Nos. 19-431, 19-454

In the Supreme Court of the United States

LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME, *Petitioner*,
v.
PENNSYLVANIA, ET AL., *Respondents*.

DONALD J. TRUMP, PRESIDENT OF THE
UNITED STATES, ET AL., *Petitioners*,
v.
PENNSYLVANIA, ET AL., *Respondents*.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF *AMICI CURIAE* CITIES OF OAKLAND, SAINT PAUL, AND 30 ADDITIONAL CITIES AND COUNTIES IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici are cities and counties from across the country.[2] We are situated in both liberal- and conservative-leaning states and include large cities and counties as well as smaller cities and towns. We act within varying regulatory backdrops, both in terms of what general authority the local governments possess and what states provide for and mandate in the health care context. Some *amici* play a central role in the delivery of health care services to residents, and others focus on public health efforts. Notwithstanding these differences, *amici* share several crucial interests at issue in this case.

First, local governments share a principal interest in maintaining the health and safety of our residents. We stand on the front lines of government by delivering essential services to our entire communities. To help our residents thrive, localities offer a diverse array of additional programming, supports, and initiatives. In some jurisdictions, these efforts include robust sexual and reproductive health services, such as contraception, pregnancy testing, family planning, teen-sensitive sexual and reproductive health services,

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[1] Pursuant to Supreme Court Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to its preparation or submission.

Pursuant to Supreme Court Rule 37.3(a), counsel of record for all parties have filed their written consent to the filing of this brief with the Clerk's Office.

[2] Appendix A provides a full list of *amici*.

sexually transmitted infection screening, emergency services, health education, and community outreach. Some *amici* serve as the health care providers of last resort and play a central role in safety-net care for low-income individuals.

Second, *amici* have a substantial interest in and are committed to fulfilling the goals of the contraceptive mandate. We understand the extensive economic and deep personal significance of access to cost-free, readily available contraceptive care. Substantial social science and other research affirms the health and economic benefits of universal access to free and effective birth control.[3] *Amici*'s experience supporting some of the Nation's most vulnerable populations—whether in the health care or social services context—confirms these findings. We also have seen the impact of disruption in care and coverage. The lived experiences of our communities and health care providers offer us regular reminders that even seemingly small obstacles can ultimately deny access to care or make it significantly less impactful. As a result of the religious and moral exemptions, the promise of the mandate will erode. Many people will lose access to contraceptive care altogether, experience disruption due to transfer of care, or be required to adopt less effective contraceptive alternatives. In addition to the affected individuals and their families, local governments will bear the consequences of reduction in coverage, which range from costs associated with pregnancy and childbirth to

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[3] See, *e.g.*, Resp. Br. 5 (describing the benefits of access to free and effective birth control); see generally Br. of Guttmacher Institute (same); Br. of National Women's Law Ctr. et al. (same).

other downstream medical, economic, and social impacts on parents and children.

Third, we write this brief while our communities are confronting an urgent public health crisis of a magnitude and impact far exceeding any other in recent history. Our resources and capabilities are being put to a great test by the Novel Coronavirus Disease 2019 (COVID-19). In the face of a global pandemic, our ability to reach everyone—to provide preventive and emergency health services, to protect the public health, and to offer economic and other forms of support to our communities—is more critical than ever. We share an interest in focusing our resources on addressing the urgent pandemic, instead of diverting those limited resources to respond to gaps in coverage the federal government has created.

SUMMARY OF ARGUMENT

The federal government has spent the past decade implementing the Affordable Care Act (ACA) to extend comprehensive preventive care to individuals regardless of gender—including contraceptive care—while taking steps to account for any exemptions required by the Religious Freedom Restoration Act (RFRA). It has done this through a series of rulemakings, which initially exempted some entities while giving others—in particular, religiously affiliated employers—the option of an accommodation to maintain broad coverage of contraception and minimize any burden on religious beliefs. This Court's decision in *Burwell v. Hobby Lobby Stores, Inc.* expanded eligibility for this accommodation. 573 U.S. 682 (2014). Subsequent lawsuits challenged the validity of this

accommodation and sought to broaden the availability of exemptions. Efforts to refine the accommodation continued following the remand order in *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

Prior to adoption of the current rules, the agencies implementing the ACA had sought to balance the need to maintain individuals' coverage with RFRA's direction to limit the burden on employers who objected based on sincerely held religious beliefs. The recently adopted religious and moral exemptions represent a dramatic and fundamental shift in approach.[4] These rules are not a further fine-tuning of the contraceptive coverage mandate, nor an effort to find some "play in the joints," *Locke v. Davey*, 540 U.S. 712, 718 (2004) (citing *Walz v. Tax Comm'n of City of New York*, 397 U.S. 664, 669 (1970)). Rather, they are a remarkable attempt to enable virtually any employer to restrict the availability of contraceptive coverage to their employees and dependents, without requiring any justification or meaningful showing of burden.

Amici join respondents and respondents' other *amici* in opposition to the broadened exemptions found within the religious rule. The rule lacks legal justification, and whatever concerns this Court may

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[4] See Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018) (codified at 45 C.F.R. pt. 147) [hereinafter "religious exemption" or "religious rule"]; Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018) (codified at 45 C.F.R. pt. 147) [hereinafter "moral exemption" or "moral rule"].

have surfaced in *Zubik* do not warrant such a dramatic departure from precedent. We write separately to emphasize the legal flaws underlying the moral rule.

