare costs and also 'indirect' costs such as absenteeism). More specifically, offering this "free" to enrollees "results in a healthier population and reduces health care costs."[2] (2) Women are disadvantaged relative to men, because only they have the capability (or burden, from the perspective of this rule-making) of bearing children – so women need legal intervention to achieve equal status.[3] (3) The "compelling government interest" in reducing overall healthcare costs and in achieving equal status for women trumps the guarantees of religious liberty contained in the Constitution's First Amendment.[4] In the view of HHS, these three points are valid, and therefore the mandate is justified (and legal).

The HHS Claims of "costless contraception"

The first major finding, that contraceptive coverage reduces overall costs, is particularly crucial, because it is a "get out of jail free" card. That is, it circumvents several otherwise difficult obstructions along the path to promulgating the rule. HHS uses this claim of reduced costs to avoid the cost-benefit analyses required by, *inter alia*, Executive Orders 13563 and 12866, which "direct agencies to assess all costs and benefits of available

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regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits."[5]

This finding of "costless contraception" enables HHS to declare that the mandate does not impose a burden on any entity, particularly including insurance carriers. These carriers, HHS announces, will be required in the next phase of this proceeding[6] to offer "free" contraceptive coverage at no additional charge to employees of objecting religious institutions. As an "accommodation" to religious beliefs, this coverage is not to be mentioned in the insurance policies those institutions purchase.[7] Because HHS finds that there is no net cost to the insurance carriers (that is, HHS claims carriers' costs will decrease by more than the cost of providing the contraceptive services), these carriers can be ordered to provide the services "free" and without compensation.

Perhaps most importantly, given the controversy that has erupted over this mandate, if contraception really does reduce net costs to the insurance company, this greatly weakens the argument of offended religious groups that they should not "be forced to pay for contraception" (or abortion, in the case of certain of the methods included in the mandate). The HHS argument is that no one pays, because there is no net cost to be paid. Thus we should examine this claim by HHS with particularly strict scrutiny.

Ignoring Executive Orders

Before turning to this claim, there is a more subtle difficulty. Simply put, the HHS approach is astonishingly crude and ignorant. Consider this question: Is every contraceptive method equally cost-effective? Of course not. A moderately competent introductory econ student should be able to conceive of arranging the various methods in order from most cost-effective to least cost-effective.[8] At some point along this array, we will cross the border between cost-effective and inefficient. As Executive Order 12866[9] puts it,

> In general, both the benefits and costs associated with a regulation will increase with the level of stringency (although marginal costs generally increase with stringency, whereas marginal benefits decrease). It is important to consider alternative levels of stringency to better understand the relationship between stringency and the size and distribution of benefits and costs among different groups.

In this context, greater "stringency" would mean mandating coverage of more types of contraceptive methods (that is, including less cost-effective types). The statements that marginal costs generally increase and marginal benefits decrease reflect fundamental economic principles covered in an introductory economics class.

Such sophistication is evidently far beyond the competence of HHS, which considered only an all-or-none approach and decided to mandate <u>all</u> FDA-approved methods. But the FDA's focus is on safety and clinical effectiveness, not on cost-effectiveness. By totally ignoring marginal analysis, thus refusing to contemplate mandating only the more cost-effective contraceptive methods, HHS violated not only Executive Order 12866, but also Executive Order 13563. The latter Executive Order reiterates the earlier one and requires that an agency "tailor its regulations to impose the least burden on society…" and "select, in choosing among alternative regulatory approaches, those approaches that maximize net benefits."

Note that this requirement is not simply that a proposed rule should reduce overall costs. The rule must be shaped, in fact *tailored,* to reduce costs as much as possible ("*maximize* net benefits"). HHS comes nowhere close to showing that mandating coverage of ALL contraceptive methods meets this test.

It is particularly astonishing that HHS completely ignored Executive Order 13563. The ink was barely dry on this, because it had just been issued in January 2011 by President Barack Obama. The failure to consider the requirements of these Executive Orders (and, to the extent it affects state and local governments, the "Unfunded Mandates Reform Act of 1995" P.L. 104-4) would seem at minimum to leave the HHS mandate vulnerable to serious legal challenge.

