No. 10-2347

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

LIBERTY UNIVERSITY, *et al.*,
Plaintiffs-Appellants,
v.
TIMOTHY GEITHNER, *et al.*,
Defendants-Appellees.

On Appeal from the United States District Court for the
Western District of Virginia

BRIEF *AMICUS CURIAE* OF THE NATIONAL WOMEN'S LAW CENTER, AMERICAN ASSOCIATION OF UNIVERSITY WOMEN, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AMERICAN MEDICAL WOMEN'S ASSOCIATION, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, BLACK WOMEN'S HEALTH IMPERATIVE, CHILDBIRTH CONNECTION, IBIS REPRODUCTIVE HEALTH, INSTITUTE OF SCIENCE AND HUMAN VALUES, MARYLAND WOMEN'S COALITION FOR HEALTH CARE REFORM, MENTAL HEALTH AMERICA, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL COALITION FOR LGBT HEALTH, NATIONAL COUNCIL OF JEWISH WOMEN, NATIONAL COUNCIL OF WOMEN'S ORGANIZATIONS, NATIONAL EDUCATION ASSOCIATION, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, OLDER WOMEN'S LEAGUE, PHYSICIANS FOR REPRO CHOICE AND HEALTH, RAISING WOMEN'S VOICES, SARGENT SHRIVER NATIONAL CENTER ON POVERTY LAW, SOUTHWEST WOMEN'S LAW CENTER, WIDER OPPORTUNITIES FOR WOMEN, MARYLAND WOMEN'S LAW CENTER, & WOMEN'S LAW PROJECT IN SUPPORT OF APPELLEE

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STATEMENT OF IDENTITY, INTEREST IN CASE AND SOURCE OF AUTHORITY TO FILE

The National Women's Law Center (NWLC) is a nonprofit legal advocacy organization dedicated to the advancement and protection of women's legal rights since its founding in 1972. Women have long faced great difficulty obtaining comprehensive, affordable health coverage due to harmful and discriminatory health insurance industry practices. NWLC is profoundly concerned about the impact that the Court's decision may have on women's access to health insurance.

Statements of interest of 25 additional amici organizations committed to removing discriminatory barriers to access to health insurance and health care are set out in Appendix A.

No counsel for a party authored this brief in whole or in part and none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this *amicus* brief, pursuant to Federal Rule of Appellate Procedure 29(a).

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereinafter collectively referred to as the "The Affordable Care Act" or "the ACA"), makes important advances in women's health care, addressing a crisis of discrimination and obstacles to access truly national in scope. Indeed, a major purpose and concern of Congress in passing the ACA was improving women's health and ameliorating the disadvantages and discrimination women have faced in obtaining health care and health insurance.

The law's overall approach to achieving near-universal health insurance coverage, lowering health insurance premiums, and eliminating or reforming an array of widespread practices that deny or limit coverage in the health care market throughout the United States has, and was intended to have, a particularly important effect on women. By eliminating insurance companies' ability to deny coverage based on pre-existing conditions, it remedies long-standing insurer practices of refusing to sell insurance to women with "pre-existing conditions" such as pregnancy, a previous Caesarean section or a history of having survived domestic abuse. Moreover, the Act explicitly targets a range of practices that discriminate against or disadvantage women, such as overcharging women for

insurance coverage based solely on their sex and refusing to cover or overcharging women for essential services such as maternity care. Like the civil rights laws of the past 50 years, in regulating economic conduct the Affordable Care Act aims at "a moral and social wrong" that itself has profound economic consequences. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 257 (1964).

The authority of the federal legislature to regulate health insurance and the national market for health care services is well settled. An individual responsibility provision, requiring individuals to be insured, has been proven central to effective implementation of the requirement that insurance companies make insurance available to all who seek it and cover all pre-existing conditions, and thus essential to advancing the ACA's goals of removing barriers to women's participation in the health insurance market. The ACA thus requires that all Americans, unless otherwise exempt, carry some minimum level of insurance as part of the comprehensive regulatory scheme established under the new law. Like other federal laws, including particularly laws prohibiting discrimination, the Act generally prohibits "opting out" because Congress's legitimate regulatory goals are best served by full participation. As a component of Congress's comprehensive regulatory scheme for addressing failures in the health insurance market and barriers to individuals' participation in that market, the individual responsibility provision is a valid exercise of the federal Commerce Clause power.

Moreover, through its many provisions protecting against discrimination and removing obstacles that women and other disadvantaged groups face in gaining access to health insurance and care, the ACA does more than simply regulate the commercial relationship between insurance companies and covered individuals. The Act is also properly viewed as a significant piece of civil rights legislation, seeking to address the economic impacts of the disadvantage and discrimination that women face, remove the barriers to women's full participation in the health insurance market, and advance women's health. Like other major modern civil rights statutes, the ACA is a valid exercise of Commerce Clause authority in pursuit of a moral and social ideal whose recognition must be national in scope.

ARGUMENT

I. A MAJOR PURPOSE OF THE AFFORDABLE CARE ACT IS IMPROVING WOMEN'S ACCESS TO HEALTH CARE AND HEALTH INSURANCE AND ELIMINATING INSURANCE PRACTICES THAT DISCRIMINATE AGAINST AND DISADVANTAGE WOMEN.

The Affordable Care Act is a comprehensive system of regulation designed to lower health care costs throughout the United States, to provide minimum standards of coverage for health insurance and to end some of the most significant barriers to broadly inclusive health care access. Many of the ACA's most important provisions were enacted with the express purpose of addressing the

myriad ways in which the existing insurance market has discriminated against and failed to meet the basic needs of women**.** As Congresswomen Barbara Lee explained days before the law's passage:

> While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children.

156 Cong. Record H1632, (daily ed. March 18, 2010)**;** *see also, e.g.*, *infra* n. 3 and accompanying text.

The nationwide consequences of the insurance market's failure to meet women's needs are significant. In 2009, nearly one in five women ages 18-64 was uninsured. That same year, over two million fewer women had job-based insurance than had the year before**.** *See* U.S Census Bureau, *2009 American Community Survey*, at http://factfinder.census.gov. More than half of all women reported forgoing needed health care for financial reasons during the year preceding the law's enactment. *See* Sheila D. Rustgi *et al.*, The Commonwealth Fund, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* 5 (2009), *at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf. "Compared with men, women require more health care services during their reproductive years (ages 18 to 45), have higher out-of-pocket medical costs, and

have lower average incomes." *Id.* at 1. While the problems are worse for low-income women and women of color, gender disparities in access to health insurance and health care affect women broadly as a class. In enacting the ACA, Congress recognized the need for uniform national legislation to end some of the most significant discriminatory and exclusionary practices and their consequences for women.