To begin, the federal government offers only a minimal defense of the moral rule by collapsing it with the religious rule. Neither the ACA nor RFRA—the statutory authority offered to defend the religious rule—supports such a broad moral exemption. In addition, none of the laws cited in the published rule justify such an exemption in this instance. To the extent Congress has, in other contexts, called for exemptions for moral objectors, it has expressly said so. The contraceptive mandate lacks such a clear statement.[5]

Amici also write to emphasize the local impacts of the religious and moral rules, because "in applying RFRA 'courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.'" *Hobby Lobby*, 573 U.S. at 729 n.37 (quoting *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005) (applying the Religious Land Use and Institutionalized Persons Act (RLUIPA))). Many people who lose essential contraceptive health care from their employers will seek alternative options through clinics that are administered or funded by local governments, or other supports from local safety-net programs. The federal government, in fact, relies on the availability of

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[5] *Amici* do not take a position that there is any difference in value between a moral objection and a religious objection. Instead, *amici* assert that, in addition to failing to authorize the religious rule, Congress did not provide grounds to the agencies for an exemption based on moral objection.

local options to minimize the impact on those who lose coverage due to the rules. However, these clinics and programs are not equal to private, no-cost insurance coverage. They already serve a sizable population in need of services,[6] and will struggle to provide adequate replacement contraceptive options to a group denied contraceptive coverage by the rules. The present public health crisis (and its aftermath) imposes additional barriers to the receipt of care and financially burdens a system already without sufficient funding.

Even before the widespread outbreak of COVID-19, the federal government had eroded the very safety net to which it points. Federal policy shifts, particularly in the Title X program, have altered the reproductive health landscape in many jurisdictions. The agencies' choice to rely on state and local actors to fill gaps in coverage cannot withstand scrutiny, especially when other agency action makes those efforts fundamentally more difficult. This context shows that the new rules dramatically shift a minimal burden from objecting employers onto local governments and communities, imposing significant burdens on both people seeking alternative coverage or affordable care and the communities that support them. Neither the ACA nor RFRA authorizes such an inequitable outcome.

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[6] See Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, Guttmacher Institute (Nov. 13, 2019), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf (finding 20.6 million U.S. women in need of public support for contraceptive services in 2016 and approximately 9 million women receiving publicly supported services per year).

ARGUMENT

I. THE MORAL EXEMPTION LACKS ANY PLAUSIBLE LEGAL JUSTIFICATION.

The federal government casts the moral and religious rules as two sides of the same coin. It repeatedly refers to "religious and moral objections," U.S. Br. 18, or "religious and moral precepts," *id.* at 42, and appears to argue that the rules rise and fall together. However, the two rules are legally distinct, and require distinct justifications. As made clear by the numerous federal statutes and case law cited by the federal agencies when issuing the final rules, Congress knows how to authorize exemptions for moral objections. It has not done so here. Even if the religious exemption were justified—and it is not, as explained in respondents' brief, see Resp. Br. 36-52—the moral exemption cannot stand.

A. Neither the ACA nor RFRA Justifies a Blanket Moral Exemption.

The federal government's briefing treats the religious and moral rules as one, and relies heavily on the ACA and RFRA to justify both rules. Neither law supports the moral rule.

Nothing in the ACA authorizes creation of a moral exemption to the contraceptive mandate. The contraceptive mandate originates from the Women's Health Amendment to the ACA. Patient Protection and Affordable Care Act, 42 U.S.C. § 300gg-13(a)(4) (2010). The Amendment requires health plans and health insurance issuers to provide certain preventive health services for women, and instructs the Health Resources

and Services Administration (HRSA) to determine the scope of those services. *Id.* (providing that health plans "shall, at a minimum provide coverage for and shall not impose any cost sharing requirements . . . with respect to women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by [HRSA]"). Through the amendment, HRSA is charged with determining "*what types* of preventive care must be covered." *Hobby Lobby*, 573 U.S. at 697 (emphasis added); see also *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 799 (E.D. Pa. 2019) (contraceptive mandate is the product of "interlocking statutory and regulatory requirements").

Congress selected HRSA for this task because the agency's expertise in women's health and preventive medicine would enable it to provide "evidence-based [recommendations]" for women's preventive services. 155 Cong. Rec. S12058-59 (Dec. 1, 2009) (statement of Sen. Cardin). Moreover, HRSA's guidelines must be developed "for the purposes" of the Amendment, 42 U.S.C. § 300gg-13(a)(4), which means consideration of the statutory mandate to ensure that women receive full and equal health coverage. The Amendment simply does not confer upon HRSA the authority to determine *who* must provide those services, or as the agencies have done, to exempt whole categories of health plans and insurance issuers from the mandate without some other statutory basis. See generally Resp. Br. 29-35; Br. of Mass. et al. 7-8, 10-13.[7]

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[7] Subsequent legislative history underscores the lack of Congressional authorization for the moral rule. The Senate voted down a conscience-based amendment, which would have allowed

Nor does RFRA—which protects religious, not moral, freedom—give HRSA and the other agencies which promulgated this rule authority to create a moral exemption from the ACA's mandate. RFRA provides that the "Government shall not substantially burden a person's exercise of religion" unless it can demonstrate that the burden is the least restrictive means of furthering a compelling governmental interest. Religious Freedom Restoration Act, 42 U.S.C. § 2000bb-1 (1994). Congress passed RFRA in response to *Employment Division, Department of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990), in which this Court held that "the Constitution does not require judges to engage in a case-by-case assessment of the religious burdens imposed by facially constitutional laws." *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 424 (2006) (citation omitted). Neither before nor after RFRA's passage has the Supreme Court interpreted the Free Exercise Clause to apply to non-religious, morality-based beliefs.

Subsequent changes to RFRA affirm this distinction. In 2000, Congress amended RFRA through the Religious Land Use and Institutionalized Persons Act (RLUIPA), defining the "exercise of religion" to include "any exercise of religion, whether or not compelled by, or central to, a system of religious belief." 42 U.S.C. § 2000bb–2(4) (2000) (importing RLUIPA

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employers or insurance providers to deny coverage based on "religious beliefs or moral convictions." 158 Cong. Rec. S539 (Feb. 9, 2012); see also *id.* at S1162–S1173 (Mar. 1, 2012) (debate and vote).

definition). Through RLUIPA, Congress amended RFRA so that the term "exercise of religion" would "be construed in favor of a broad protection of religious exercise, to the maximum extent permitted by the terms of this chapter and the Constitution." 42 U.S.C. § 2000cc–3(g) (2000); see also *Hobby Lobby*, 573 U.S. at 696. Thus, once again Congress made plain that RFRA (and RLUIPA) were intended to codify established understandings of "exercise of religion," not break new ground regarding moral beliefs. See *Holt v. Hobbs*, 574 U.S. 352, 360–61 (2015) (citing *Hobby Lobby*, 573 U.S. at 717 n.28) (noting that even under RLUIPA's broad definition of religion, "a prisoner's request for an accommodation [under the statute] must be sincerely based on a *religious* belief and not some other motivation" (emphasis added)).