"I was just following orders" from HRSA

In response to such a legal challenge, HHS lawyers would surely argue that they were simply following Section 2713:[10]

> … a health insurance issuer … shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for …
> (4) with respect to women, such additional preventive care and screenings … as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

The problem is that the Health Resources and Services Administration (HRSA) did not employ any cost-benefit analyses. HRSA simply adopted without further review the recommendations of the Institute of Medicine (IOM) study committee. That committee explicitly rejected consideration of any sort of cost-benefit analysis.[11] As described elsewhere [http://scandhouse.org/liberty/cbstuff/alice_wonderland.html] , this IOM committee was dominated by contraceptive service providers and academics whose institutions receive major funding from the pharmaceutical companies who stand to profit tremendously from the HHS mandate.[12] The IOM panel opted to recommend mandating every possible contraceptive method permitted by FDA, with no consideration of costs.

HHS attempts to skirt this issue by declaring,[13]

> PHS Act section 2713 reflects a determination by Congress that coverage of recommended preventive services … without cost sharing is necessary to achieve basic health care coverage for more Americans.

OK, Congress has spoken. However, this does not solve the problem. The key word here is "recommended." Congress did not determine that all services should be "free," only those "recommended" to be offered "without cost sharing." If Congress had intended all FDA-approved methods to be supplied "free," it could have simply said so and cut the $7 billion HRSA budget.

HHS actually rigged the recommendations of the IOM committee. As noted on page 22 of the IOM Report, "…the committee was restricted from considering cost-effectiveness in its process for identifying gaps in current recommendations." [14]

To put a sharper point on the matter, HRSA simply did not follow the statute in developing its guidelines. HHS admits as much in its own words in this excerpt from the "Amended Interim Final Rule":

> The Departments note that … the statute contemplated HRSA Guidelines that would be developed with the knowledge that certain group health plans and health insurance issuers would be required to cover the services recommended without cost-sharing …[15]

In English, this means that HRSA was to develop its guidelines taking into consideration that the covered services were to be provided "free" to covered persons, that the price would be set to zero. Even our introductory econ student would understand that Congress did not (and cannot) repeal the "Law of Demand." When something is "free," consumers will greatly increase their consumption. Even HHS acknowledges this elsewhere in its decision:

> "Individuals are more likely to use preventive services if they do not have to satisfy cost sharing requirements (such as a copayment, coinsurance, or a deductible)."[16]

Setting all prices to zero not only increases usage, it distorts its composition. If all services are "free," patients will have no incentive to choose less expensive treatments, even when the more expensive add little or no incremental benefit. Thus setting all co-pays at zero also virtually guarantees a cost explosion. If all cars were supplied "free" of charge, would you choose a Nissan Versa or a Lexus? Prices are vitally important social signals. If they are all set to zero, serious problems ensue. Among these problems is that the market no longer produces efficient results. In plain English, this means people will have less output (goods and services) available to consume.

Is preventive care really "costless"?

In justifying its decision, HHS flatly claims, "Use of preventive services results in a healthier population and reduces health care costs …" It's only support for this claim is a highly generalized statement in the IOM Report that is not specifically discussing contraceptive services:

> Prevention is a well-recognized, effective tool in improving health and well-being and has been shown to be cost-effective in addressing many conditions early (Maciosek et al., 2010). Prevention goes beyond the use of disease prevention measures. For example, interventions to prevent injuries and binge drinking can increase positive health outcomes and reduce harm.

HHS misinterprets even this statement, which actually says prevention is cost-effective "in addressing many conditions," not all conditions. For that matter, neither the IOM Report nor the source it cites claims that all preventive services are always cost-effective, yet that is precisely the interpretation by HHS.

Although the proverb that "a stitch in time saves nine," has great popular appeal, even it does not claim that all stitches always reduce costs. It is only the stitch "in time," the one that is applied when an actual tear appears imminent or can reasonably be expected, that saves costs. Such subtlety is beyond the Secretary of HHS.