A. The Ban on Pre-Existing Condition Exclusions, the Guaranteed Issue Requirement, and Their Impact on Women

As Congress recognized in passing the Affordable Care Act, women have been sharply affected by insurance providers' practices in the individual insurance market of refusing to sell health coverage to individuals with an array of pre-existing conditions.[1] This is both because several of the pre-existing conditions excluded by insurers exclusively or primarily affect women and because women are more likely than men to suffer from chronic conditions requiring ongoing treatment, like asthma or arthritis, *see* Alina Salganicoff *et al.*, Kaiser Family Foundation,

[1] To cite just a couple of examples from among the hundreds of references to women's health in the debates around health care reform, e.*g*., "Health care reform here will provide women the care that they need [and] . . . ban the insurance practice of rejecting women with a preexisting condition." 156 Cong. Rec. H1637 (daily ed. March 18, 2010) (Statement of Rep. Moore); "Nine States allow private plans to refuse coverage for domestic violence survivors. . . . In many policies, a previous C-section and being pregnant are considered preexisting conditions." 155 Cong. Rec. H12368-69 (daily ed. Nov. 5, 2009) (Statement of Rep. Hirono).

Women and Health Care: A National Profile 8 (2005), *at* http://www.kff.org/womenshealth/7336.cfm.

For example, women have regularly been charged significantly more for insurance coverage because they had previously given birth by Caesarean section. *See, e.g.,* Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, New York Times (June 1, 2008), *at* http://www.nytimes.com/2008/06/01/health/01insure.html?pagewanted=1&r=2. Other women have been denied coverage altogether unless they have been sterilized or are no longer of child-bearing age, or have been subject to an exclusionary period during which the insurer will not cover costs related to Caesarean sections or pregnancy. These exclusions have a broad impact, as nearly one third of births in the United States are by Caesarean section. *See* Faye Menacker and Brady Hamilton, *Recent Trends in Cesarean Delivery in the United States*, NCHS Data Brief No. 35 (March 2010), *at* http://www.cdc.gov/nchs/data/databriefs/db35.pdf.

Some insurers deny coverage to women who have survived domestic violence. *See* Jenny Gold, *Domestic Abuse Victims Struggle With Another Blow: Difficulty Finding Health Insurance*, Kaiser Health News (October 7, 2009), *at* http://www.kaiserhealthnews.org/Stories/2009/October/07/Domestic-Abuse.aspx. As Congresswoman Betty McCollum recounted in the days before the passage of the ACA:

> In 2006, attorney Jody Neal-Post tried to get health insurance but was rejected. Why? Because of treatment she received after a domestic abuse incident. Her insurer told her that her medical history made her a higher risk, more likely to end up in an emergency room and need care. 1.3 million American women are victims of physical assault by an intimate partner each year, and 85 percent of domestic violence victims are women. We can help the one out of every four women who are victims of domestic violence by stopping them from being victimized again by their insurance companies.

Statement of Representative McCollum, 156 Cong. Record H1659 (daily ed. March 19, 2010).

Other women have been denied health insurance coverage because they have previously received medical treatment for sexual assault. For instance, insurance agent Chris Turner received counseling and anti-HIV preventative medication after she was sexually assaulted in 2002. Because she received this medical treatment, she could not obtain health insurance for three years, as insurance companies refused to extend coverage based on the anti-HIV medication, even though she tested negative for HIV. *See* Danielle Ivory, *Rape Victim's Choice: Risk AIDS or Health Insurance?* Huffington Post (March 18, 2010), at http://www.huffingtonpost.com/2009/10/21/insurance-companies-rape-n_328708.html. Other women report being denied insurance coverage because of a diagnosis of post-traumatic stress disorder stemming from a previous assault. *Id.*

Women also have been routinely denied health insurance in the private market on the basis of pregnancy. For example, in 2010 the House Committee on

Energy and Commerce investigated pre-existing condition denials by the four largest private for-profit health insurers in the country (Aetna, Humana, UnitedHealth Group, and WellPoint), and found that all four identified pregnancy as a health condition resulting in automatic denial of coverage. Chairmen Henry A. Waxman and Bart Stupak, 111th Congress, Memorandum to Members of the Committee on Energy and Commerce Re. Maternity Coverage in the Individual Health Insurance Market 3-4 (October 12, 2010), *at* http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Maternity.Coverage.Individual.Market.2010.10.12.pdf; *see also* Remarks of Representative Woolsey, 156 Cong. Rec. H1719 (daily ed. March 19, 2010) ("There are documented cases in which pregnancy was treated as a preexisting condition, with women denied the very basic prenatal care benefits that they needed.").

The ACA makes this discriminatory conduct a thing of the past by prohibiting insurance companies from denying coverage based on pre-existing conditions**.** *See* Pub. L. No. 111-148, § 1201. In addition, the law adopts "guaranteed issue," a requirement that insurance companies sell policies to any person or employer who wishes to purchase a policy. *Id.* These provisions are made possible by the individual responsibility provision challenged in the present case**.** As set out by the United States, significant empirical evidence has demonstrated that a ban on pre-existing conditions and a guaranteed issue

requirement will not work effectively in the absence of a regulatory scheme that also includes an individual responsibility provision**.** Br. of Appellees at 30-31. In states that have tried to enact the former without the latter, the costs of insurance have skyrocketed**.** Under such a regulatory regime, people who are healthy forgo insurance until they are sick and purchase insurance just at the moment when the insurer will have to expend the most on their care, without having previously paid premiums that would cover some portion of these costs**.** In order to make up for these losses, insurance companies must substantially increase premium rates for everyone. *See Fed Ins. Co. v. Raytheon Co.*, 426 F.3d 491, 499 (1st Cir. 2005). When premiums increase, there is even greater incentive for healthy individuals not to purchase insurance, leaving only the truly sick in the insurance pool, leading to what is referred to as a "death spiral."

To avoid that spiral, the ACA included its individual responsibility provision. *See* Pub L. No. 111-148, § 1501. If all people have some minimum coverage, regardless of their health at a particular moment, then when they do need to use the plan, they will have been paying into the system. The balanced and relatively predictable income into the system makes it possible for insurers to cover all comers, including people with pre-existing conditions. *See id.* §§ 1501(a)(2)(I), 10106(a). Thus, one of the centerpieces of the regulatory system envisioned in the ACA, and one of the key measures for ending gender inequities

in health access and outcomes, turns on the full participation that the individual responsibility provision seeks to achieve.

B. The ACA's Comprehensive Approach to Women's Health

The ban on pre-existing condition exclusions and the guaranteed issue requirement will, as discussed above, significantly improve women's access to health insurance and care across the nation. In addition, the ACA includes a broad range of other specific, related policies that, in combination with the ban on pre-existing condition exclusions and guaranteed issue, are designed to end discrimination against women in health care.