A plain reading of RFRA similarly provides no support for the moral rule. RFRA defines the exercise of religion as a practice or belief that could exist independently from a "system of religious belief," but the belief must be *religious*. The statute does not provide support for a moral exemption based on objections to contraception that are not grounded in or connected to religion at all. In fact, the promulgating agencies themselves admit that they chose to create a moral exemption in part because "previous regulations contained no exemption concerning moral convictions, *as distinct from religious beliefs*." Moral Exemption, 83 Fed. Reg. at 57,614 (emphasis added). Thus, the agencies admit that the moral rule is not about the type of beliefs protected by RFRA—that is, beliefs related to the "exercise of religion."

B. None of the Statutes Cited in the Moral Rule Support Its Promulgation.

1. Congress's inclusion of explicit exemptions for moral objections in other statutes demonstrates the lack of authorization for the moral rule.

As support for its promulgation, the moral rule cites several statutes in which Congress authorized or created both moral and religious exemptions together. The agencies imply that because other laws surrounding the delivery and coverage of health care and, more specifically, federal laws relating to abortion, include moral exemptions, the agencies have latitude to create these exemptions anywhere. This oblique argument—which is not advanced in the federal government's brief—is without basis. Congress knows how to create a moral exemption when it wishes to include one in a statute and has not done so with respect to the contraceptive mandate. The agencies' citations to instances in which Congress explicitly created such exemptions only serve to support arguments in opposition to the rule.

For example, the 2018 Appropriations Act underscores the weakness of the agencies' position. There, Congress included a conscience clause covering both religious beliefs and moral convictions as they relate to contraceptive coverage legislation in the District of Columbia. Consolidated Appropriations Act 2018, Pub. L. No. 115-141, 132 Stat. 348, 603 ("Nothing in this Act may be construed to prevent the Council or Mayor of the District of Columbia from addressing the issue of the provision of contraceptive coverage by

health insurance plans, but . . . *any legislation enacted on such issue should include a 'conscience clause' which provides exceptions for religious beliefs and moral convictions*." (emphasis added)). In contrast to the ACA's contraceptive mandate, Congress clearly articulated in the 2018 bill that if the District of Columbia were to mandate contraceptive coverage, Congress required the inclusion of a moral exemption. The agencies' reliance on the 2018 appropriation is entirely inconsistent with the fundamental notion that "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Conn. Nat'l. Bank v. Germain*, 503 U.S. 249, 253-54 (1992) (citations omitted)).

The Church Amendments provide another example of the agencies' misplaced reliance on other federal laws protecting the conscience objections of providers. The Church Amendments establish limited religious and conscience protections for health care providers and institutions that receive certain types of federal funds. 42 U.S.C. § 300a-7 (2012). The law provides that certain federal funding streams do "not authorize any court or any public official or other public authority to require such individual to perform or assist in the performance of any sterilization procedure or abortion *if [her or] his performance or assistance in the performance of such procedure or abortion would be contrary to [her or] his religious beliefs or moral convictions*."[8] *Id.* § 300a-7(b)-(b)(1) (emphasis added);

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[8] The moral rule also references a conscience-based objection provision from the Court's decision in *Doe v. Bolton*, 410 U.S. 179 (1973). The case largely struck down a Georgia abortion statute

see also *id.* § 300a-7(b)(2) (analogue protection for institutions).

The Church Amendments also contain a related anti-discrimination provision protecting both those physicians and other providers who refuse to engage in sterilization and abortion, as well as those who do. *Id.* § 300a-7(c)(1). The statute protects providers in the *delivery* of care, not the *coverage* of care through a health plan. Additionally, in each provision, Congress clearly stated that protections extended based on *both* religious beliefs and moral convictions. Critically, no clear statement of that nature can be found in the ACA.[9] If Congress had intended for its mandate not to apply to any entity with a moral objection, it would have said so directly. See, *e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2495 (2015) ("Congress 'does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions.'" (quoting *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001))).

The agencies likewise point to statutory provisions relating to Medicare and Medicaid as supporting moral exemptions in health care coverage. Neither example

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and noted without analysis a provision of the statute that allowed doctors to refuse to provide abortions based on moral objection. *Id.* at 197-98.

[9] The Church Amendments' anti-discrimination provisions contain balanced protections both for those who refuse and those who want to perform abortions (or, for example, scientific research). If the Church Amendments have any relevance, it is to demonstrate Congress's more general efforts to balance obligations and opportunities on both sides of these issues. The expanded exemptions distort this balance.

justifies the moral rule. For example, Medicare Part C programs are private insurance plans that include both hospital and medical coverage and other benefits including dental, hearing, and vision coverage. The specific Medicare provision noted in the moral rule is extremely narrow in its application. See 42 U.S.C. § 1395w-22(j)(3)(B). It states that providers are expressly allowed to counsel about or refer for medical treatments that are not covered by the Medicare plan. *Id.* § 1395w-22(j)(3)(A). The conscience provision states only that plans need not "reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan objects to the provision of such service on moral or religious grounds." *Id.* § 1395w-22(j)(3)(B)-(B)(i). The plan must provide written notice to prospective or current enrollees regarding its objection. *Id.* § 1395w-22(j)(3)(B)(ii).