Recently, health economists have examined the broad, generalized claims that preventive services reduce healthcare costs. An especially prominent study was reported in the *New England Journal of Medicine* in 2008.[17] Its authors examined actual evidence of cost-benefit ratios for 279 preventive measures. They conclude,

> Although some preventive measures do save money, **the vast majority reviewed in the health economics literature do not**. Careful analysis of the costs and benefits of specific interventions, rather than broad generalizations, is critical. Such analysis could identify not only cost-saving preventive measures but also preventive measures that deliver substantial health benefits relative to their net costs … [emphasis added]

This finding that preventive services are not magic bullets that always and everywhere produce cost-savings is also supported by the Congressional Budget Office. In fact, CBO concludes the opposite:

> Although different types of preventive care have different effects on spending, the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall.[18]

Columnist Charles Krauthammer, a physician and political commentator who studied economics as an undergraduate, makes the same point in a column in the *Washington Post*:

> … prevention is not, as so widely advertised, healing on the cheap. It is not the magic bullet for health-care costs.
> You will hear some variation of that claim a hundred times in the coming health-care debate. Whenever you do, remember: It's nonsense …[19]

As each of these researchers points out, the fact that preventive care is not always cost-effective does not imply that it should never be employed. Health care is not entirely about dollars. However, the broad claim that preventive care has no net costs is stretching the truth. Using this claim to avoid the careful analyses required by Executive Orders 12866 and 13563, and to decree that insurance carriers will bear no burden, is simply illegitimate.

Are "preventive" contraceptive services costless?

HHS does provide cost evidence more specifically focused on "preventive" contraceptive services. Given the legal significance of the HHS "finding" that the contraception mandate is actually costless, or actually produces net savings, we should look closely both at what HHS actually means by "costless," and at whether their finding withstands strict scrutiny. Let's examine first the type of evidence HHS cites, and then the types of "costs" they consider.

There are two major problems with the evidence cited. First, as discussed above, it does not consider particular services, but lumps them together in a crude all or none analysis. HHS cannot be bothered to study particular methods, as required, but prefers to issue a sweeping, all-encompassing mandate. In particular, HHS does not look specifically or

separately at those services that are most problematic to religious persons or institutions. Second, the evidence that is cited is overwhelmingly from publications or organizations with a long track record of advocacy of radically pro-contraception and/or pro-abortion policies.

To be more specific, only one single source cited to support the claim that contraceptive coverage is costless appears to be from a putatively neutral medical journal. All the others are from Planned Parenthood affiliates (The Guttmacher Institute is their "scientific" propaganda arm) or organizations strongly advocating population control, particularly aimed at minorities and the "lower classes."[20] The publications cited on cost issues, with the one exception mentioned, are ***all*** published either by Guttmacher, the Population Council, or the Association of Reproductive Health Providers (ARHP). The Population Council describes itself as dedicated to reducing births.[21] ARHP, according to its website,[22] consists of "physicians and clinicians who provide abortion care." These are not unbiased "scientific" sources, as HHS claims.

To be sure, some of these publications describe themselves as "peer-reviewed." Just what does this mean? If an abortionist writes an article, then another abortionist reviews it, that article is "peer-reviewed." The problem is that an entire industry of "family planning" or "population control" advocates has grown up, cloaked itself with university degrees in these or related fields, and presented itself as "peer-reviewed science." As such, it is to be considered immune from criticism from mere commoners. Very few dare point out that this new emperor has no clothes, or at least that the G-string is rather skimpy.

<u>Which costs are considered by HHS … and which are excluded?</u>

The cost savings claims of HHS are highly questionable and raise troubling questions. Let's look at some of the specific aspects.

One serious problem glossed over by HHS is that this "Final Rule" is about mandating an extension of contraceptive coverage to employees of religiously-affiliated institutions or businesses owned by persons with strong religious objections to these "services." The decision itself notes that the overwhelming majority of other employees are already covered.[23] This means we should not be estimating the effects of providing contraceptive coverage for the general population, but only of extending this to the largely religiously motivated employees of these institutions – a more difficult estimate. Are the incremental cost savings to be gleaned from this mandate really worth the cost of violating the consciences of these charitable organizations? Are these savings worth destroying these mediating institutions[24] that make our society function much more smoothly and humanely? These are not questions amenable to a dollars and cents answer, but this concern is highly relevant, particularly in analyzing the First Amendment issues involved.