1. ***Ending gender rating***

The widespread practice of "gender-rating"—insurance companies charging women higher premiums than they charge men of the same age—has long made insurance prohibitively costly for women purchasing insurance in the individual market and for small businesses that employ significant numbers of women. While several states had banned gender-rating by the time Congress considered health care reform, the overwhelming majority of states still permitted this discriminatory practice; in those states that permitted gender rating, 95 percent of surveyed best-selling plans charged a 40-year-old woman more than a 40-year-old man for identical coverage. *See* National Women's Law Center, Still Nowhere to Turn:

Insurance Companies Treat Women Like a Pre-Existing Condition 5-6 (2009), *at* http://www.nwlc.org/resource/still-nowhere-turn-insurance-companies-treat-women-pre-existing-condition. Almost none of these plans included maternity coverage (as discussed further below), and thus health care costs associated with pregnancy and childbirth did not explain this gender rating. *Id.* Rather, the differences in premiums charged as a result was arbitrary and highly variable. One insurer in Missouri charged 40-year-old women 140 percent more than men of the same age. In Arkansas, the differences in premiums among the ten best-selling plans ranged from 13 to 63 percent more for women than for men. *See* National Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 10 (2008), *at* http://www.nwlc.org/resource/nowhere-turn-how-individual-health-insurance-market-fails-women-1. One small employer with an almost entirely female workforce estimated that she paid $2,000 more per employee for the cost of health coverage due to the gender makeup of her workforce. *See* Jenny Gold, *Fight Erupts Over Health Insurance Rates for Businesses with More Women*, Kaiser Health News (October 25, 2009), *at* http://www.kaiserhealthnews.org/Stories/2009/October/23/gender-discrimination-health-insurance.aspx.

As Representative Jackie Speier queried on the floor of the House of Representatives:

> Is a woman worth as much as a man? One would think so, unless, of course, one was considering our current health care system, a system where women pay higher health care costs than men. Now, believe it or not, in 60 percent of the most popular health care plans in this country, a 40-year-old woman who has never smoked will pay more for health insurance than a 40-year-old man who has smoked.

156 Cong. Rec. H1637 (daily ed. March 18, 2010); *see also* Still Nowhere to Turn at 6 (setting out analysis and comparison of insurance treatment of female nonsmokers and male smokers). The Affordable Care Act makes gender-rating illegal in every state—for both individuals and small employers. *See* Pub. L. No. 111-148, § 1201.

2. Making maternity coverage available to all

Approximately 85 percent of women in the United States have given birth by age 44, and maternity care is one of the most common types of medical care that women of reproductive age receive. But the vast majority of individual market insurance plans in 2009 did not offer any maternity coverage; others required women to pay high supplemental coverage fees to obtain even limited coverage for basic maternity care. A 2009 study of 3600 individual market plans around the United States found that only 13 percent of the plans included any coverage for maternity care. *See* Still Nowhere to Turn at 6. In some instances, women in the individual market had an option to purchase supplemental maternity benefits for an additional premium (known as a rider), but this coverage was often expensive and limited in scope. *See* Nowhere to Turn at 11. For instance, maternity riders in

Kansas and New Hampshire cost over $1,100 *per month* in 2008. *Id.* Other maternity riders limited total maximum benefits to $3,000 to $5,000 in 2008, when the average cost for an uncomplicated hospital-based vaginal birth was $7,488 in 2006, not including prenatal or postpartum care. *Id.* Moreover, an investigation by the House Energy and Commerce Committee found that health insurer business plans were designed specifically to reduce or eliminate coverage of maternity expenses in order to reduce expenses; for example, company executives for one insurer noted the "risk" that "by offering a maternity rider we would be attractive to potential members who are likely to have children." Memorandum to Members of the Committee on Energy and Commerce Re. Maternity Coverage in the Individual Health Insurance Market at 6-8.

Uninsured pregnant women are considerably less likely to receive proper prenatal care and are thus at risk of complications that could be prevented or managed given appropriate care**.** Amy Bernstein, Alpha Center, *Insurance Status and Use of Health Services by Pregnant Women* (1999), *at* www.marchofdimes.com/berstein_paper.pdf; Susan Egerter *et al.*, *Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women*, 92 Am. J. Public Health 423-27 (2002). The Affordable Care Act addresses the problems posed by insurance companies' refusal to provide affordable maternity coverage**.** Beginning in 2014, new health plans in the individual and small-group

markets must cover maternity and newborn care as "essential health benefits." Pub. L. No. 11-148, § 1302(b)(D). Moreover, health plans will no longer be permitted to require authorization or prior approval for women seeking obstetric or gynecological care. *Id.* at *§* 2719(A)(d). This will ensure greater access to prenatal care that is essential to healthy pregnancy and birth.

3. Prohibiting sex discrimination in health care and health insurance

The ACA prohibits discrimination on the basis of sex, race, national origin, disability, or age in health programs or activities receiving federal financial assistance, as well as discrimination by programs administered by an Executive Agency or any entity established under Title I of the new law (such as the new Health Insurance Exchanges, the "insurance shopping centers" where individuals and small employers will be able to compare and purchase health plans)**.** *See* Pub. L. No. 111-148, § 1557. This nondiscrimination provision (which in its design largely mirrors Title IX, the federal law prohibiting sex discrimination in education) is the first time federal law has ever broadly prohibited sex discrimination in the provision of health care and health insurance. It provides a groundbreaking legal remedy to individual women who experience discrimination at the hands of health insurers and health care providers.

4. Supporting nursing mothers

Breastfeeding provides important health benefits to both mother and child. Evidence indicates that it reduces the risk type 2 diabetes, breast cancer, ovarian cancer and postpartum depression for mothers, and the risk of ear infections, diarrhea, lower respiratory infections, asthma, types 1 and 2 diabetes, obesity, childhood leukemia, and other conditions in children. *See* Stanley Ip *et al.*, U.S. Department of Health and Human Services, Agency for Health Research and Quality, *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries* (April 2007), *at* http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf. The ACA seeks to make these benefits more widely available to mothers and children by making it easier for working mothers to continue to breastfeed. Under the ACA, employers with more than 50 employees must provide employees break times and a private location other than a bathroom for expressing breast milk. Pub. L. No. 111-148, § 4207.

5. Providing Pap tests and mammograms without copayments

Women need more preventative care on average than men, but studies have shown that women are more likely than men to forgo essential preventative services, such as cancer screenings, because of their high cost. *See, e.g.,* Asch et al., *Who is At Greatest Risk for Receiving Poor-Quality Health Care?*, 354 New

Eng. J. of Med. 1147-56 (2006)**.** In 2007, more than half of women reported difficulty in obtaining needed medical services because of the cost of such basic care. *See* Women at Risk at 3. The ACA requires that plans cover recommended preventative services and screenings at no cost to the individual. *See* Pub. L. No. 111-148, § 2713(a)(4). Many women who otherwise would not be able to get basic screening like Pap tests and mammograms will have access to this potentially life-saving medical care as a consequence of the new law.

