IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
BEAUMONT DIVISION

CATHOLIC DIOCESE OF BEAUMONT; CATHOLIC CHARITIES OF SOUTHEAST TEXAS, INC.,	
Plaintiffs,	
v.	
KATHLEEN SEBELIUS, in her official capacity as Secretary of the U.S. Department of Health and Human Services; THOMAS PEREZ, in his official capacity as Secretary of the U.S. Department of Labor, JACOB J. LEW, in his official capacity as Secretary of the U.S. Department of Treasury; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF LABOR; and U.S. DEPARTMENT OF TREASURY,	**Civil Action No. 1:13-cv-00709-RC**
	DEMAND FOR JURY TRIAL
Defendants.	

PLAINTIFFS' RESPONSE TO DEFENDANTS' STATEMENT OF MATERIAL FACTS

Plaintiffs Diocese of Beaumont and Catholic Charities of Southeast Texas, Inc. (collectively, "Plaintiffs"), submit that the following objections and responses to Defendants' Statement of Material Facts.

1. Before the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), due largely to cost, Americans used preventive services at about half the recommended rate. *See* INST. OF MED., CLINICAL PREVENTATIVE SERVICES FOR WOMEN: CLOSING THE GAPS 19-20, 109 (2011) ("IOM REP."), AR at 317-18, 407.

RESPONSE: Disputed and unsupported. To the extent Defendants refer to preventive services generally, this statement is immaterial, as Plaintiffs challenge only the aspects of the preventive service requirements regarding "FDA-approved contraceptive methods and contraceptive counseling"—a term that includes abortion-inducing products, contraception,

sterilization, and related counseling and education (collectively, "contraceptive services"). To the extent that Defendants are suggesting that "preventive services" include contraceptive services, the pages of the IOM Report Defendants cite do not support their assertion.

The only related statement in these pages is a single survey "indicat[ing] that less than half of women are up to date with recommended preventive care screenings and services (Robertson and Collins, 2011)." IOM REP. at 20. That survey, however, did not consider contraceptive coverage to be "preventive care." Rather, "[t]he survey asked women whether they had received a set of recommended preventive screening tests: blood pressure, cholesterol, cervical cancer, colon cancer (for ages 50 to 64) and breast cancer (for ages 50 to 64) screens." *See* Robertson & Collins, *Women at risk: Why increasing numbers of women are failing to get the health care they need and how the Affordable Care Act will help*, in *Realizing Health Reform's Potential* (2011), at 8-9. Similarly, the only study referenced in the cited IOM pages actually relating to contraception does not discuss rates of women's use of contraceptive services; rather, it analyzes women who already use some type of contraception, but decided to switch to another type. *See* IOM REP. at 119.

2. Section 1001 of the ACA requires all group health plans and health insurance issuers that offer non-grandfathered group or individual health coverage to provide coverage for certain preventive services without cost-sharing, including, "[for] women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration [(HRSA)]." 42 U.S.C. § 300gg-13(a)(4).

RESPONSE: Undisputed that the quoted text appears in Section 1001 of the ACA, but Section 1001 of the ACA is a provision of law, not a statement of fact.

3. Because there were no existing HRSA guidelines relating to preventive care and screening for women, the Department of Health and Human Services (HHS) tasked the Institute of Medicine (IOM) with developing recommendations to implement the requirement to provide coverage, without cost-sharing, of preventive services for women. IOM REP. at 2, AR at 300.

RESPONSE: Disputed. Plaintiffs do not dispute that HHS tasked IOM with developing recommendations to implement the requirement to provide coverage, without cost-sharing, of preventive services for women, but dispute the propriety of HHS delegating its authority for creating preventive care guidelines to IOM, the impartiality of the IOM committee that was formulated to recommend preventive care guidelines, the methods the IOM committee employed to take on this task, and the recommendations the IOM offered. Specifically, HHS outsourced its deliberations to the IOM, which in turn created a "Committee on Preventive Services for Women" that invited presentations from several "pro-choice" groups, such as Planned Parenthood and the Guttmacher Institute (named for a former president of Planned Parenthood), without inviting any input from groups that oppose government-mandated coverage for abortion, contraception, and sterilization. *See* IOM REP. at 218-19.

In addition, "[t]he Report acknowledges" that it suffered from an "unacceptably short time frame for the [ ] committee to conduct or solicit meaningful reviews of the evidence associated with the preventive nature of the services considered," IOM Rep. at 231-32. Further, "the committee process for evaluation of the evidence lacked transparency and was largely subject to the preferences of the committee's composition. Troublingly, the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy." *Id.* at 232. Ultimately, "the committee erred [in] their zeal to recommend something despite the time constraints and a far from perfect methodology" and "failed to demonstrate [transparency and strict objectivity] in the Report." *Id.* at 232-33. The "evidence evaluation process [was] a fatal flaw of the Report." *Id.* at 233.

4. After conducting an extensive science-based review, IOM recommended that HRSA guidelines include, among other things, "the full range of [FDA]-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." *Id*. at 10-12, AR at 308-10.

RESPONSE: Undisputed that the quoted text appears in the IOM Report, but disputed that the IOM's review was "extensive" and "science-based." *See* Response to Paragraph 3, above. Plaintiffs incorporate herein their response to Paragraph 3, *supra.*

5. FDA-approved contraceptive methods include diaphragms, oral contraceptive pills, emergency contraceptives (such as Plan B and Ella), and intrauterine devices ("IUDs"). *See id*. at 105, AR at 403.