Turning to the cost savings claims themselves, on page 8727 of the Final Rule HHS claims, "there are significant cost savings to employers from the coverage of

contraceptives. A 2000 study estimated that it would cost employers 15 to17 percent more not to provide contraceptive coverage in employee health plans than to provide such coverage …" But the testimony arrives at this estimate only "after accounting for both the direct medical costs of pregnancy and the indirect costs such as employee absence and reduced productivity." These types of indirect costs are very difficult to measure and are likely to rely heavily on subjective evaluations, so one would want to be careful to have an unbiased estimate. What evidence does HHS cite? The footnote is to "Testimony of Guttmacher Institute" that cites a newsletter from the "Washington Business Group on Health." They also cite articles in Guttmacher publications and the journal *Contraception* published by the population control advocates, Population Council. These sources simply do not pass the smell test.

The one (and only) putatively neutral source cited regarding cost savings arrives at its savings estimate by including not only "the medical costs incurred by contraceptive provision … but also cost-savings resulting from the prevention of outcomes of unintended pregnancies …. social service costs and costs associated with adoptions and welfare payments …"[25] Prevention of "outcomes of unintended pregnancies" sounds ever so much nicer than "prevention of babies," doesn't it? We return to this point below.

The other main evidence HHS cites is … itself. The decision states (p. 8728), "Actuaries and experts have found that coverage of contraceptives is at least cost neutral when taking into account all costs and benefits in the health plan." The sources supporting this claim are HHS officials, not neutral, outside analysts (although some of the actuarial studies they say they summarize are by outside analysts). In fact, these HHS officials include political appointees. The fact that one is a political appointee is not proof that he or she is a liar; on the other hand, it hardly inspires confidence as to objectivity.

These estimates arrive at their savings by counting the costs of pre-natal care, maternity, post-natal care, and often continuing care for a number of years – for example, to age five. Guess what these studies show? Children are expensive! Who knew?

Our sole "neutral" article shows the same approach, including even the costs that would have been incurred educating the children to be prevented. "The World Bank found that in a typical low-fertility Latin American country, each dollar spent on family planning saved the government $12 in health and education costs alone."[26]

The point is, precisely, that the cost savings resulting from "preventive contraceptive care" arise only from preventing children.

Note that virtually every healthcare policy *already* covers contraceptive drugs and procedures when they are used to treat actual diseases or conditions, as they sometimes are. Each of the clergy witnesses who testified before the House Oversight and Government Reform Committee on February 16 stated that his religious body had no moral objection to using these drugs and procedures for such treatments, and that their insurance policies did provide such coverage, so this is not an issue. The only "prevention" being accomplished by the HHS mandate is the prevention of children.

This point needs further exploration. First, observe that preventing children also prevents future adults. From a purely pecuniary perspective, if we are to count the savings from preventing children, we must also account for the costs, the losses, from preventing future adults. In economic terms, children are an investment in the future – particularly if one includes such costs as education. Certainly, investments have costs, but they also pay dividends. Children are not *merely* investments, of course, but it is no coincidence that the Commandment to "Honor your father and your mother" is called "the first commandment with a promise,"[27] that is, "that it may go well with you and that you may live long in the land." Until 1935, children were a large component of the social security system and multi-generational families were the norm (and the elderly were not warehoused in lonely "retirement homes," but that's another issue). From a government perspective, if some children absorb tax revenues while young, they also become taxpayers as adults. That is, unless the education and welfare system, by design or accident, produces unproductive subjects rather than productive citizens (but this is also a topic for another day). One major reason our social security system is so near collapse is that since 1973 abortions have "prevented" about a third of the rising generation of social security taxpayers. The point is, it is fraudulent accounting to consider the savings from preventing children while ignoring the future losses from having simultaneously prevented future adults.