6. Expanding Medicaid eligibility

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for women. Women comprise about three-quarters of the program's adult beneficiaries, and one in ten women receives health coverage through Medicaid. *See* Kaiser Family Foundation, *Women's Health Insurance Coverage* (Oct. 2009), *at* http://www.kff.org/womenshealth/upload/6000-08.pdf. While Medicaid thus provides crucial health coverage for women, currently even women living in extreme poverty are unlikely to qualify for Medicaid unless they are also pregnant, parenting or disabled. Under the ACA, by 2014 Medicaid has the potential to cover up to an additional 8.4 million women, because eligibility will be expanded to those up to 133 percent of the poverty level, or roughly $30,000 a year for a family of four. *See* Sarah Collins *et al.*, The Commonwealth Foundation, *Realizing Health*

Reform's Potential: Women and the Affordable Care Act of 2010, (2010), *at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Jul/1429_Collins_Women_ACA_brief.pdf.

7. Making private health insurance more affordable

Under the ACA, beginning in 2014, subsidies will be available to help an additional 11 million low- and middle-income women pay for health insurance in the individual market, as well as out-of-pocket health care costs**.** Because women are poorer on average than men, are more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, and struggle more with medical bills or debt, *see* Elizabeth M. Patchias & Judy Waxman, National Women's Law Center, *Issue Brief: Women and Health Coverage: The Affordability Gap* 5 (2007), *at* http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2007/Apr/Women-and-Health-Coverage-The-Affordability-Gap.aspx, these reforms, among many others included in the ACA, are essential for addressing continuing gender health disparities and insurance coverage disparities in the United States.

Given the importance of all of these elements of the ACA for removing obstacles to women's equal treatment in the insurance market and the provision of women's health care, the ACA is appropriately understood as following in the

tradition of our nation's civil rights laws and their recognition and protection of the rights of all to fair treatment and equal access to basic needs.

II. AS A REASONABLE COMPONENT OF A COMPREHENSIVE PLAN RESPONDING TO A NATIONAL CRISIS IN THE HEALTH INSURANCE MARKET WITH A PARTICULAR FOCUS ON THE NEEDS OF WOMEN, THE INDIVIDUAL RESPONSIBILITY PROVISION FALLS WELL WITHIN COMMERCE CLAUSE AUTHORITY.

Through the Affordable Care Act, Congress adopted a comprehensive regulatory plan designed to address a national economic crisis in health care, with a particular focus on the impacts of this crisis on those subject to disadvantage and discrimination in the insurance market, including women. Addressing this crisis and these impacts is well within Congress's power under the Commerce Clause, given the settled authority that the Commerce Clause empowers Congress to regulate both the insurance industry and health care services. *See, e.g.*, *United States v. Southeastern Underwriters' Ass'n*, 322 U.S. 533 (1944).

Appellants nevertheless argue that the individual responsibility provision goes beyond what Congress can reasonably do in the exercise of its Commerce Clause authority, and that the ACA as a whole must fall as a result. Specifically, they assert that the individual responsibility provision is beyond Congress's Commerce Clause authority because it requires individuals to engage in economic

transactions in which they would otherwise choose not to engage. Br. for Appellants at 7. But on numerous previous occasions, by exercise of its Commerce Clause power, as part of its efforts to address behavior with broad consequences on the national economy and to remove barriers to full economic participation by women and other disadvantaged and disfavored groups, Congress has required individuals to engage in private commercial transactions they would otherwise have disdained**.** For example, Title II of the Civil Rights Act of 1964, required hotel and restaurant owners to serve customers they did not want to serve and thus engage in commercial transactions that they wished to avoid**.** In upholding that law, the Supreme Court rejected the argument that a local motel owner should be able to deny service to African-American customers because that local decision was unrelated to interstate commerce. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258 (1964). The same analysis underlies Congress's power to prohibit employers from refusing to employ an individual on the basis of her sex or race, or refusing to give a woman a pay raise provided to a similarly situated man on the basis of her sex, thus requiring employers to enter into economic relationships in certain circumstances**.** *See, e.g.*, *U.S. v. Gregory*, 818 F.2d 1114 (4th Cir. 1987) (noting that Title VII was enacted under the Commerce Clause); *Nesbit v. Gears Unlimited, Inc.*, 347 F.3d 72 (3rd Cir. 2003) (same); *Siler-Khodr v. University of Texas Health Science Center San Antonio*, 261 F.3d 542 (5th Cir. 2001) (Equal Pay

Act enacted pursuant to Commerce Clause). Similarly, the Fair Housing Act, passed pursuant to Congress's Commerce Clause power, regulates the failure to rent or sell housing to an individual on the basis of her sex, familial status, race, or disability, and thus compels owners of real estate to engage in commercial transactions they would otherwise have rejected. *See, e.g., Groome Resources Ltd v. Parish of Jefferson*, 234 F.3d 192, 209 (5th Cir 2000).

Congress realized in passing these laws and others like them, from the Equal Credit Opportunity Act to the Family and Medical Leave Act, that a national crisis of discrimination could only be solved through legislation reaching individual refusals to transact. Similarly, Congress understood in 2010 that regulating the interstate health insurance market would only work with near-universal participation and thus must reach individual refusals**.** As Congress is regulating within an area of its authority—-and the health insurance and health care markets are unquestionably areas of appropriate national authority--there is no prohibition against the federal government requiring individuals to participate in economic transactions they would otherwise avoid.

Appellants' argument misunderstands the nature of the conduct being regulated, for the individual responsibility provision is itself regulation of commercial activity. Just as a hotel's decision not to rent rooms to African-Americans is not a decision that avoids participation in the market for lodging, but

rather is a decision about how to engage in that market, the choice not to purchase health insurance is not a decision that avoids participation in the health care market, but is simply a decision about when and how to pay for the costs of health care. *See Mead v. Holder*, Civil Action No. 10-950, at 37-41 (D.D.C. February 22, 2001). Moreover, analogous to decisions to discriminate, the cumulative impact of these decisions has significant consequences for the larger health care market and other participants in it. In 2005 alone, 48 million Americans were uninsured, and they incurred $43 billion in medical costs that they could not pay themselves, which were in turn passed to the broader public**.** *See generally* Pub L. No. 111-148, §§ 1501(a)(2)(F), 10106(a)**.** As this Court has noted, "[a]lthough the connection to economic or commercial activity plays a central role in whether a regulation will be upheld under the Commerce Clause, economic activity must be understood in broad terms." *Gibbs v. Babbitt*, 214 F.3d 483, 491 (4th Cir. 2000)**.** The decision to eschew health insurance coverage is an economic choice, with economic consequences, under even a limited definition of "commercial" or "economic," just as a decision to refuse to rent a room to an individual because of her race is an economic choice, with economic consequences.