This exemption differs from the moral rule in at least three notable ways: Congress expressly provided for a moral objection; the denial of coverage must be clearly communicated to the insured; and the insured has options to select other coverage from the same program.[10] Whereas Medicare recipients receiving a notice of declination of coverage for moral or religious

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[10] *Amici* searched relevant websites to determine the availability of Medicare Part C choices in various markets throughout the United States. A recent survey of several of the largest metropolitan areas revealed the following number of options: New York (50), Philadelphia (49), Chicago (46), Houston (44), and Seattle (41). See *2020 Medicare Advantage Plans*, Medicare Help, https://www.medicarehelp.org/2020-medicare-advantage (as visited Apr. 6, 2020).

reasons can readily enroll in other plans in their area, employees (or their beneficiaries) confronted by an exercise of the ACA moral exemption have far more limited choices. The agencies' reliance on 42 U.S.C. § 1396u-2(b)(3), a parallel conscience protection for managed care options in the Medicaid program, rings hollow for the same reasons.

2. The Court's decisions in cases of conscientious objection to military service do not authorize the moral rule.

The federal agencies' reliance on this Court's interpretation of the conscientious objector provision under Section 6(j) of the Universal Military Training and Service Act is similarly unavailing. 50 U.S.C. §§ 451-473 (1958). In those cases, the Court carefully considered the nature and strength of each objector's individual beliefs, and upheld conscientious objections when the objector was willing to sacrifice deeply for his belief, which functioned like a religious belief in his life. The moral rule, by contrast, provides none of these checks on the nature, strength, or significance of an objector's conviction.

In *United States v. Seeger*, 380 U.S. 163 (1965), the Court reviewed conscience objections raised by three individuals to induction into the armed services. The 1948 amendment to the statute provided that individuals who objected to participation in war by reason of their "religious training and belief" could be exempted from military service. *Id.* at 165. The term "religious training and belief" meant "an individual's belief in a relation to a Supreme Being involving duties

superior to those arising from any human relation, but (not including) essentially political, sociological, or philosophical views or a merely personal moral code." *Id.* at 172 (citing 50 U.S.C. § 456(j)). The Court concluded that a conscientious objection to war can be considered religious within the meaning of the statute if the opposition "stem[s] from the registrant's moral, ethical, or religious beliefs about what is right and wrong," and these beliefs are "held with the strength of traditional religious convictions." *Welsh v. United States*, 398 U.S. 333, 339-40 (1970) (describing the Court's decision in *Seeger*). Notably, the Court in *Seeger* based its holding in part on the conclusion that "the beliefs which prompted [Seeger's] objection occupy the same place in his life as the belief in a traditional deity holds in the lives of his friends, the Quakers." 380 U.S. at 187. Later, applying this standard in *Welsh*, the Court ruled that a conscientious objector qualified for religious exemption in part on the basis that his pacifist beliefs were held with the strength of traditional religious convictions. 398 U.S. at 343-44.

Seeger and *Welsh* grapple with the extent to which moral objections, informed by a traditional religious background (as noted about each objector by the Court), meet the standard for conscientious objection with the Selective Services. Ultimately the Court sought to determine whether an objector's beliefs "function as a religion in his life." *Welsh*, 398 U.S. at 340. For the named defendants in those cases, the potential consequences of objection demonstrated both the sincerity of their beliefs and their centrality. *Id.* at 338 ("Their objection to participating in war in any form could not be said to come from a 'still, small voice

of conscience'; rather, for them that voice was so loud and insistent that both men preferred to go to jail rather than serve in the Armed Forces."); see also *Gillette v. United States*, 401 U.S. 437, 445 (1971) ("[L]egislative materials simply do not support the view that Congress intended to recognize any conscientious claim whatever as a basis for relieving the claimant from the general responsibility or the various incidents of military service.").

Here, the religious rule allows an employer to exempt itself from the mandate "based on its sincerely held religious beliefs." Religious Exemption, 83 Fed. Reg. at 57,590. The overlap between that language and Section 6(j) *at most* supports an implicit inclusion of a limited moral exemption within the religious rule (which is likewise invalid), but cannot support the agencies' standalone moral rule.

The conscientious objector cases and the moral exemption diverge in several additional and crucial ways. Those cases interpreted a *statute* in which Congress provided for a religious exemption, signaling at minimum an intention for an exemption to exist. No parallel statutory exemption exists in this context; the agencies, not Congress, seek to create a moral exemption. Additionally, the moral rule makes no effort to cabin the exemption by reference to the weight of the consequences of the objection or the place it holds in the objector's life. According to the terms of the rule, the moral objection must be "sincerely held," but is not required to hold the same place as a religious view or meet any other specific standard. See Moral Exemption, 83 Fed. Reg. at 57,631. Finally, the

mechanics relating to the invocation of the moral exemption essentially only require the business to communicate its wishes to the insurer. *Id.* at 57,614-15. The rule does not require businesses to submit sworn statements or seek agency approval in order to qualify for the exemption. *Id.* Without any concrete definition of the term "moral," and without any oversight, the bar for a moral objection as set forth in the rule is so low that one could potentially invoke it for any reason whatsoever.

C. Federal Agencies Lack General Authority to Create Exemptions from Federal Law Due to Non-Religious, Conscientious Objections.

Lacking specific statutory authority to promulgate the moral rule, the agencies also attempt to point to general principles in our legal tradition to support the regulation. Moral Exemption, 83 Fed. Reg. at 57,601-02. As an initial matter, vague principles do not provide agencies with specific authority to promulgate rules. Even if they did, the principles they cite do not support the agencies' broad action here.