RESPONSE: Undisputed, but incomplete. FDA-approved contraceptive methods also include, *inter alia*, sterilization. *See* IOM REP. at 104-05. Further, Ulipristal (trade name "Ella") is a close analogue to the abortion drug RU-486, with the same biological effect—that is, it can induce an abortion even after implantation. See Comments of the U.S. Conference of Catholic Bishops (Mar. 20, 2013) (citing European Medicines Agency, Evaluation of Medicines for Human Use: CHMP Assessment for Ellaone (2009)); Comments of the U.S. Conference of Catholic Bishops (Aug. 31, 2011) (citing A. Tarantal, et al., "Effects of Two Antiprogestins on Early Pregnancy in the Long-Tailed Macaque (Macaca fascicularis)," 54 Contraception 107-115 (1996), at 114 ("studies with mifepristone and HRP 2000 have shown both antiprogestins to have roughly comparable activity in terminating pregnancy when administered during the early stages of gestation"); G. Bernagiano & H. von Hertzen, "Towards more effective emergency contraception?", 375 The Lancet 527-28 (Feb. 13, 2010), at 527 ("Ulipristal has similar biological effects to mifepristone, the antiprogestin used in medical abortion")).

There is no authoritative agency interpretation of the term "abortion" in the context of the Weldon Amendment, the Government cites no statutory definition, no medical definition, and no case interpreting the term in that context. Stedman's Medical Dictionary, for example, defines

"abortion" as the "[e]xpulsion from the uterus of an embryo or fetus [before] viability." STEDMAN'S MEDICAL DICTIONARY 4 (27th ed. 2000) (emphasis added). On this definition, some of the Mandate's covered services clearly qualify as "abortion."

Further, Defendants' definition of pregnancy and when an abortion occurs is contradictory with Roman Catholic teaching on the subject: "Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo." See Ethical and Religious Directives for Catholic Health Care Services, 5th Ed. (2009) (emphasis added).

6. Coverage, without cost-sharing, for these services is necessary to increase access to such services, and thereby reduce unintended pregnancies (and the negative health outcomes that disproportionately accompany unintended pregnancies) and promote healthy birth spacing. *See id*. at 102-03, AR at 400-01.

RESPONSE: Disputed and unsupported. The pages of the IOM Report that Defendants cite do not support this assertion. The only related points in these pages are references to (1) another IOM report observing, without citation, that "[p]rogress in reducing unintended pregnancies will require not only making contraceptive methods more available, accessible, and acceptable through improved services, but also the development of new methods that meet additional needs," *see* Inst. of Med., Women's Health Research: Progress, Pitfalls, and Promise (2010), at 147; and (2) two studies that observed that increased rates of contraceptive use by unmarried women and adolescents, respectively, were associated with decreased rates of unintended pregnancies. IOM REP. at 105. Neither the referenced IOM report nor the cited studies discussed coverage of contraception without cost sharing at all, let alone that coverage without cost-sharing is necessary for increasing access to these services and thereby reducing the

rate of unintended pregnancies and promoting healthy birth spacing, or that requiring religious organizations to provide such coverage is a necessary means to either of those ends.

7. On August 1, 2011, HRSA adopted guidelines consistent with IOM's recommendations, encompassing all FDA-approved "contraceptive methods, sterilization procedures, and patient education and counseling," as prescribed by a health care provider, subject to an exemption relating to certain religious employers authorized by regulations issued that same day (the "2011 amended interim final regulations"). *See* HRSA, Women's Preventive Services: Required Health Plan Coverage Guidelines ("HRSA Guidelines"), AR at 283-84.

RESPONSE: Undisputed.

8. To qualify for the religious employer exemption contained in the 2011 amended interim final regulations, an employer had to meet the following criteria:

> (1) The inculcation of religious values is the purpose of the organization;
> (2) the organization primarily employs persons who share the religious tenets of the organization;
> (3) the organization serves primarily persons who share the religious tenets of the organization; and
> (4) the organization is a nonprofit organization as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011), AR at 220[1].

RESPONSE: Undisputed, but this is a provision of law, not a statement of fact.

9. Group health plans established or maintained by religious employers (and associated group health insurance coverage) are exempt from any requirement to cover contraceptive services consistent with HRSA's guidelines. *See* HRSA, Women's Preventive Services: Required Health Plan Coverage Guidelines ("HRSA Guidelines"), AR at 283-84; 45 C.F.R. § 147.131(a).

RESPONSE: This is a disputed proposition of law, not a statement of fact. Moreover, under the government's initial interpretation of the "religious employer" exemption, if a nonexempt religious organization "provided health coverage for its employees through" a plan offered by a separate, "affiliated" organization that was "exempt from the requirement to cover contraceptive services, then neither the [affiliated organization] nor the [nonexempt entity would

[1] Plaintiffs do not concede that the Administrative Record is properly before the Court. To the extent Defendants rely on the Administrative Record, references herein by Plaintiffs to the Administrative Record are to demonstrate that it does not support Defendants' Statement of Facts.

be] required to offer contraceptive coverage to its employees." 77 Fed. Reg. 16,501, 16,502 (Mar. 21, 2012). But the Final Rules eliminated that safeguard, and now interpret the exemption to require "each employer" to "independently meet the definition of eligible organization or religious employer in order to take advantage of the accommodation or the religious employer exemption with respect to its employees and their covered dependents." 78 Fed. Reg. 39,870, 39,886; *See also* 78 Fed. Reg. 8,456, 8,467 (Feb. 6, 2013) (NPRM). Nevertheless, the language of 45 C.F.R. § 147.131(a) explicitly exempts "group health plan[s] established or maintained by a religious employer (and health insurance coverage provided in connection with a group health plan established or maintained by a religious employer)" from "any requirement to cover contraceptive services" under the HRSA guidelines. *Id.* By its terms, this exemption does not solely exempt the religious *employer*; rather, it exempts the entire "group health plan" that the religious employer "establishe[s] or maintain[s]," *id.*, which in the case of the diocesan plaintiffs here provides coverage to affiliated religious entities.