Even if the decision to defer medical costs until after they were incurred, and the concurrent decision to shift the risk of individual inability to pay for these costs to the broader market, were somehow construed not to be an economic activity, the

individual responsibility provision would still be within congressional authority to enact as part of a complex regulatory scheme. Congress has the authority to use any "means that is rationally related to the implementation of a constitutionally enumerated power." *United States v. Comstock*, 130 S.Ct. 1949, 1956-57 (2010). "A complex regulatory program can survive a Commerce Clause challenge without a showing that every single facet of the program is independently and directly related to a valid congressional goal. It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfied this test." *U.S. v. Gould*, 568 F.3d 459, 475 (4th Cir. 2009) (upholding the registration requirements of the Sex Offender Registration and Notification Act; *citing Hodel v. Indiana*, 452 U.S. 314, 329 n.7 (1981)). *See also U.S. v. Malloy*, 568 F.3d 166, 179 (4th Cir. 2009) ("well-settled" that purely local production of pornography could be regulated when Congress "possessed a rational basis" for concluding it substantially affected interstate commerce); *United States v. Forrest*, 429 F.3d 73, 78 (4th Cir.2005) (reaffirming "long-standing principle that the Commerce Clause empowers Congress to regulate purely local intrastate activities, so long as they are part of an economic class of activities that have a substantial effect on interstate commerce."); *Hoffman v. Hunt*, 126 F.2d 575, 588 (4th Cir. 1997) (upholding the Free Access to Clinics Act and noting "[a]lthough this regulated activity is not itself commercial or economic in

nature, it is closely connected with, and has a direct and profound effect on, the interstate commercial market in reproductive health care services.").

Congress certainly had a rational basis for its conclusion that the individual responsibility provision was necessary to effective implementation of important elements of the ACA, including Congress's purpose in addressing health insurer practices that excluded women from coverage**.** Pub. L. No. 111-148 §§ 150(a)(2)(H), (I), 10106(a). Individuals who do not carry insurance are nonetheless participants in the health care market, and, collectively, shift billions of dollars of costs onto third parties**.** Cong. Budget Office, Key Issues in Analyzing Major Health Proposals 114 (2008), at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf**.** The individual responsibility provision addresses this cost-shifting and forms a key part of the ACA's reforms. The individual responsibility provision is a reasonable provision permitting the ban on pre-existing condition exclusions, including insurers' exclusion of women from insurance coverage because of pregnancy, past Caesarean-section deliveries, cervical or breast cancer, or even a history of domestic or sexual abuse.

III. AS LEGISLATION INTENDED TO PROMOTE WOMEN'S HEALTH AND END DISCRIMINATION AGAINST WOMEN, THE ACA FOLLOWS IN A LONG TRADITION OF CIVIL RIGHTS LAWS FIRMLY WITHIN CONGRESS'S COMMERCE CLAUSE POWER.

As set out above, as part of its effort to address a national market failure, the Affordable Care Act (including but not limited to the individual responsibility provision) seeks to remove barriers and end discrimination that has prevented women from obtaining insurance and compromised women's health. Throughout the congressional debate over the ACA, the significant impact that national reform would have on women was of paramount concern**.** The Congressional Record is rich with statements recognizing that "[h]ealth care reform here will provide women the care that they need; the economic security they need; prohibit plans from charging women more than men; ban the insurance practice of rejecting women with a preexisting condition; and include maternity services." 156 Cong. Record H1637 (daily ed. March 18, 2010) (Statement of Rep. Moore).[2]

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[2] *See also, e.g.,* 155 Cong Record H12368 (Nov. 5, 2009) (Statement of Rep. Hirono) ("Fifty-two percent of women reported postponing or foregoing medical care because of cost. Only 39 percent of men report having had those experiences. Nine States allow private plans to refuse coverage for domestic violence survivors. Eighty-eight percent of private insurance plans do not cover comprehensive maternity care."); Senate Con. Res. 6, 111th Cong. (2009) (enacted) (women pay 68 percent more than men for out-of-pocket medical costs; 13 percent of all pregnant women are uninsured, making them less likely to seek prenatal care in the first trimester of their pregnancies, less likely to receive the optimal number of prenatal health care visits during their pregnancies, and 31 percent more likely to experience an adverse health outcome after giving birth; heart disease is the

The ACA should thus be recognized as following not only in a long tradition of economic regulatory laws appropriately enacted pursuant to Commerce Clause power, but also a long tradition of antidiscrimination legislation that has sought to remove barriers to full economic participation by disadvantaged and disfavored groups. Here, too, the Commerce Clause has been understood to provide the congressional authority to address these issues, allowing Congress simultaneously to address the impact on interstate commerce that arises from these discriminatory exclusions and to forward moral and social goals of equality and inclusion.

In enacting a broad range of federal civil rights laws over the past 50 years, Congress has determined that the problem of discrimination against and exclusion of disfavored groups is one that cannot be left to local solutions; it is a problem that spills over state lines and is national in scope and impact. Like modern civil rights laws such as the Civil Rights Act of 1964, the Equal Pay Act, and the Family and Medical Leave Act, the ACA seeks to address a national problem, one that not only has an economic and commercial dimension, but also implicates inequality and sex discrimination that our nation has a moral and social obligation to address. Indeed the ACA, like the civil rights laws that preceded it, recognizes that inequality and sex discrimination themselves have a significant economic impact

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leading cause of death for women and men, but women are less likely than men to receive lifestyle counseling, diagnostic and therapeutic procedures, and cardiac rehabilitation and are more likely to die or have a second heart attack).

and that addressing these economic consequences requires confronting inequalities and discrimination. Thus, by regulating commerce in health insurance and health care, the ACA also takes an important step to ensuring equality of access to health care—-forwarding fundamental civil rights principles of equal treatment and equal opportunity.[3] This only enhances Congress's Commerce Clause power to enact the law.

In the famous pair of cases upholding the constitutionality of the Civil Rights Act of 1964, *Heart of Atlanta Motel v. U.S.*, 379 U.S. 241 (1964) and *Katzenbach v. McClung*, 379 U.S. 294 (1964), the Supreme Court acknowledged "the overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse," *Heart of Atlanta,* 379 U.S. at 257, and concluded "that the legislators, in light of the facts and testimony before them, ha[d] a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce." *Katzenbach,* 379 U.S. at 304. The far-reaching gender inequities that

[3] *See generally, e.g.*, *United States v. Virginia,* 518 U.S. 515, 532 (1996) (noting fundamental principle that is violated when "women, simply because they are women" are denied the "equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities"); *Roberts v. United States Jaycees*, 468 U.S. 609, 626 (1984) (noting "the changing nature of the American economy and of the importance, both to the individual and to society, of removing the barriers to economic advancement and political and social integration that have historically plagued certain disadvantaged groups, including women"); *see also Newport News Shipbuilding Co. v. EEOC*, 462 U.S. 669, 676 (1983) (employer-provided health insurance that denies pregnancy coverage to female beneficiaries discriminates on the basis of sex).

have pervaded the national market for health insurance and health care have been similarly disruptive to this area of indisputably interstate commerce.