Moreover, the same cost arguments that support the prevention of children apply with much greater force to the prevention of children with disabilities or imperfections. Pre-natal screening followed by abortion of the imperfect is increasingly practiced. Even more troubling, "bioethicists" are beginning to make a serious case for infanticide of "undesirable" newborns, largely on cost avoidance grounds. Articles proposing and defending "post-natal abortion" of children who are either imperfect or inconvenient to the parent(s) have appeared recently in "respectable" publications.[28] These "ethicists" advocate a return to the pagan Roman practice under which the father decided whether a newborn should live or die, a practice challenged and eventually ended by the spread of Christianity.[29] Pressures to control medical costs are likely eventually to produce pressures to limit, or even prohibit, care of imperfect infants in an increasingly centralized healthcare system. This raises difficult questions about the nature of such a world, and whether the disabled add something special that will be lost in this brave new world.[30]

If the cost savings from preventing infirm infants are alluring, those attainable by preventing elderly persons are vastly more so. Much has been written about the disproportionately high share of medical costs incurred in the last years of life[31] and about whether expensive treatments should be given to the elderly. Sometimes even relatively inexpensive treatments for older persons are questioned. This, in fact, was the situation that gave rise to President Obama's comment, "Maybe you're better off not having the surgery, but taking the painkiller." [32] Recall the circumstances: the patient was 100 years old and needed a pacemaker – not a particularly exotic or expensive procedure. After an initial refusal, a second doctor provided the pacemaker. The patient's daughter explained that as a result her mother had (to date) enjoyed five more years of happy life.

She asked whether such factors could be considered in deciding whether to authorize care. Mr. Obama said no. This is precisely the attitude that gives rise to concerns such as Governor Sarah Palin's warning about "death panels." Under Obamacare, there are panels that will determine which patients qualify for which types of treatment. Although the law bars "rationing," it is not clear quite what this means – patients considered unqualified will not receive the treatments, and the government panels will eventually set these rules (not immediately, everything is phased in gradually over time).

The HHS contraceptive mandate actually prohibits a category of insurance policies: those that allow the Roman Catholic approach in which sexual relations are open to the possibility of conception, the possibility of life. This may be a minority view, but it is the official teaching of a major Christian denomination. These policies were once the standard and are still the version deliberately chosen by their purchasers. They are now to be prohibited by government mandate.

The world envisioned by the population-control advocates who prepared these cost studies is one that offers a poorer quality of service (in that a widely preferred option is prohibited) and quality of life – not necessarily in material terms, but in spiritual. Various studies claim that a third to nearly half of all births are 'unplanned,'[33] and imply that these babies are also unwanted. The cost savings arise from preventing these children. Some higher-end savings estimates presume all or most such births are prevented. But the definition of 'unplanned' is very broad. It includes 'mistimed' pregnancies (e.g., the couple is unable to conceive precisely when they wish – some couples try for years) and couples that don't plan a specific target date. The IOM study itself reveals that the majority of these "unplanned" pregnancies are carried to term. The parents demonstrate by their actions that "unplanned" does not necessarily mean "unwanted." In any case, the demographic consequences of a reduction in the birth rate as sharp as advocates seem to desire would be disastrous.

The world implied by Obamacare seems to be a modern attempt to create Plato's utopian Republic. This was an imaginary but brutish, totalitarian state ruled by elites.[34] Births were severely limited, particularly among the lower classes. Racial purity and eugenics were emphasized through regulating reproduction. Medical care was denied the chronically ill and the elderly, with euthanasia at government direction. Individuals were expected to subject their own interests to the greater good of the commune. This utopian dream was very much a pre-Christian concept. It also seems to be the root of virtually every totalitarian scheme. But this notion actually long predates Plato, stretching back to that day when the serpent hissed in the Garden, "You will be like God."[35]

Conclusion

In summary, we have shown that HHS ignored the Executive Orders that require it to tailor any regulation to minimize impact and maximize benefits. HHS ignored statutes requiring it to choose particular preventive measures for "free" delivery, choosing instead to mandate provision of all contraceptive techniques. HHS rigged the IOM study by forbidding any cost-benefit analysis. HHS relied on unfounded generalizations about the

value of preventive care, and then on biased and, indeed, fraudulent cost studies to conclude that contraceptive coverage is costless. The brave new world HHS appears to envision is a totalitarian horror that has plagued human history since the days of Plato … and even from The Beginning.