10. In February 2012, the government adopted in final regulations the definition of "religious employer" contained in the 2011 amended interim final regulations while also creating a temporary enforcement safe harbor for non-grandfathered group health plans sponsored by certain non-profit organizations with religious objections to contraceptive coverage (and any associated group health insurance coverage). *See* 77 Fed. Reg. 8725, 8726-27 (Feb. 15, 2012), AR at 213-14.

RESPONSE: Undisputed.

11. The government committed to undertake a new rulemaking during the safe harbor period to adopt new regulations to further accommodate non-grandfathered non-profit religious organizations' religious objections to covering contraceptive services. *Id*. at 8728, AR at 215.

RESPONSE: Undisputed that the government undertook new rulemaking, but disputed that the new rulemaking in fact accommodated non-grandfathered non-profit religious organizations' religious objections to covering contraceptive services.

12. The regulations challenged here (the "2013 final rules") represent the culmination of that process. *See* 78 Fed. Reg. 39,870, AR at 1-31; *see also* 77 Fed. Reg. 16,501 (Mar. 21, 2012) (Advance Notice of Proposed Rulemaking (ANPRM)), AR at 186-93; 78 Fed. Reg. 8456 (Feb. 6, 2013) (Notice of Proposed Rulemaking (NPRM)), AR at 165-85.

RESPONSE: Undisputed, but Plaintiffs incorporate herein their response to Paragraph 11, *supra*, with respect to what "that process" is.

13. Under the 2013 final rules, a "religious employer" is "an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (a)(3)(A)(iii) of the Internal Revenue Code of 1986, as amended," which refers to churches, their integrated auxiliaries, and conventions or associations of churches, and the exclusively religious activities of any religious order. 45 C.F.R. § 147.131(a).

RESPONSE: This is an undisputed proposition of law, not a statement of fact.

14. The 2013 final rules establish accommodations with respect to the contraceptive coverage requirement for group health plans established or maintained by "eligible organizations" (and group health insurance coverage provided in connection with such plans). *Id*. at 39,875-80, AR at 7-12; 45 C.F.R. § 147.131(b).

RESPONSE: This is a disputed proposition of law, not a statement of material fact. While defendants purport to have established an "accommodation" regarding contraceptive coverage for certain religious "eligible organizations," that so-called "accommodation" does not resolve Plaintiffs' religious objections and still requires Plaintiffs to facilitate access to products and services the use of which is antithetical to Plaintiffs' mission and beliefs and the Roman Catholic faith.

15. An "eligible organization" is an organization that satisfies the following criteria:

> (1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under § 147.130(a)(1)(iv) on account of religious objections.
> (2) The organization is organized and operates as a nonprofit entity.
> (3) The organization holds itself out as a religious organization.
> (4) The organization self-certifies, in a form and manner specified by the Secretary, that it satisfies the criteria in paragraphs (b)(1) through (3) of this section, and makes such self- certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (c) of this section applies.

45 C.F.R. § 147.131(b); *see also* 78 Fed. Reg. at 39,874-75, AR at 6-7.

RESPONSE: This is an undisputed proposition of law, not a statement of material fact.

16. Under the 2013 final rules, an eligible organization is not required "to contract, arrange, pay, or refer for contraceptive coverage" to which it has religious objections. 78 Fed. Reg. at 39,874, AR at 6.

RESPONSE: This is a disputed proposition of law, not a statement of material fact. The Final Rules compel Plaintiffs to designate a third party administrator as plan administrator and claims administrator for the purpose of providing payments for contraceptive services for Plaintiffs' health plan participants. The Final Rules require Plaintiffs to find a third party administrator willing to provide the mandated coverage, contract with that party, and provide a self-certification to that party to be eligible for the accommodation. *See* 78 Fed. Reg. at 39,879 (providing requirements for self-certification and providing that, "[u]pon receipt of the copy of the self-certification, the third party administer may decide not to enter into, or remain in, a contractual relationship with the eligible organization to provide administrative services for the plan"). Upon locating a willing third party administrator, entering into a contract with that party, and providing the party with the requisite self-certification, "the third party administrator becomes an ERISA section 3(16) plan administrator and claims administrator solely for the purpose of providing payments for contraceptive services for participants and beneficiaries in a self-insured plan." 78 Fed. Reg. at 39,879. "[A] plan administer is defined in ERISA section 3(16)(A)(i) as 'the person specifically so designated by the terms of the instrument under which the plan is operated.' . . . [As such, T]he self-certification is one of the instruments under which the employer's plan is operated under ERISA section 3(16)(A0(i)." *Id.* Accordingly, the Final Rules require the non-exempt Plaintiffs to find and designate a third party administrator as plan administrator and claims administrator for the purpose of providing payments for contraceptive services for Plaintiffs' health plan participants and to provide the requisite self-certification to the

designated third party administrator in order to facilitate those payments. Moreover, Plaintiffs' employees would receive access to the mandated payments only by virtue of their participation in the health plan Plaintiffs choose to offer. *See* 29 C.F.R. § 2590.715-2713A(d); 45 C.F.R. § 147.131(c)(2)(i)(B) (indicating that payments are available only "so long as" Plaintiffs' employees remain on Plaintiffs' insurance plan").

17. To be relieved of any such obligations, the 2013 final rules require only that an eligible organization complete a self-certification form stating that it is an eligible organization and provide a copy of that self-certification to its issuer or third party administrator (TPA). *Id*. at 39,878-79, AR at 10-11.

RESPONSE: This paragraph is argumentative, and is a disputed proposition of law, not a statement of material fact. Plaintiffs incorporate herein their response to Paragraph 16, *supra.*

18. Its participants and beneficiaries, however, will still benefit from separate payments for contraceptive services made by the issuer or TPA, without cost sharing or other charge. *Id*. at 39,874, AR at 6.