Specifically, as set out above, women have been prevented from obtaining adequate insurance coverage, and thus have faced significant obstacles to accessing needed health care goods and services, including those goods and services moving in interstate commerce**.** *See, e.g.*, Patchias & Waxman, *supra*, at 5 (68 percent of uninsured women, compared to 49 percent of uninsured men, have difficulty obtaining needed health care); Bernstein, *supra* (describing uninsured pregnant women's lower likelihood of obtaining prenatal care); Egerter *et al.*, *supra* (same); Asch et al., *supra*, at 1147-56 (describing women's greater propensity to forego preventative care because of cost)**.** When women cannot purchase insurance coverage, or when the insurance coverage available to them does not cover basic health care costs such as maternity care or imposes high out-of-pocket costs for preventive care, their health care expenses will be significant, thus restricting their ability to purchase goods and services in interstate commerce**.** *See, e.g.*, Patchias & Waxman, *supra*, at 4, 5 (16 percent of insured women, compared to 9 percent of insured men, considered underinsured because of high out-of-pocket costs relative to income; 38 percent of women, compared to 29 percent of men, report problems paying medical bills); David H. Himmelstein *et al.*, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. of Med. 741-746

(2009) (finding that being female increased the odds of filing for medical bankruptcy); Elizabeth Warren *et al.*, *Medical Problems and Bankruptcy Filings*, Norton's Bankruptcy Adviser (May 2000), *at* http://bdp.law.harvard.edu/pdfs/papers/Warren/Med_Problem_Bankruptcy.pdf ("among single filers, the number of women filing alone who identify a medical reason for their bankruptcies is nearly double that of men filing alone"). Finally, to the extent that uninsured or underinsured women are unable to pay for the health care they require, those costs are passed onto third parties through increased health care and health insurance costs, including increased costs for goods and services moving in interstate commerce. *See generally* Pub L. No. 111-148, §§ 1501(a)(2)(F), 10106(a) (finding that the American public has paid tens of millions of dollars to cover the costs of health care for uninsured Americans).

Because of the economic impact of discrimination and the need for national solutions to the problems it poses, over the course of the past several decades, in cases upholding a range of federal civil rights legislation, the courts of appeals have recognized that, far from being an impediment to the exercise of Commerce Clause authority, "civil rights … are traditionally of federal concern." *U.S. v. Allen*, 341 F.3d 870, 881 (9th Cir. 2003) (upholding federal hate crimes legislation under Commerce Clause). So, for example, in *Groome Resources Ltd v. Parish of Jefferson*, 234 F.3d 192, 209 (5th Cir. 2000), the Fifth Circuit, upholding the Fair

Housing Amendments Act (FHAA), "emphasize[d] that in the context of the strong tradition of civil rights enforced through the Commerce Clause… we have long recognized the broadly defined "economic" aspect of discrimination." *See also Oxford House-C v. City of St. Louis*, 77 F.3d 249, 251 (8th Cir. 1996) ("Congress had a rational basis for deciding that housing discrimination against the handicapped … has a substantial effect on interstate commerce"); *Morgan v. Sec. of Hous. & Urban Dev.*, 985 F.2d 1451, 1455 (10th Cir. 1993); *Seniors Civil Liberties Ass'n v. Kemp*, 965 F.2d 1030, 1034 (11th Cir. 1992).

On this basis, recognizing the significant federal responsibility for addressing persistent problems of discrimination and inequality, courts have upheld a wide range of federal civil rights laws as appropriately enacted under the Commerce Clause**.** *See, e.g., Nevada v. Department of Human Resources v. Hibbs*, 531 U.S. 721, 726-27 (2003) (Family Medical Leave Act is a valid Commerce Clause enactment); *EEOC v. Wyoming*, 460 U.S. 226, 234, 243 (1982) (Age Discrimination in Employment Act); *U.S. v. Mississippi Department of Public Safety*, 321 F.3d 495, 500 (5th Cir. 2003) (Americans with Disabilities Act); *U.S. v. Lane*, 883 F.2d 1484, 1493 (10th Cir. 1989) (federal hate crimes legislation); *American Life League v. Reno*, 47 F.3d 642, 647 (4th Cir. 1995) (Freedom of Access to Clinics Act); *Terry v. Reno*, 101 F. 3d 1412, 1413 (D.C. Cir. 1996) (same); *U.S. v. Dinwiddie*, 76 F.3d 913. 921 (8th Cir. 1996) (same); *U.S. v.*

Soderna, 82 F.3d 1370, 1374 (7th Cir. 1996) (same); *United States v. Gregg*, 226 F.3d 253, 262 (3d Cir. 2000) (same).

The Affordable Care Act, like these other statutes, is an appropriate exercise of federal Commerce Clause authority. It is unquestionably a law that regulates commerce—the health insurance and health care markets make up 17.5 percent of our nation's gross domestic product. In particular, the ACA corrects fundamental gender inequities in the health insurance and health care markets and bars discrimination against women in multiple forms, thus alleviating the severe economic consequences of such inequities and discrimination. In taking this legislative action, Congress was continuing "the strong tradition of civil rights enforced through the Commerce Clause." *Groome*, 234 F.3d 209.

Conclusion

For these reasons, this court should affirm the district court's dismissal of appellants' claims.

Dated: Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE
WITH TYPEFACE AND LENGTH

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6, 973 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in Times New Roman, 14 point font.

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CERTIFICATE OF SERVICE

I hereby certify that on February 25, 2011, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system.

I hereby certify that on February 25, 2011, the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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APPENDIX A

AMICI STATEMENTS OF INTEREST

American Association of University Women

For 130 years, the American Association of University Women (AAUW), an organization of over 100,000 members and donors, has been a catalyst for the advancement of women and their transformations of American society. In more than 1000 branches nationwide, AAUW members work to break through barriers for women and girls. AAUW plays a major role in mobilizing advocates on AAUW's priority issues, including increased access to quality affordable health care. Therefore, AAUW supports efforts to ensure patient protection, equitable treatment of consumers, coverage of preventive care, and other initiatives to improve the collective health of the American people.

American Federation of State, County and Municipal Employees

AFSCME International is an unincorporated labor union with more than 1.6 million active members working in the public sector, child care, and health care, and retired members. AFSCME International is headquartered in Washington, D.C. and has approximately 3,400 local unions and fifty-nine council affiliates around the country. AFSCME has filed briefs as amicus curiae before state and federal courts in numerous cases in which the interests of its affiliates and/or working people are implicated. The matter of affordable health care for all presents an

important issue of health policy, labor policy and fundamental principles of equality and human rights. These issues impact the day to day lives of AFSCME's members and their families. AFSCME supports the policies of the Affordable Care Act.

American Medical Women's Association

The American Medical Women's Association is an organization which functions at the local, national, and international level to advance women in medicine and improve women's health. We achieve this by providing and developing leadership, advocacy, education, expertise, mentoring, and through building strategic alliances. AMWA supports the Affordable Care Act as its members believe it provides more complete care for women and families and advances the medical careers of women doctors with its provisions to increase primary care physicians and other support healthcare workers. This Act is the most important advance in healthcare since Medicare/Medicaid. It can be strengthened, certainly not repealed.