As a professional regulatory bureaucrat, I am proud of the skill and care that my colleagues and I applied to the rule-making proceedings we handled over my four decades in Washington. We handled complex laws and complex issues, and usually got it right. OK, political pressures prevailed a few times, but not often. Consumers benefited greatly from the increased competition we made possible (mostly by clearing away anti-competitive regulations) in transportation and communications. I think even the suffering taxpayers generally got a good return for their dollars.[36] There are many excellent workers in the federal government (also some others). Upon closely scrutinizing this HHS rule-making decision, however, I am embarrassed by the shoddy work and the dishonesty of those who prepared it. This abuse of law and procedure brings disrepute on many who labor diligently and with devotion to the Constitution they swore to protect and defend.

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[1] The rule-making was actually a joint effort by HHS, Treasury and Labor. HHS is the lead agency, and I will simply refer throughout to HHS rather than to the three departments.

[2] Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725 , p. 8727.

[3] Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725, p. 8728.

[4] Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725, p. 8729.

[5] HHS is well aware of this requirement, because this citation is taken directly from the "Amended Interim Final Rule" issued in this proceeding, 76 FR 46621 https://www.federalregister.gov/citation/76-FR-46621 , p.46625.

[6] An "Advance Notice of Proposed Rule-Making" was issued March 16 and published March 21, 2012. It is available at https://federalregister.gov/a/2012-6689 . In addition to the mandate on insurance carriers, it would extend the contraception mandate to students at all institutions of higher learning and to self-insured entities. A 90-day public comment period expires June 19, 2012.

[7] "Specifically, the Departments plan to initiate a rulemaking to require issuers to offer insurance without contraception coverage to such an employer (or plan sponsor) and simultaneously to offer contraceptive coverage directly to the employer's plan participants (and their beneficiaries) who desire it, with no cost-sharing." Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725 , p. 8728.

[8] Precisely this analysis was performed in a 2008 article in the *New England Journal of Medicine*: see Joshua T. Cohen, Ph.D., Peter J. Neumann, Sc.D., and Milton C. Weinstein, Ph.D. N Engl J Med 2008; 358:661-663, February 14, 2008 http://www.nejm.org/doi/full/10.1056/NEJMp0708558.

[9] Executive Order 12866, issued in 1993 by President Bill Clinton, is found at http://www.whitehouse.gov/omb/inforeg_riaguide/ . A helpful summary is at http://www.ombwatch.org/node/224 .

[10] Section 2713 of the Amended Title XXVII of the Public Health Service Act (Coverage of preventive health services).

[11] "At the first committee meeting, it was agreed that cost considerations were outside the scope of the [committee's] charge … " Inst. of Med., Clinical Preventive Services for Women: Closing the Gaps, Wash., DC: Nat'l Acad. Press, 2011 [IOM Report], p. 235. This was the subject of a vigorous dissent by the sole economist on the panel (see this page http://scandhouse.org/liberty/cbstuff/alice_wonderland.html).

[12] This is not to say the panel members do not sincerely believe their recommendation is the best policy. It is to suggest that they have little knowledge of cost-effectiveness – in fact reject contemplating the topic – and may be subject to institutional biases of which they are not even aware.
[13] Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725 , p. 8727
[14] IOM Report, p. 22.
[15] Amended Interim Final Rule, 76 FR 46621 https://www.federalregister.gov/citation/76-FR-46621 p.46623.
[16] Final Rule, 77 FR 8725 https://www.federalregister.gov/citation/77-FR-8725 , p. 8727

[17] Joshua T. Cohen, Ph.D., Peter J. Neumann, Sc.D., and Milton C. Weinstein, Ph.D. N Engl J Med 2008; 358:661-663, February 14, 2008 http://www.nejm.org/toc/nejm/358/7/ .

[18] CBO Letter to Congressman Nathan Deal, August 7, 2009.
http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/104xx/doc10492/08-07-prevention.pdf .