RESPONSE: Disputed. Plaintiffs do not dispute that the 2013 final rules anticipate that health plan participants and beneficiaries will receive separate payments for contraceptive services made by the issuer or TPA without cost sharing or other charge. But Plaintiffs dispute that contraceptive services are a "benefit"; Plaintiffs believe they are immoral.

19. In the case of an organization with a self-insured group health plan—such as plaintiffs here—the organization's TPA, upon receipt of the self-certification, must, among other things, provide or arrange separate payments for contraceptive services for participants and beneficiaries in the plan without cost-sharing, premium, fee, or other charge to plan participants or beneficiaries, or to the eligible organization or its plan. *See id*. at 39,879-80, AR at 11-12.

RESPONSE: This is an incomplete proposition of law, not a statement of material fact. Plaintiffs incorporate herein their responses to Paragraph 16, *supra* and 20, *infra.* The 2013 final rules allow third party administrators to "decide not to enter into, or remain in, a contractual

relationship with the eligible organization to provide administrative services for the plan." 78 Fed. Reg. at 39,879.

20. Any costs incurred by the TPA will be reimbursed through an adjustment to Federally-facilitated Exchange (FFE) user fees. *See id*. at 39,880, AR at 12.

RESPONSE: Undisputed that the 2013 final rules anticipate that costs incurred by the TPA will be reimbursed through an adjustment to the FFE user fees, but disputed that such mechanisms will fully compensate TPAs. These fee reductions are to be established through a highly regulated and bureaucratic process for evaluating, approving, and monitoring fees paid in compensation to third-party administrators. Such regulatory regimes invariably fail to fully compensate the regulated entities for the costs and risks incurred. As a result, few if any third-party administrators are likely to participate in this regime, and those that do are likely to increase fees charged to self-insured organizations.

21. The government "propose[d] to make the accommodation or the religious employer exemption available on an employer-by-employer basis" in the NPRM. 78 Fed. Reg. 8456, 8467 (Feb. 6, 2013), AR at 176.

RESPONSE: Undisputed.

22. The 2013 final rules generally apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2014, *see id*. at 39,872, AR at 4, except the amendments to the religious employer exemption apply to group health plans and group health insurance issuers for plan years beginning on or after August 1, 2013, *see id*. at 39,871, AR at 3.

RESPONSE: This is an undisputed proposition of law, not a statement of material fact.

23. The regulations specifically prohibit TPAs from charging any premium or otherwise passing on any costs to eligible organizations with respect to the TPAs' payments for contraceptive services. *See* 78 Fed. Reg. at 39,880, AR at 12.

RESPONSE: This is an incomplete proposition of law, not a statement of material fact. The 2013 final rules allow TPAs to "decide not to enter into, or remain in, a contractual relationship with the eligible organization to provide administrative services for the plan." 78 Fed. Reg. at 39,879. Plaintiffs incorporate herein their response to paragraph 20, *supra.*

24. The primary predicted benefit of the preventive services coverage regulations is that "individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease." 75 Fed. Reg. 41,726, 41,733 (July 19, 2010), AR at 233; *see also* 77 Fed. Reg. at 8728, AR at 215; 78 Fed. Reg. at 39,872, 39,887, AR at 4, 19.

RESPONSE: This not a statement of fact, but unsupported speculation. Defendants' regulations are not evidence of the fact asserted, namely, that "individuals will experience improved health as a result of reduced transmission, prevention or delayed onset, and earlier treatment of disease." *See Williams v. City of New York*, No. 06-CV-6601 (NGG), 2009 WL 3254465, at *11 (E.D.N.Y. Oct. 6, 2009) ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient.").

In addition, contraceptive services, "unlike other mandated 'preventive services,' do not 'prevent' disease. Instead, they disrupt the healthy functioning of the human reproductive system." *See* Comments of the U.S. Conference of Catholic Bishops (Mar. 20, 2013). "Furthermore, various contraceptives are associated with adverse health outcomes, including an increased risk of such serious conditions as breast cancer, cardiac failure, and stroke." *Id.* The publishers of the *Physicians' Desk Reference* warn women of these, and other "[s]erious, and possibly life-threatening, side effects." Comments of the U.S. Conference of Catholic Bishops at 4 (Sept. 17, 2010) (discussing PDR Network, "Oral contraceptives," at *PDRhealth* (2009)).

25. "By expanding coverage and eliminating cost sharing for recommended preventive services, [the regulations are] expected to increase access to and utilization of these services, which are not used at optimal levels today." 75 Fed. Reg. at 41,733, AR at 233; *see also* 78 Fed. Reg. at 39,873 ("Research [ ] shows that cost sharing can be a significant barrier to access to contraception." (citation omitted)), AR at 5.

RESPONSE: Undisputed that the quoted text appears in the 2013 final rules, but the statement itself is disputed, unsupported, and speculative. Defendants' regulations are not evidence of the fact asserted, namely, that "expanding coverage and eliminating cost sharing for recommended preventive services, [will] increase access to and utilization of these services,

which are not used at optimal levels today." *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

In addition, the cited page of the Administrative Record in turn cites a study entitled "A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change," which analyzes changes in contraceptive use after the Kaiser Foundation Health Plan in California changed its coverage policy to include universal coverage for contraception. *See* Postlethwaite, D., et al, 76 Contraception 360 (2007). But, this study provides no support for the government's assertion that cost sharing is a barrier to contraception. In any event, the sole purpose of the study was to evaluate whether eliminating cost sharing for contraceptive coverage "would lead to a change in the mix of contraceptive methods prescribed and purchased by a large health plan and whether those changes could theoretically result in averting a greater number of unintended pregnancies." *Id*. Ultimately, the study concluded that removing cost for contraception "may" result in increased use, not of contraception generally, but of what the study deemed more effective forms of contraception—that is, whether women would switch to a more expensive but perhaps more effective *type* of contraception if cost were not a concern. *Id*.