As explained in the preceding sections, the agencies have failed to identify any specific authority to support the moral rule. Accordingly, they are left to rely on general principles, see, *e.g.*, Moral Exemption, 83 Fed. Reg. at 57,601 (citing letter from President George Washington regarding "liberty of conscience"), and previously issued Executive Orders. *Id.* at 57,598 (referring to Executive Order 13,535 (implementing the ACA consistent with certain conscience laws)). These attempts are unpersuasive. As this Court has

recognized, agencies must have a statutory basis for their action. See, *e.g.*, *City of Arlington, Tex. v. F.C.C.*, 569 U.S. 290, 297 (2013) (noting that "[n]o matter how it is framed, the question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, whether the agency has stayed within the bounds of its statutory authority"); see also *La. Pub. Serv. Comm'n v. F.C.C.*, 476 U.S. 355, 374 (1986) (noting that "an agency literally has no power to act . . . unless and until Congress confers power upon it").

No federal law currently requires all religious exemptions to be paired with a non-religious moral opt-out. Nor does this Court's jurisprudence. See, *e.g.*, *Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 338 (1987) ("Where, as here, government acts with the proper purpose of lifting a regulation that burdens the exercise of religion, we see no reason to require that the exemption comes packaged with benefits to secular entities."). The Court has repeatedly concluded, instead, that protections for religious organizations are given "special solicitude" under the First Amendment. See, *e.g.*, *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. EEOC*, 565 U.S. 171, 189 (2012); *Real Alts. v. Sec'y Dep't of Health & Human Servs.*, 867 F.3d 338, 350 (3d Cir. 2017) (expansion of contraceptive mandate's accommodation to non-religious objections "lies in direct contradiction to the Supreme Court's refusal to broaden religion-based exemptions in similar contexts" (citation omitted)).

II. LOCAL GOVERNMENTS WILL STRUGGLE TO PROVIDE FOR INCREASED NEED IN THE ABSENCE OF PRIVATE INSURANCE COVERAGE.

In the Nation's uneven health insurance landscape, states and localities provide vital safety-net and public health services to support our communities, especially for the most vulnerable groups.[11] These efforts are a crucial investment, as comprehensive health care contributes to a positive feedback loop—a healthier populace fosters a stronger economy and vice versa.[12] Family planning services, particularly access to contraceptive coverage, are a central component of this community-benefitting health coverage. When individuals are able to plan their reproductive decisions, their economic contributions to their communities increase and their health outcomes

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[11] State funding and programs provide vital public health and safety-net care as well, see, *e.g.*, Matthew Newman & Eunice Roh, *California's Health Care Safety Net: A Patchwork of Programs and Providers*, California Health Care Foundation (Mar. 2019), https://www.chcf.org/wp-content/uploads/2019/03/HealthCareSafetyNetAlmanac2019.pdf, but this brief focuses on *amici*'s particular expertise—local governments' contributions. See also Br. of Mass. et al. 14-27.

[12] See, *e.g.*, Julio Frenk, *Health and the Economy: A Vital Relationship*, OECD Observer (May 2004), https://oecdobserver.org/news/archivestory.php/aid/1241/Health_and_the_economy:_A_vital_relationship_.html. Unfortunately, the COVID-19 pandemic provides a stark counter-example of this proposition. As a result of the public health crisis, stock markets have plummeted, and long-term economic effects are likely to be severe, if difficult to predict.

improve.[13] In contrast, when people lose this vital coverage, it falls to local governments to address the many health, economic, and social consequences to these individuals and our communities.

Many who do not have access to, or lose, contraceptive coverage will turn to state and local government-funded sources to replace it. Indeed, the federal government seeks to justify the religious and moral rules by touting these alternative state and locally funded resources in order to minimize the impact of private coverage denial on low-income women. See U.S. Br. 26-27. This assertion is crucial to its defense, as the federal government must account for burden to third parties under RFRA. See, *e.g.*, *Hobby Lobby*, 573 U.S. at 729 n.37; see also *Holt*, 574 U.S. at 370 (Ginsburg, J., concurring) ("Unlike the exemption this Court approved in [*Hobby Lobby*], accommodating petitioner's religious belief in this case would not detrimentally affect others who do not share petitioner's belief." (citations omitted)). The flawed analysis, especially in light of subsequent changes to the Title X program and the ongoing public health crisis of COVID-19, further erodes the federal government's purported justifications.

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[13] See, *e.g.*, Kelly Jones & Anna Bernstein, *The Economic Effects of Contraceptive Access: A Review of the Evidence*, Institute for Women's Policy Research (Sept. 26, 2019), https://iwpr.org/wp-content/uploads/2019/09/Contraception-fact-sheet_final.pdf; see also Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730 (2002).

The religious and moral rules expand the uninsured population and stress an overtaxed safety net. Even in the best fiscal times, state and local governments expend significant resources but are not always able to meet all community needs with the highest quality care. Disruptions in care, routine challenges accessing alternative providers, and the higher costs of more effective contraception, however, place these state and local programs at a decided disadvantage when attempting to fill in gaps caused by exemptions to the contraceptive mandate. Adding to these challenges, the federal government fundamentally reshaped the Title X program, which has further limited the available trusted alternatives for people who lose their primary health care coverage through an employer. Now, in this moment of public health crisis due to COVID-19, cities and counties are re-purposing our resources. We are working urgently with state and federal authorities to provide testing, treatment, transport, guidance, information, and more to combat the spread of coronavirus. Although local governments are making every effort to preserve delivery of care for many other critical needs, including contraceptive care, some jurisdictions and health providers are limiting and delaying in-person preventive care in light of the pandemic.[14]

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[14] As just one example, in Santa Clara County, California, the county hospital system is limiting visitors, *For Patients*, Santa Clara Valley Medical Center, https://www.scvmc.org/patients-and-visitors/for-patients/Pages/Visiting-Hours-and-Parking.aspx (as visited Apr. 6, 2020), and other major health care providers in the county are limiting clinic visits and postponing wellness programing. *Clinical Care and Services (Operational Updates)*,

A. Cities and Counties Provide a Critical Health Safety Net, Especially for People Without Any or Adequate Insurance Coverage.