Asian & Pacific Islander American Health Forum

The Asian & Pacific Islander American Health Forum ("APIAHF") influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders

(AAs and NHPIs). AA and NHPIs face numerous barriers to attaining quality health care, including high rates of uninsurance and limited English proficiency. For these reasons, APIAHF is concerned about the impact the Court's decision may have on AA and NHPI access to health insurance and quality care.

Black Women's Health Imperative

The Black Women's Health Imperative ("Imperative") is the only national Black non-profit organization dedicated to promoting optimum health for Black women across the life span. The Imperative strongly believes that everyone in the U.S. should receive equal access to health coverage and that health disparities based on health status, gender, and race must be eliminated. The Imperative joins in support of NWLC's amicus brief to uphold the Affordable Care Act.

Childbirth Connection

Childbirth Connection is a 93-year-old national not-for-profit organization that works on behalf of women and newborns to improve the quality of maternity care, through research, education, advocacy, and policy. Childbirth Connection's Transforming Maternity Care project engaged stakeholders from across the health care system in creating a consensus "2020 Vision for a High-Quality, High-Value Maternity Care System" (2010) and in charting the path to such a system through

a consensus “Blueprint for Action” report (2010). During the current implementation phase of the project, Childbirth Connection and many stakeholders are engaged in implementing Blueprint recommendations. The Affordable Care Act includes many essential provisions for this population and facilitates implementation of many “Blueprint for Action” recommendations. These efforts will help realize substantial achievable gains for over 4 million mother-newborn pairs annually in the United States and for Medicaid/taxpayers and private insurers/employers, who cover the considerable maternity care costs for about 42% and 50% of this population, respectively.

Ibis Reproductive Health

Ibis Reproductive Health is a nonprofit research and advocacy organization that aims to improve women’s reproductive autonomy, choices, and health worldwide. Ibis has a portfolio of work focused on the impact of Massachusetts health care reform on women’s access to reproductive health services, which has shown that low-income women and young women have largely benefitted from reform in the Commonwealth. Ibis is concerned about the impact that the Court’s decision may have on women’s access to health insurance and services.

Institute of Science and Human Values

The Institute for Science and Human Values (ISHV) is a non profit educational organization committed to the enhancement of human values and scientific inquiry. It focuses on the principles of personal integrity: individual freedom and responsibility. It includes a commitment to social justice, planetary ethics, and developing shared values for the human family. Women have continually faced great barriers to accessing comprehensive, affordable health coverage due to harmful and discriminatory health insurance industry practices. ISHV is deeply worried about the powerful effect that the Court's decision may have on women's right to and access to health insurance.

Maryland Women's Coalition for Health Care Reform

The Maryland Women's Coalition for Health Care Reform supports the Amicus Brief submitted by the National Women's Law Center. As a statewide coalition that includes 53 women's organizations, including all of the state's County Commissions for Women and hundreds of individuals, we are committed to ensuring that every Marylander has access to all of the health care services they need and deserve. We fully support the provisions of the ACA that support this goal. In light of that we endorse the arguments made in this Brief.

Mental Health America

Mental Health America (MHA) is a national non-profit advocacy and public policy organization that that has been working since 1909 to advance the rights of individuals with mental health conditions and improve the mental health of all Americans. Individuals with mental health conditions, including those suffering from depression, anxiety, post traumatic stress, and other illnesses that disproportionately affect women, have long faced difficulty obtaining comprehensive, affordable health coverage due to harmful and discriminatory insurance industry practices. MHA is profoundly concerned about the impact this case may have on access to health insurance for all Americans, especially women and those with mental illnesses.

National Asian Pacific American Women's Forum

NAPAWF is the only national, multi-issue Asian and Pacific Islander (API) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. Access to quality, comprehensive primary and reproductive health care is an important founding platform for NAPAWF. As such, NAPAWF is a co-leader of the Women of Color United for Health Care Reform (WOCUHR) coalition, co-chair

of the National Council of Asian Pacific Americas (NCAPA) Health Committee, and a member of numerous national coalitions seeking to ensure access to health care for immigrants and access to comprehensive reproductive health care for women. Successful implementation of the Affordable Care Act is essential for our members.

National Association of Social Workers (NASW)

Established in 1955, the National Association of Social Workers (NASW) is the largest association of professional social workers in the world with 145,000 members and 56 chapters throughout the United States and internationally. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the NASW Code of Ethics, conducts research, publishes books and studies, promulgates professional criteria, and develops policy statements on issues of importance to the social work profession. NASW supports "efforts to increase health care coverage to uninsured and underinsured people until universal health and mental health coverage is achieved" and "efforts to eliminate racial, ethnic, and economic disparities in health service access, provision, utilization, and outcomes." (NASW, SOCIAL WORK SPEAKS, 167, 169, 8th ed., 2009). NASW recognizes that discrimination

and prejudice directed against any group are not only damaging to the social, emotional, and economic well-being of the affected group's members, but also to society in general. NASW has long been committed to working toward the elimination of all forms of discrimination against women. The NASW Code of Ethics directs social workers to "engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully." NASW's policies support "access to adequate health and mental health services regardless of financial status, race and ethnicity, age, or employment status, which would require universal health care coverage…" NATIONAL ASSOCIATION OF SOCIAL WORKERS, Women's Issues, SOCIAL WORK SPEAKS, 367, 371 (8th ed., 2009). Given NASW's policies and the work of its members, NASW has expertise that will assist the Court in reaching a proper resolution of the questions presented in this case.

National Coalition for LGBT Health

The National Coalition for LGBT Health ("the Coalition") is a nationwide coalition of more than 75 organizations committed to improving the health and well-being of the lesbian, gay, bisexual, and transgender (LGBT) community through federal health policy advocacy. Because LGBT people and their families

are regularly discriminated against in employment, relationship recognition, and insurance coverage, the LGBT population faces significant disparities in health status and insurance coverage. The Affordable Care Act is a key component of health system reform that seeks to eliminate these disparities, and the Coalition is deeply concerned about the negative effect that the Court's decision may have on the health and well-being of millions of LGBT individuals and their families.

National Council of Jewish Women

The National Council of Jewish Women (NCJW) is a grassroots organization of 90,000 volunteers, advocates, and supporters who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW's Resolutions state that the organization endorses and resolves to work to for "quality, comprehensive, confidential, nondiscriminatory health-care coverage and services, including metal health, that are affordable and accessible for all." Consistent with our Resolutions, NCJW joins this brief.