Further, Plaintiffs' sincerely-held Catholic religious beliefs provide that there are no "optimal levels" of the use of contraceptive services, as "[t]he Church teaches that . . . artificial interference with life and conception is immoral."

26. Although a majority of employers cover FDA-approved contraceptives, *see* IOM REP. at 109, AR at 407, many women forgo preventive services because of cost-sharing imposed by their health plans, *see id*. at 19-20, 109, AR at 317-18, 407.

RESPONSE: Disputed, unsupported, and immaterial. The pages of the IOM Report that Defendants cite do not support this assertion. The only related points in these pages are references to studies regarding preventive services *other than* contraceptive services. *See* IOM

REP. at 19 (discussing women's use of preventive care, including cancer screenings, dental examinations, mammograms, and Pap smears); *Id.* at 20 (referencing study asking women whether they had received a set of recommended preventive screening tests that did not include contraceptive services: blood pressure, cholesterol, cervical cancer, colon cancer (for ages 50 to 64) and breast cancer (for ages 50 to 64) screens); *Id.* at 109 (mentioning research on preventive and primary care services in general). The one study mentioned that touches on contraceptive services examined women who were already taking contraception and the likelihood that they would switch to another method in light of reduced or eliminated out-of-pocket costs.

In fact, more than 89 percent of insurance plans "cover[ed] contraceptive methods in 2002." IOM REP. at 109. Further, 89% of women trying to avoid pregnancy are already practicing contraception. *See* The Guttmacher Institute, "Fact Sheet: Contraceptive Use in the United States," (Aug. 2010), *available at* http://www.guttmacher.org/pubs/ fb_contr_use.html. Among the other 11%, lack of access is not a statistically significant reason why they do not use contraceptives. Mosher WD and Jones J, "Use of contraception in the United States: 1982–2008," Vital and Health Statistics, 2010, Series 23, No. 29, at 14 and Table E, *available at* http://www.cdc.gov/NCHS/data/series/ sr_23/sr23_029.pdf. Even among the most at-risk populations, cost is not the reason those women do not use contraceptives. *See* R. Jones, J. Darroch and S.K. Henshaw "Contraceptive Use Among U.S. Women Having Abortions," Perspectives on Sexual and Reproductive Health 34 (Nov/Dec 2002): 294–303 (Perspectives is a publication of the Guttmacher Institute); *see also* CDC, "Prepregnancy Contraceptive Use Among Teens with Unintended Pregnancies Resulting in Live Births — Pregnancy Risk Assessment Monitoring System (PRAMS), 2004–2008," Morbidity and Mortality Weekly

Report 61(02);25-29 (Jan. 20, 2012), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6102a1.htm?s_cid=mm6102a1_e (2012 CDC study showed that even among those most at risk for unintended pregnancy, only 13% cite cost as a reason for not using contraception).

Moreover, Defendants have admitted that "85 percent of employer-sponsored health insurance plans cover[] preventive services," and that they do so "without [beneficiaries] having to meet a deductible," 75 Fed. Reg. at 41,732—in other words, without a significant form of cost sharing.

27. Unintended pregnancies have proven in many cases to have negative health consequences for women and developing fetuses. *See* 78 Fed. Reg. at 39,872, AR at 4.

RESPONSE: Disputed and unsupported. Defendants' regulations are not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient. Plaintiffs incorporate herein their response to Paragraph 24, *supra*.

28. Unintended pregnancy may delay "entry into prenatal care," prolong "behaviors that present risks for the developing fetus," and cause "depression, anxiety, or other conditions." IOM REP. at 20, 103-04, AR at 318, 401-02.

RESPONSE: Undisputed, but incomplete. Plaintiffs incorporate herein their response to Paragraph 24, *supra*.

29. Contraceptive coverage further helps to avoid "the increased risk of adverse pregnancy outcomes for pregnancies that are too closely spaced." *Id*. at 103, AR at 401; *see also* 78 Fed. Reg. at 39,872 ("Short interpregnancy intervals in particular have been associated with low birth weight, prematurity, and small-for-gestational age births.") (citing studies), AR at 4.

RESPONSE: Disputed and unsupported. The pages of the IOM Report that Defendants cite do not support their assertion. Also, Defendants' regulations are not evidence of

the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

Furthermore, the quoted text does not bear on whether contraceptive coverage has any impact on the incidence of the referenced negative consequences of short interpregnancy intervals. In addition, Plaintiffs incorporate herein their response to Paragraph 24, *supra*.

30. "Contraceptives also have medical benefits for women who are contraindicated for pregnancy, and there are demonstrative preventive health benefits from contraceptives relating to conditions other than pregnancy (for example, prevention of certain cancers, menstrual disorders, and acne)." 78 Fed. Reg. at 39,872, AR at 4; *see also* IOM REP. at 103-04 ("[P]regnancy may be contraindicated for women with serious medical conditions such as pulmonary hypertension . . . and cyanotic heart disease, and for women with the Marfan Syndrome."), AR at 401-02.

RESPONSE: Undisputed that the quoted text appears in the 2013 final rules, but the statement itself is disputed, unsupported, and immaterial. Defendants' regulations are not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

Furthermore, "contraceptive methods have both risks and benefits," negative consequences of which range from "side effects" to death. IOM REP. at 105-06. And, "[f]or women with certain medical conditions or risk factors, some contraceptive methods may be contraindicated." *Id.* at 105. Plaintiffs also incorporate herein their response to Paragraph 24, *supra*.

In addition, Plaintiffs have no objection to (and this case is not about) the use of contraceptives for non-contraceptive purposes, and Plaintiffs currently cover contraceptives when prescribed for such medically-necessary, non-contraceptive purposes.