Local governments across the country provide a wide range of safety-net health care services. Twenty-nine states have local public health agencies that are independent of the state agencies.[15] In twenty-three states, counties are required to provide medical services to their low-income and chronically ill residents.[16] In Texas, for example, counties must provide medical services to eligible residents without

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Stanford Health Care, https://stanfordhealthcare.org/stanford-health-care-now/2020/novel-coronavirus/shc-clinical-care-and-services.html (as visited Apr. 6, 2020). Nationally, clinics that serve low-income patients are being forced to lay off employees as the postponement of routine care appointments depletes their revenues. Kirk Johnson & Abby Goodnough, *Just When They're Needed Most, Clinics for the Poor Face Drastic Cutbacks*, N.Y. Times (Apr. 4, 2020), https://www.nytimes.com/2020/04/04/us/coronavirus-community-clinics-seattle.html.

[15] Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, Nat'l Health Pol'y F. 9-10 (Aug. 18, 2010), https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf ("Of the 2,794 local health departments in the United States, most (60 percent) serve counties; some (18 percent) serve a city, town, or township; some (11 percent) serve a joint city/county jurisdiction; and some (9 percent) serve a multicounty region.").

[16] See *Counties' Role in Health Care Delivery and Financing*, National Association of Counties 3 (July 2007), http://www.naco.org/sites/default/files/documents/Counties'%20Role%20in%20Healthcare%20Delivery%20and%20Financing.pdf.

other sources of care.[17] Tex. Health & Safety Code Ann. § 61.022. In California, all counties are required to provide safety-net health care services. Cal. Welf. & Inst. Code § 17000. Tennessee local and regional health departments provide a range of health care services, including primary care, child health, and family planning.[18] Federal requirements impose additional obligations on local government health systems to provide some forms of safety-net care.[19] In much of the country, even local governments that do not provide

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[17] See *Texas Hospital Uncompensated Care Report*, Texas Health & Human Services 6 (rev. Jan. 16, 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider-10-hospital-uncompensated-care-report-dec-2018.pdf ("The Texas Constitution states that care for the uninsured is a local government responsibility. The Texas Department of State Health Services oversees this law in the form of The County Indigent Health Care Program. Counties must provide select medical care to all [eligible] residents.").

[18] *Services Offered by Local Health Departments*, Tennessee Department of Health, https://www.tn.gov/health/health-program-areas/localdepartments/lrhd/local-services.html (as visited Apr. 6, 2020).

[19] See, *e.g.*, 42 U.S.C. § 254b (2018) (requiring Federally Qualified Health Centers to serve all residents of their communities regardless of their ability to pay); Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (1990) (requiring providers to offer HIV/AIDS medications and health care services to poor patients who need these medications and services but cannot otherwise access them).

hospital or clinical care offer life-saving emergency health care through fire departments and paramedics.[20]

Many localities fund or support safety-net health centers that provide free or reduced-fee services to patients. These health centers offer a wide range of services that include adult and child immunizations; communicable or infectious disease programs and other programs for particular diseases and conditions; emergency medical services; maternal and child health care; and even comprehensive primary care.[21] In addition, they often provide contraceptive care, prenatal care, sexually transmitted disease testing, and other maternal and child health services.[22] The passage and implementation of the ACA has not abated the crucial role such centers play in supporting the reproductive health of their residents. In 2015, eighty-two percent of U.S. counties had at least one safety-net health center providing family planning services.[23]

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[20] See, *e.g.*, *Fire Department, Medical Services Division*, City of Oakland California, http://www2.oaklandnet.com/government/o/OFD/o/EmergencyMedicalServices/index.htm (as visited Apr. 6, 2020).

[21] See *2016 National Profile of Local Health Departments*, National Association of County & City Health Officials 77-82 (2017), http://nacchoprofilestudy.org/wp-content/uploads/2017/10/ProfileReport_Aug2017_final.pdf.

[22] See *Publicly Supported Family Planning Services in the United States*, Guttmacher Institute (Oct. 2019), https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states; Salinsky, *supra* note 15.

[23] See *Publicly Supported Family Planning Services in the United States*, *supra* note 22.

B. Those Who Lose Coverage Under the Expanded Exemptions Will Turn to State and Local Sources of Support.

Based on *amici*'s experience delivering family planning services, we know that those who lack (or who lose) coverage for their contraception will turn to locally subsidized services. Those services will provide a suitable substitute for some, while others will experience disruptions in coverage, changes in providers, or substitutions in the type of contraception they receive that will impose barriers to care. Even in a system that was cost-free and easy to navigate, these disruptions would cause some changes in behavior as well as overall efficacy. But the U.S. system is neither, and in this time of public health crisis, it is even more expensive and harder to understand. As a result, there will be unintended pregnancies and other health impacts, which cost states and localities significantly both over the short and long term.

From 2006 to 2010, immediately prior to the passage of the ACA, one in four women who obtained contraceptive services did so at a publicly funded center.[24] The ACA's coverage expansions dramatically decreased the proportion of women relying on publicly

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[24] See Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use*, *1995–2010*, Guttmacher Institute 16 (2013), https://www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf.

funded family planning services.[25] However, the need for publicly funded programs persists. For example, California's Family PACT Program offers comprehensive family planning services at no cost to families below two-hundred percent of the federal poverty level with no other source of family planning coverage.[26] Annually, Family PACT serves approximately 1.6 million state residents.[27] More than half of states offer some program to extend family planning services to low-income women; thirteen of these programs are similar to California's.[28] As those with private health insurance lose contraceptive coverage, more low-income individuals will need services through Family PACT or other state and local

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[25] See Jennifer J. Frost et al., *Contraceptive Needs and Services, 2014 Update*, Guttmacher Institute 15 (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf ("Between 2013 and 2014 . . . the number of women in need of publicly funded contraceptive care who had neither public nor private health insurance fell by nearly 20%, from 5.6 million to 4.5 million.").

[26] See, *e.g.*, *Family PACT*, California Department of Health Care Services, http://www.familypact.org/ (as visited Apr. 6, 2020) (describing California's programs providing comprehensive family planning services to eligible residents).