National Council of Women's Organizations

The National Council of Women's Organizations is a non-profit, non-partisan

coalition of more than 230 progressive women's groups that advocates for the 12 million women they represent. While these groups are diverse and their membership varied, all work for equal participation in the economic, social, and political life of their country and their world. The Council addresses critical issues that impact women and their families: from workplace and economic equity to international development; from affirmative action and Social Security to the women's vote; from the portrayal of women in the media to enhancing girls' self-image; and from Title IX and other education rights to health and insurance challenges. Healthcare has always been at the top of the NCWO agenda. Among our many member organizations that research and advocate for women's health/healthcare are the American College of Nurse-Midwives, the American Medical Women's Association, the American College of Women's Health Physicians, the Association of Reproductive Health Professionals, the Center for Health and Gender Equity, the National Asian Women's Health Organization, the National Association of Nurse Practitioners in Women's Health, the National Congress of Black Women, United American Nurses, and the Ovarian Cancer National Alliance.

National Education Association

The National Education Association (NEA) is a nationwide employee

organization with more than 3.2 million members, the vast majority of whom are employed by public school districts, colleges and universities. NEA strongly supports adequate health care for all members of our society and to this end opposes constitutional attacks on the Affordable Care Act.

National Latina Institute for Reproductive Health (NLIRH)

The National Latina Institute for Reproductive Health ("NLIRH") works to ensure the fundamental human right to reproductive health for Latinas, our families, and our communities. Latinas suffer from large health disparities in most of the major health concerns in our country including cancer, heart disease, obesity and sexually transmitted diseases. In addition, Latinas are one of the populations least likely to have access to health insurance. The issues addressed in this case will profoundly affect Latinas' health and access to care and therefore are a central concern to our organization.

Older Women's League (OWL)

OWL is a national grassroots membership organization that focuses solely on improving the status and quality of life for midlife and older women. For the past thirty years, OWL has worked toward the goal of comprehensive, accessible healthcare that is publicly administered and financed. OWL has consistently advocated for a single-payer health care system. As the momentum for health care

reform legislation gathered speed, OWL worked with a diverse set of organizations to foster change that addressed persistent problems including millions of Americans without insurance, ever-rising costs, lack of affordable long-term care coverage and inequities in the health insurance industry. OWL took a strong leadership position on gender and age rating of health insurance premiums and moved the dialogue forward on this topic despite strong opposition. As a result, the Patient Protection and Affordable Care Act (PPACA) essentially eliminated gender rating, and insurers are restricted to a 3 to 1 age ratio (rather than a 5 to 1 ratio). Maintaining these important provisions in the PPACA is key to the quality of life for midlife and older women and compels OWL to support this brief.

Physicians for Repro Choice and Health

PRCH is a doctor-led national advocacy organization. We use evidence-based medicine to promote sound reproductive health policies. As physicians, we believe every American deserves unfettered access to all reproductive health care. The health of our country depends on it. The ACA is a valid use of congressional authority and means that millions of Americans will finally have the health coverage they need.

Raising Women's Voices

Raising Women's Voices for the Health Care We Need (RWV) is a national initiative working to make sure women's voices are heard in the health reform debate and women's concerns are addressed by policymakers developing national and state health reform plans. RWV has a special focus on engaging women of color, low-income women, immigrant women, young women, women with disabilities and members of the lesbian, gay, bisexual and transgender community. In addition to bringing the concerns of these constituencies to federal advocacy forums, RWV has 22 regional coordinators in 20 states who do community organizing, advocacy and public education with women at the state and local levels. RWV and the women it represents recognize that the ACA makes a real and significant difference in the lives of millions of our families, neighbors and communities. By prohibiting insurance companies from denying coverage to people with pre-existing conditions, like breast cancer or having a c-section delivery, and from charging women more than men for the same policies, it has increased our health security. Women will also gain from the availability of affordable health insurance for millions more families, from the guarantee that maternity care will be covered and from the availability of screening and preventive services without any cost-sharing barriers. With the promise of access to quality, affordable health care that meets the needs of women and our families

the ACA has the potential to bring equity and fairness for women to the health care arena where it has been lacking for too long.

Sargent Shriver National Center on Poverty Law

The Sargent Shriver National Center on Poverty Law (Shriver Center) champions social justice through fair laws and policies so that people can move out of poverty permanently. Our methods blend advocacy, communication, and strategic leadership on issues affecting low-income people. National in scope, the Shriver Center's work extends from the Beltway to state capitols and into communities building strategic alliances. The Shriver Center works on issues related to women's health and access to quality health care and insurance coverage. Discriminatory policies and practices have a negative impact on women's immediate and long-term health, and in turn, an negative impact on their economic well-being. The Shriver Center has a strong interest in the eradication of unfair and unjust health insurance policies and practices that limit women's access to quality care and serve as a barrier to leading healthy lives and economic equity.

Southwest Women's Law Center

The Southwest Women's Law Center (SWLC) is a nonprofit public interest organization based in Albuquerque, New Mexico. Its mission is to create the

opportunity for women to realize their full economic and personal potential by: (i) eliminating gender bias, discrimination and harassment; (ii) lifting women and their families out of poverty; and (iii) ensuring that women have full control over their reproductive lives through access to comprehensive reproductive health services and information. The SWLC has worked diligently in the implementation of the ACA in New Mexico because access to health care is critical to improve the lives of women in the state.

Wider Opportunities for Women (WOW)

Wider Opportunities for Women (WOW) works nationally and in our home community of Washington, DC, to help women achieve economic security and equality of opportunity for themselves and their families at all stages of life. Access to affordable health care, as provided in the ACA, is essential to the economic well-being of families and elder households. WOW has developed indexes of income needed to cover basic needs, including out-of-pocket health care costs in local economies, at the county level and for different family types and ages. ACA assures access to affordable coverage for those who have per-existing conditions, it fills the expensive hole in prescription drug coverage for seniors in Medicare Part D, establishes a voluntary mechanism to insure long-term care, and begins to curb rising health care costs that affect all. WOW is deeply

concerned about the impact of the Court's decision on the access of women and elders to health insurance.

Women's Law Center of Maryland, Inc.

The Women's Law Center of Maryland, Inc. is a nonprofit membership organization established in 1971 with a mission of improving and protecting the legal rights of women, particularly regarding gender discrimination, sexual harassment, employment law and family law. Through its direct services and advocacy the Women's Law Center seeks to protect women's legal rights and ensure equal access to resources and remedies under the law.

Women's Law Project

The Women's Law Project (WLP) is a nonprofit legal advocacy organization dedicated to creating a more just and equitable society by advancing the rights and status of all women throughout their lives. To this end, we engage in high impact litigation, advocacy, and education. The WLP has a long and effective track record working to improve access to comprehensive, quality, and affordable health care for women. Since 1994, the Women's Law Project (WLP) has engaged in extensive advocacy on the federal and state levels to eliminate insurance practices that deny insurance coverage to victims of domestic violence.

We advocated for adoption of the ACA to reduce the significant barriers to health care that confront women in the existing insurance market and thus have an interest in full implementation of the ACA.