31. "[W]omen have different health needs than men, and these needs often generate additional costs. Women of childbearing age spend 68 percent more in out-of-pocket health care costs than men." 155 Cong. Rec. S12106-02, S12114 (daily ed. Dec. 2, 2009); 78 Fed. Reg. at 39,887, AR at 19; IOM REP. at 19, AR at 317.

RESPONSE: Undisputed that the quoted text appears in the Congressional Record, but the statement itself is disputed and unsupported. Defendants' self-serving selection of the legislative history of the statute, individual Congresspersons' statements, or Defendants' own regulations do not provide evidentiary support for the underlying factual statement. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient"). The statement also has no bearing on the utilization of contraceptive services at all. Likewise, Defendants' citation to the IOM Report provides support only for the general proposition that some women have significant health care expenses, including paying for prescriptions for themselves and their families and paying for screening and preventive services entirely unrelated to contraception. *See* IOM REP. at 19.

32. These costs result in women often forgoing preventive care and place women in the workforce at a disadvantage compared to their male coworkers. *See, e.g.*, 155 Cong. Rec. S12265-02, S12274 (daily ed. Dec. 3, 2009); 78 Fed. Reg. at 39,887, AR at 19; IOM REP. at 20, AR at 318.

RESPONSE: Disputed and unsupported. Defendants' self-serving selection of the legislative history of the statute, individual Congresspersons' statements, or Defendants' regulations does not provide evidentiary support for the underlying factual statement. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient"). The statement also has no bearing on the utilization of contraceptive services at all. Additionally, Defendants' citation to the IOM Report provides support only for the general proposition that some women have difficulty paying medical bills and for screening and preventive services

unrelated to contraception, while also noting that women are more likely than men to be dependents on a health care plan, which is irrelevant to their participation in the workforce. *See* IOM REP. at 20.

33. The grandfathering of certain health plans with respect to certain provisions of the ACA is not specifically limited to the preventive services coverage regulations. *See* 42 U.S.C. § 18011; 45 C.F.R. § 147.140.

RESPONSE: This is an incomplete statement of law, not a statement of material fact. While the grandfathering provisions may not be specifically limited to excluding the ACA's preventive services coverage requirements, Defendants themselves highlighted in the regulations that grandfathered health plans are not subject to the preventive services coverage requirements. Specifically, Defendants' model disclosure to plan beneficiaries provides that "[b]eing a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing." 45 C.F.R. §147.140(a)(2)(ii). In other words, grandfathered health plans are exempt from the preventive services coverage regulations regardless of whether that is the only provision of the ACA for which they can avoid compliance.

34. The effect of grandfathering is not really a permanent "exemption," but rather, over the long term, a transition in the marketplace with respect to several provisions of the ACA, including the preventive services coverage provision. *See* 78 Fed. Reg. at 39,887 n.49.

RESPONSE: Disputed, unsupported, and speculative. Defendants' regulations are not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

At any rate, Defendants have acknowledged in their own regulations that grandfathered health plans are "exempt" from provisions of the ACA, including the preventive services

coverage provision. *See, e.g.,* 75 Fed. Reg. 70,114, 70,117 (Nov. 15, 2010) ("Because grandfathered health plans are exempt from many of [the provisions of the Affordable Care Act] while group health plans and group and individual health insurance coverage that are not grandfathered health plans must comply with them, it was critical for plans and issuers to receive clear guidance as to whether they were so exempt as soon as possible"); 75 Fed. Reg. 34,538, 34,545 (June 17, 2010) ("Grandfathered health plans are exempt from many of these provisions while group health plans and group and individual health insurance coverage that are not grandfathered health plans must comply with them."); HHS, *Grandfathered Plans*, *available at* http://www.hhs.gov/healthcare/insurance/grandfather/ ("The Affordable Care Act exempts most plans that existed on March 23, 2010 — the day the law was enacted — from some of the law's consumer protections.").

In addition, the predicted "majority of group health plans [that] will lose their grandfathered status by the end of 2013" is a bare majority, leaving 49% still possessing grandfathered status. 75 Fed. Reg. at 34,553. Defendants' data further estimates that a majority of "large employer" group health plans will still possess grandfathered status by the end of 2013. *Id*. Because 49% of total group health plans and 55% of large employer group health plans are predicted to maintain grandfathered status through the end of 2013, and because twice as many people are in large group health plans as are in small ones, Defendants' data predicts that a majority of total persons covered by group health plans (large and small) will be in grandfathered health plans through the end of 2013. 75 Fed. Reg. at 34,550, 34,553. And, as Defendants' own estimates acknowledge, "[m]ost of the 133 million Americans with employer-sponsored health insurance through large employers will maintain the coverage they have today," *i.e.*, will retain grandfathered health coverage. HHS, *U.S. Departments of Health and Human Services, Labor,*

and Treasury Issue Regulation on "Grandfathered" Health Plans under the Affordable Care Act, *available at* http://www.hhs.gov/news/press/2010pres/06/20100614e.html (June 14, 2010) ("June 14, 2010 Press Release").

Further, the grandfathering exclusion has no sunset provision; a health plan has a "right" to keep its grandfathered status. 75 Fed. Reg. at 34,540, 34,558, 34,562, 34,566. A health plan can maintain its grandfathered status indefinitely while increasing costs to employees if it stays within the parameters of Defendants' regulations for grandfathered plans. 75 Fed. Reg. at 34,538. Indeed, Defendants' assertion contradicts the President's promise that "if you like your plan, you can keep it." *See* June 14, 2010 Press Release.

35. A majority of group health plans will have lost their grandfather status by the end of 2013. *See id.* at 34,552; *see also* Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2012 Annual Survey at 7-8, 190 (indicating that 58 percent of firms had at least one grandfathered health plan in 2012, down from 72 percent in 2011, and that 48 percent of covered workers were in grandfathered health plans in 2012, down from 56 percent in 2011), AR at 663-64, 846.