[27] *Office of Family Planning*, California Department of Health Care Services, https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx (as visited Apr. 6, 2020).

[28] Usha Ranji, Yali Bair, & Alina Salganicoff, *Medicaid and Family Planning: Background and Implications of the ACA*, The Henry J. Kaiser Family Foundation 6 (Feb. 2016), https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/.

government programs, at a direct cost to governments. Increasing the number of individuals needing care from these providers will further burden an already strained system.

Further, decades of research confirm that individuals use contraception most effectively absent upfront financial and logistical barriers.[29] Some of the most highly effective forms of contraception also are those with the greatest upfront costs, which makes them more difficult to access without health coverage and more costly for local governments to include in our care options.[30] Three of the most commonly used and effective methods of contraception—oral contraception (the pill), female sterilization, and intrauterine devices (IUDs)[31]—are ultimately cost-effective but entail high

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[29] See, *e.g.*, Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 Persp. on Sexual & Reprod. Health 226, 226 (2007); Lydia E. Pace et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 Health Aff. 1616 (2016).

[30] After the ACA was implemented, use of more expensive and effective forms of contraception rose sharply. See Ashley H. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs Among Privately Insured Women*, Women's Health Issues (May-June 2018),https://www.whijournal.com/article/S1049-3867(17)30527-3/fulltext.

[31] See Megan L. Kavanaugh & Jenna Jerman, *Contraceptive Method Use in the United States: Trends and Characteristics Between 2008, 2012 and 2014*, 97 Contraception 14, 16 (2017); U.S. Food & Drug Admin., *Birth Control Guide*, https://www.fda.gov/media/135111/download (as visited Apr. 6, 2020).

upfront costs. Absent "the contraceptive coverage guarantee, many women would need to pay more than $1,000 to start using one of these methods—nearly one month's salary for a woman working full-time at federal minimum wage."[32] Use of these more effective forms of contraception rose sharply after the ACA's implementation.[33] The expanded exemptions threaten to undo that progress.

The experience in Texas offers some indication of expected impact. In 2013, Texas replaced its federally funded family planning program with a state-funded program in order to exclude providers that also served as abortion providers or that were "affiliated" with them. After Texas excluded Planned Parenthood and other independent providers from its family planning program, the number of individuals receiving expensive and long-acting forms of contraception decreased by thirty-five percent, while Medicaid-paid births among this cohort increased by twenty-seven percent.[34] In other words, when these Texans lost access to more effective contraception, their rate of pregnancies and related health care and other costs increased. These are costs that state and local governments will be forced to bear.

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[32] Adam Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee?*, 20 Guttmacher Pol'y Rev. 8, 9 (2017).

[33] See Snyder, *supra* note 30.

[34] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. Engl. J. Med. 853, 853 (2016).

Even where individuals do not rely on local governments to provide contraceptive care lost through the exemptions, they may still rely on them for their ensuing health needs. When our populations do not have adequate contraceptive access, local and state governments incur greater costs providing pregnancy, delivery, and early childhood care.[35] In 2010, every $1.00 invested in publicly funded family planning services saved $7.09 in Medicaid expenditures that would otherwise have been needed to pay the medical costs of pregnancy, delivery, and early childhood care.[36] Such costly outcomes associated with unplanned births are well established.[37] As safety-net health care funders and providers, local jurisdictions will have to fund many of the medical services associated with unintended pregnancies for our eligible residents.[38]

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[35] See, *e.g.*, Frost et al., *supra* note 6; Kavanaugh & Jerman, *supra* note 31, at 14 ("95% of unintended pregnancies occur among women who either use their [contraceptive] method inconsistently or incorrectly, or use no method at all.").

[36] Frost et al., *supra* note 6.

[37] See, *e.g.*, Mary Tschann & Reni Soon, *Contraceptive Coverage and the Affordable Care Act*, 42 Obstetrics & Gynecology Clinics N. Am. 605, 606 (2015).

[38] For many people, certain health conditions make pregnancy dangerous or life-threatening. As a result, health care costs are not just limited to the pregnancy itself but also the ripple effects on other underlying conditions.

C. Fundamental Changes to the Title X Program Combined with the Current Public Health Crisis Undermine the Agencies' Assumptions about States' and Localities' Ability to Meet Increased Needs.

The federal government repeatedly has asserted that the burden of these exemptions on individuals (and consequently on *amici*) will be minimal because of other "mechanisms by which the Government advances contraceptive coverage," Moral Exemption, 83 Fed. Reg. at 57,605, as well as "existing federal, state, and local programs [that] provide free or subsidized contraceptives to low-income women." U.S. Br. 27 (citing Religious Exemption, 83 Fed. Reg. at 57,551). These assurances, however, are contradicted by the federal government's own actions. Rather than preserving (or expanding) the capacity of the safety net to serve *amici*'s most vulnerable residents, the federal government has systematically undermined it. In addition, the urgent and pressing need to respond to COVID-19 further strains *amici*'s already limited resources.

In the rules, the agencies purport to rely in part on the Title X federal Family Planning Program, which provides comprehensive family planning services and preventive health services for low-income populations, to "reduce any potential effect" of the rules on "women's access to contraceptives." Religious Exemption, 83 Fed. Reg. at 57,551. Over the past fifty years, Title X has served a crucial role in the delivery of contraceptive care in the United States. In fact, for 4.3 million

women, Title X providers have been the only accessible health care providers that offer the full range of contraceptive options.[39] However, recent regulatory changes restricting Title X funding have resulted in significant impacts on the contraceptive care delivery landscape. Last year, the federal government issued a final rule that effectively disqualifies any provider that offers abortion services, is affiliated with an abortion provider, or seeks to counsel patients on abortion. See Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7,714 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59). Application of this new rule already has reduced the Title X national family planning network's patient capacity by half, jeopardized care for 1.6 million patients nationwide, and left six states with no providers remaining in the Title X network.[40] Many *amici* are located in states where fifty percent or more of capacity has vanished.