[19] Charles Krauthammer, "Preventive Care Isn't the Magic Bullet for Health Care Costs," *Washington Post*, August 14, 2009.
http://www.washingtonpost.com/wp-dyn/content/article/2009/08/13/AR2009081302898.html?hpid=opinionsbox1
[20] The racism and eugenics efforts of Planned Parenthood founder Margaret Sanger are so well established that they are documented even in her "Wikipedia" entry http://en.wikipedia.org/wiki/Margaret_Sanger . An Internet search on "Planned Parenthood racism" returns pages of documentation. See also: George Grant, *Grand Illusions: The Legacy of Planned Parenthood,* Cumberland House Publishing, 1999. The pattern is more subtle today, but see page 102 of the IOM Report, which identifies as particular targets women "who have a low income, who are not high school graduates, and who are members of a racial or ethnic minority group."

[21] From it website: "In 1952, the world was awakening to the rapid growth in population that was occurring around the globe. Impressed by the complexities of population issues, … and undeterred by the sensitivity then associated with birth control, John D. Rockefeller 3rd convened a group of scientists to discuss the implications of the dramatic demographic change …" http://www.popcouncil.org/who/history.asp

[22] http://www.arhp.org/About-Us/Position-Statements

[23] Page 8728 of the Final Rule notes, "A 2002 study found that more than 89 percent of insured plans cover contraceptives. A 2010 survey of employers revealed that 85 percent of large employers and 62 percent of small employers offered coverage of FDA-approved contraceptives."
[24] For this very important concept, see here http://www.heritage.org/events/2007/11/civil-society-mediating-institutions-and-domestic-policy-to-empower-people-after-30-years

[25] Free library version of the article, available at
http://www.thefreelibrary.com/The+economics+of+contraception.-a0204073872

[26] Ifigeneia Mavranezouli, "Health economics of contraception," *Best Practice & Research Clinical Obstetrics and Gynaecology,* (2009) Vol. 23, No. 2, 187-198pp., Free Library version.
http://www.thefreelibrary.com/The+economics+of+contraception.-a0204073872

[27] Ephesians 6:2.
[28] Some recent articles either advocating or reporting on this movement are at the following links:
http://jme.bmj.com/content/early/2012/03/01/medethics-2011-100411.full
http://jme.bmj.com/content/early/2012/03/01/medethics-2011-100411/suppl/DC1

http://thegospelcoalition.org/blogs/tgc/2012/02/28/60-second-summary-after-birth-abortion-why-should-the-baby-live/
http://www.lifesitenews.com/news/journal-editor-defends-pro-infanticide-piece-killing-newborns-is-already-le
http://www.lifesitenews.com/news/judge-rules-no-jail-time-for-infanticide-because-canada-accepts-abortion/ .

The same pressures exist to an even greater degree in Sweden, which has a long and difficult history in such matters: http://www.newsmill.se/node/44017 .

[29] A concise summary is found at Fay Voshell, "Infanticide on Demand," *The American Thinker*, online, March 1, 2012. http://www.americanthinker.com/2012/03/infanticide_on_demand.html#ixzz1qJlB0V1g .

[30] http://www.christianitytoday.com/ct/2012/marchweb-only/down-syndrome-day.html

[31] For example, see articles at these links:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1464043/?tool=pmcentrez end of life costs:
http://managinghealthcarecosts.blogspot.com/2010/08/end-of-life-care.html
Kaiser: http://www.kaiserhealthnews.org/Stories/2010/March/09/fiscal-times-end-of-life.aspx

[32] The two minute video is available at this link: http://iusbvision.wordpress.com/2009/06/26/obama-old-people-dont-need-life-saving-treatments-they-can-take-a-pain-pill-and-be-left-to-die/

[33] One of the higher-end estimates is at p.102 of the IOM Report.

[34] Mark R. Levin provides a concise and clear description of Plato's utopian fantasy in his recently published *Ameritopia: the Unmaking of America*, Threshold Editions, Simon & Schuster (New York: 2012), chapter 2.

[35] Genesis 3:5.

[36] I must however, recall the advice of a dear colleague at the Congressional Budget Office: "Just thank God we don't get all the government we pay for."