RESPONSE: Disputed and unsupported. Plaintiffs incorporate herein their response to Paragraph 34, *supra*.

36. 26 U.S.C. § 4980H(c)(2) does not exempt small employers from the preventive services coverage regulations. *See* 42 U.S.C. § 300gg-13(a); 78 Fed. Reg. at 39,887 n.49, AR at 19.

RESPONSE: This is a disputed proposition of law, not a statement of material fact. While small employers are technically required to provide coverage for recommended preventive services, Defendants have permanently exempted them from some of the Mandate's enforcement mechanisms. *See, e.g.,* 26 U.S.C. §§ 4980H(a), 4980H(c)(2)(A). These small employer plans cover about 20 to 40 million employees and dependents. *See* U.S. Census Bureau, Employment Size of Firms, www.census.gov/econ/smallbus.html.

37. Instead, it excludes employers with fewer than fifty full-time equivalent employees from the employer responsibility provision, meaning that, starting in 2015, such employers are not subject to the possibility of assessable payments if they do not provide health coverage to their full-time employees and their dependents. *See* 26 U.S.C. § 4980H(c)(2).

RESPONSE: This is a disputed proposition of law, not a statement of material fact. Plaintiffs incorporate herein their response to Paragraph 36, *supra*.

38. Small businesses that do offer non-grandfathered health coverage to their employees are required to provide coverage for recommended preventive services, including contraceptive services, without cost-sharing. 78 Fed. Reg. at 39,887 n.49, AR at 19.

RESPONSE: This is an incomplete statement of a proposition of law, not a statement of material fact. While small employers are technically required to provide coverage for recommended preventive services, Defendants have permanently exempted them from some of the Mandate's enforcement mechanisms. *See, e.g.,* 26 U.S.C. §§ 4980H(a), 4980H(c)(2)(A). These small employer plans cover about 20 to 40 million employees and dependents. *See* U.S. Census Bureau, Employment Size of Firms, www.census.gov/econ/smallbus.html.

39. The only exemption from the preventive services coverage regulations is the exemption for the group health plans of religious employers. 45 C.F.R. § 147.131(a).

RESPONSE: This is a disputed proposition of law, not a statement of material fact. As set forth in Plaintiffs' responses to Paragraphs 34 and 36, incorporated herein, grandfathered health plans are exempt from the preventive service coverage requirements of the ACA, and small employers are exempt from some of the Mandate's enforcement mechanisms.

40. Houses of worship and their integrated auxiliaries that object to contraceptive coverage on religious grounds are more likely than other employers to employ people of the same faith who share the same objection, and who would therefore be less likely than other people to use contraceptive services even if such services were covered under their plan. *See* 78 Fed. Reg. at 39,874, AR at 6.

RESPONSE: Disputed and unsupported. Defendants' regulations are not evidence of the fact asserted, and this statement is pure speculation. *See Williams*, 2009 WL 3254465, at *11

("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

In addition, HHS has acknowledged that there is no evidentiary basis for the conclusion that individuals who work for entities like ArchCare and Catholic Health Services of Long Island are more likely not to object to the use of contraceptives and therefore are more likely to use contraceptives. *See* Cohen Dep. at 34:9-24 ("Q. . .What was the evidentiary basis for the conclusion that individuals who work for entities like ArchCare and Catholic Health Services of Long Island are more likely not to object to the use of contraceptives and therefore are more likely to use contraceptives? A. I think that conclusion was based on just logic and common sense on the one hand and, secondly, on the evidence that a very large majority -- I've seen figures up to 95 percent of sexually active women in the United States use contraceptives at one point or another. Q. So there was no evidence particular to those types of institutions? A. No, I don't believe so.").

41. Congress did not adopt a single (government) payer system financed through taxes and instead opted to build on the existing system of employment-based coverage. *See* H.R. Rep. No. 111-443, pt. II, at 984-86 (2010).

RESPONSE: Undisputed.

42. Defendants are constrained by statute from adopting the alternative administrative schemes proposed by plaintiffs. *See* 78 Fed. Reg. at 39,888, AR at 20.

RESPONSE: This is a disputed proposition of law, not a statement of material fact. Defendants' regulations are also not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

43. Plaintiffs' proposed alternatives are not feasible because they would impose considerable new costs and other burdens on the government and would otherwise be impractical. *See* 78 Fed. Reg. at 39,888, AR at 20.

RESPONSE: This is disputed proposition of law, not a statement of material fact. Defendants' regulations are not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

44. Nor would the proposed alternatives be equally effective in advancing the government's compelling interests. *See* 78 Fed. Reg. at 39,888, AR at 20.

RESPONSE: This is a disputed proposition of law, not a statement of material fact. Defendants' regulations are also not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

45. Plaintiffs' alternatives would require establishing entirely new government programs and infrastructures or fundamentally altering an existing one, and would require women to take burdensome steps to find out about the availability of and sign up for a new benefit, thereby ensuring that fewer women would take advantage of it. *See* 78 Fed. Reg. at 39,888, AR at 20.

RESPONSE: This is argumentative and a disputed proposition of law, not a statement of material fact. Defendants' regulations are also not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient")

46. "Nothing in the[] final regulations prohibits an eligible organization from expressing its opposition to the use of contraception." 78 Fed. Reg. at 39,880 n.41, AR at 12.

RESPONSE: This is a disputed proposition of law, not a statement of material fact. Defendants' regulations are also not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient").

Further, the regulations broadly prohibit religious organizations from "directly or indirectly, seek[ing] to influence the[ir] third party administrator's decision" to provide or

procure contraceptive services, 26 C.F.R. § 54.9815–2713A, thus limiting the means by which Plaintiffs may express their opposition to the use of contraception. Moreover, Plaintiffs express their religious opposition to the use of contraception, in part, through the manner in which they have established health care coverage for their employees, which currently prohibits the use of contraceptive services consistent with plaintiffs' faith.