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[39] As a result, Title X providers also are more likely to provide same day on-site provision of long-acting reversible contraceptives, which makes both the delivery of care and the use of contraception more effective. See Ginny Erlich, *Too Many Women Lack Birth Control Access*, Power to Decide (May 22, 2019), https://powertodecide.org/news/too-many-women-lack-birth-control-access; Mia R. Zolna & Jennifer Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute (Nov. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf.

[40] Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, Guttmacher Institute (Feb. 26, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half.

The new Title X rule directly threatens the safety-net capacity of providers operated and supported by *amici* and increases costs for those seeking contraceptive care. With the implementation of the new rule, there are likely to be significant gaps in coverage as the Title X patient capacity in California has been reduced by more than half.[41] The Title X rule change has led, in some cases, to a six-fold increase in out-of-pocket costs for birth control, leading those who cannot afford to pay for contraception to cancel appointments.[42] Nor has limited supplemental Title X funding filled the gaps: In Minnesota, for instance, only one county continues to have Title X grantees, and even with supplemental funding those grantees serve a limited geographical area.[43]

Before these fundamental changes to Title X, the public health system already strained to care for the number of people in need of contraceptive care, and could not seamlessly serve the needs of all the people

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[41] *Id.*

[42] Ariana E. Cha & Shelia Regan, *Patients Face Higher Fees and Longer Waits After Planned Parenthood Quits Federal Program*, Wash. Post (Aug. 24, 2019), https://www.washingtonpost.com/business/2019/08/24/patients-face-higher-fees-longer-waits-after-planned-parenthood-quits-federal-program/.

[43] Brittni Frederiksen et al., *Data Note: Is the Supplemental Title X Funding Awarded by HHS Filling in the Gaps in the Program?*, KFF (Oct. 18, 2019), https://www.kff.org/womens-health-policy/issue-brief/data-note-is-the-supplemental-title-x-funding-awarded-by-hhs-filling-in-the-gaps-in-the-program/.

who rely upon it.[44] The increased burden on local health systems flowing from Title X changes comes at a moment of crisis. The COVID-19 pandemic is overwhelming our systems. In an effort to reallocate resources to emergency as well as inpatient care and prevent further spread of the virus,[45] many local clinics have reduced or eliminated in-person appointments and interactions altogether.[46] For clinics that continue to offer in-person appointments, they have largely ceased performing preventive invasive procedures in efforts to preserve and extend use of limited Personal Protective Equipment (PPE).[47] These additional

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[44] In 2016, an estimated 20.6 million women were likely in need of public support for contraceptive services and supplies, whereas around 9 million women received such public support. See Frost et al., *supra* note 6.

[45] John Woodrow Cox, *Fearful Doctors and Nurses at Walk-In Clinics Have a Message for Patients: Stay Away*, Wash. Post (Mar. 20, 2020), https://www.washingtonpost.com/local/fearful-doctors-and-nurses-at-walk-in-clinics-have-a-message-for-patients-stay-away/2020/03/20/710c194c-6a1c-11ea-9923-57073adce27c_storyhtml.

[46] See, *e.g.*, *Sexual Health*, Public Health Madison & Dane County, https://publichealthmdc.com/health-services/sexual-health (as visited Apr. 6, 2020) ("The Sexual & Reproductive Health Clinic has temporarily eliminated in-person client services and will serve clients through other mechanisms."); *Health Clinics and Services*, Arlington County Goverment, https://health.arlingtonva.us/public-health/health-clinics-services/ (as visited Apr. 6, 2020) (canceling Family Planning and Teen Program).

[47] For example, Monterey County, California's Clinic Services Bureau presently discourages use of birth control methods that require the use of PPE during an invasive procedure (such as IUD or Nexplanon placement).

obstacles imposed by COVID-19 will not be merely temporary; in the event of a continued economic downturn, state and local sources of funding for the provision of health care will further diminish.[48] In fact, the United Nations has raised concerns that the COVID-19 crisis has "severely disrupted" access to sexual and reproductive health services.[49]

The delivery of contraceptive care remains a crucial and urgent need. By adding to the count of residents who cannot access contraceptive care through private health coverage, and who must rely on state and local programs for the delivery of care, these rules are a detrimental and unnecessary burden to the system. Our providers and our systems need access to every available resource to confront the coronavirus crisis. As a result, the assumptions the agencies made during the rulemaking process, which were flawed from the outset, are entirely inaccurate in the current environment.

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[48] See Tracy Gordon, *State and Local Governments and the Great Recession,* Brookings Institute (Dec. 31, 2012), https://www.brookings.edu/articles/state-and-local-budgets-and-the-great-recession/.

[49] Peter Beech, *The COVID-19 Pandemic Could Have Huge Knock-On Effects on Women's Health, Says the UN*, World Econ. F. (Apr. 2, 2020), https://www.weforum.org/agenda/2020/04/covid-19-coronavirus-pandemic-hit-women-harder-than-men/.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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APPENDIX

APPENDIX

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APPENDIX A

AMICI CURIAE

City of Oakland, California

City of Saint Paul, Minnesota

City of Alameda, California

Alameda County, California

City of Albuquerque, New Mexico

City of Austin, Texas

City of Baltimore, Maryland

City of Boulder, Colorado

City of Chicago, Illinois

City of Cincinnati, Ohio

City of Columbus, Ohio

Cook County, Illinois

City of Dayton, Ohio

City of Holyoke, Massachusetts

City of Houston, Texas

King County, Washington

City of Madison, Wisconsin

Marin County, California

Milwaukee County, Wisconsin

Monterey County, California

City of New York, New York

City of Philadelphia, Pennsylvania

City of Pittsburgh, Pennsylvania

City of Providence, Rhode Island

City & County of San Francisco, California

Santa Clara County, California

City of Seattle, Washington

Shelby County, Tennessee

City of Somerville, Massachusetts

City of Stockton, California

Travis County, Texas

City of West Hollywood, California