47. The regulations only prohibit an employer's improper attempt to interfere with its employees' ability to obtain contraceptive coverage from a third party by, for example, threatening the TPA with a termination of its relationship with the employer because of the TPA's "arrangements to provide or arrange separate payments for contraceptive services for participants or beneficiaries." See 26 C.F.R. § 54.9815-2713A(b)(1)(iii); 29 C.F.R. § 2950.715-2713A(b)(1)(iii).

RESPONSE: This is argumentative and a disputed proposition of law, not a statement of material fact. Plaintiffs incorporate herein their response to Paragraph 46, *infra*.

48. The Women's Health Amendment, which contained the requirement to provide coverage for recommended preventive services for women without cost-sharing, was intended to fill significant gaps relating to women's health that existed in the other preventive care guidelines identified in the Affordable Care Act. See 155 Cong. Rec. S12021-02, S12025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer); 155 Cong. Rec. S12265-02, S12271 (daily ed. Dec. 3, 2009) (statement of Sen. Franken).

RESPONSE: This is argumentative and a disputed restatement of the law, and not a statement of material fact. Plaintiffs incorporate herein their response to Paragraph 46, *infra*.

49. The Weldon Amendment denies funds made available in the Consolidated Appropriations Act of 2012 to any federal, state, or local agency, program, or government that "subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." Pub. L. No. 112-74, §§ 506, 507, 125 Stat. 786, 1111-12 (Dec. 23, 2011).

RESPONSE: This is an incomplete statement of a proposition of law, not a statement of material fact. The Weldon Amendment defines the term "health care entity" to include "a health insurance plan." *See* Pub. L. No. 112-74, § 507(d)(2) (2011).

50. "Abortifacient drugs are not included" in the preventive services covered by the regulations. HealthCare.gov, Affordable Care Act Rules on Expanding Access to Preventive regulations. HealthCare.gov, Affordable Care Act Rules on Expanding Access to Preventive Services for Women (August 1, 2011), *available at* http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html (last visited Sept. 23, 2013); see also IOM REP. at 22 (recognizing that abortion services are outside the scope of recommendations), AR at 320.

RESPONSE: Disputed as stated in Plaintiffs' response incorporated herein, emergency contraceptives (such as Plan B and Ella) can also act as abortifacients.

51. The list of FDA-approved contraceptives includes emergency contraceptives such as Plan B. *See* IOM REP. at 105, AR at 403.

RESPONSE: Undisputed that the list of FDA-approved contraceptive includes emergency contraceptives such as Plan B, but, as stated in Plaintiffs' response herein, emergency contraceptives (such as Plan B and Ella) can also act as abortifacients.

52. The basis for the inclusion of such drugs among safe and effective means of contraception dates back to 1997, when the FDA first explained why Plan B and similar drugs act as contraceptives rather than abortifacients. *See* Prescription Drug Products; Certain Combined Oral Contra for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610, 8611 (Feb. 25, 1997) (noting that "emergency contraceptive pills are not effective if the woman is pregnant" and that there is "no evidence that [emergency contraception] will have an adverse effect on an established pregnancy"); 45 C.F.R. § 46.202(f) ("Pregnancy encompasses the period of time from implantation until delivery.").

RESPONSE: Disputed and unsupported. The cited regulation does not support this assertion. Namely, it does not describe "[t]he basis for the inclusion of [emergency contraceptives] among safe and effective means of contraception." In addition, Defendants' regulations are not evidence of the fact asserted. *See Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient"). Plaintiffs incorporate herein their response to paragraph 5, *infra*.

53. In light of this conclusion by the FDA, HHS informed Title X grantees, which are required to offer a range of acceptable and effective family planning methods—and, except

under limited circumstances, may not offer abortion—that they "should consider the availability of emergency contraception the same as any other method which has been established as safe and effective." Office of Population Affairs, Memorandum (Apr. 23, 1997), http://www.hhs.gov/opa/pdfs/opa-97-02.pdf (last visited [INSERT], 2013) [*sic*]; *see also* 42 U.S.C. §§ 300, 300a-6.

RESPONSE: Undisputed that the HHS so informed Title X grantees, but the truth of the underlying assertions is disputed. Plaintiffs incorporate herein their response to paragraph 5, *infra*.

54. Representative Weldon, the sponsor of the Weldon Amendment, did not consider the word "abortion" in the statute to include FDA-approved emergency contraceptives. *See* 148 Cong. Rec. H6566, H6580 (daily ed. Sept. 25, 2002) ("The provision of contraceptive services has never been defined as abortion in Federal statute, nor has emergency contraception, what has commonly been interpreted as the morning-after pill. . . . [U]nder the current FDA policy[,] that is considered contraception, and it is not affected at all by this statute.").

RESPONSE: Disputed and unsupported. Defendants' self-serving selection of the legislative history of the statute or individual Congresspersons' statements does not provide evidentiary support for the underlying factual statement. "What motivate[d] one legislator to make a speech about a statute [in 2002] is not necessarily what motivate[d] scores of others to enact it" in 2012. *United States v. O'Brien*, 391 U.S. 367, 384 (1968); *see also Barnhart v. Sigmon Coal Co., Inc*., 534 U.S. 438, 457 n.15 (2002) (rejecting reliance on floor statements); *see also Williams*, 2009 WL 3254465, at *11 ("On a motion for summary judgment, such conclusory assertions [of party's own testimony] unsupported by admissible evidence are insufficient"). Plaintiffs incorporate herein their response to Paragraph 5, *infra*, emergency contraceptives (such as Plan B and Ella) can also act as abortifacients.

Respectfully submitted on this 29th day of December, 2013,

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CERTIFICATE OF SERVICE

I hereby certify that on December 29, 2013 the foregoing document was filed through the Court's ECF filing system on counsel for Defendants.

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