No. 14-2396

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

WHEATON COLLEGE,

Plaintiff-Appellant,

v.

SYLVIA BURWELL, Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; THOMAS PEREZ, Secretary of the United States Department of Labor; UNITED STATES DEPARTMENT OF LABOR; JACOB J. LEW, Secretary of the United States Department of the Treasury; and UNITED STATES DEPARTMENT OF THE TREASURY,

Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of Illinois, Eastern Division No. 1:13-cv.-08910, Judge Robert M. Dow, Jr., Presiding

BRIEF OF THE NATIONAL WOMEN'S LAW CENTER AND 11 OTHER NATIONAL, REGIONAL, AND STATE ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Seventh Circuit Rule 26.1.1, the undersigned counsel certifies that, to the best of our knowledge, the following persons, firms and associations may have an interest in the outcome of this case:

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Ibis Reproductive Health

Legal Momentum

Martin, Emily J.

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NARAL Pro-Choice America

National Latina Institute for Reproductive Health

National Partnership for Women & Families

National Women's Health Network

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Planned Parenthood of Illinois

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Planned Parenthood of Wisconsin, Inc.

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Population Connection

Service Employees International Union

Amici curiae National Women's Law Center; Ibis Reproductive Health; Legal Momentum; NARAL Pro-Choice America; National Latina Institute for Reproductive Health; National Partnership for Women & Families; National Women's Health Network; Planned Parenthood of Illinois; Planned Parenthood of Indiana and Kentucky; Planned Parenthood of Wisconsin, Inc.; Population Connection; and Service Employees International Union are not publicly-held corporations, they have no parent corporations, and no publically held corporation owns 10% or more of any *amicus* organization's stock.

Dated: May 18, 2015

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INTEREST OF AMICI CURIAE

The National Women's Law Center; Ibis Reproductive Health; Legal Momentum; NARAL Pro-Choice America; National Latina Institute for Reproductive Health; National Partnership for Women & Families; National Women's Health Network; Planned Parenthood of Illinois; Planned Parenthood of Indiana and Kentucky; Planned Parenthood of Wisconsin, Inc.; Population Connection; and Service Employees International Union are national, regional, and state organizations committed to protecting and advancing women's health, with a particular interest in ensuring that women receive the full benefits of access to no-cost contraceptive coverage as intended by the Affordable Care Act.[1]

BACKGROUND AND SUMMARY OF ARGUMENT

Contraceptives are a key component of preventive health care for women. To further the goals of bettering the health and welfare of all Americans, the Patient Protection and Affordable Care Act ("ACA") and implementing regulations require all new insurance plans to cover all Food and Drug Administration ("FDA") approved contraceptive methods, sterilization procedures, and patient education and counseling, without cost-sharing ("the contraception regulations" or "regulations"). Health Res. & Servs. Admin., U.S. Dep't of Health

[1] Pursuant to Fed. R. App. P. 29(c)(5), the undersigned counsel certify that no party's counsel authored this brief in whole or in part; no party or party's counsel, or any other person, other than *amici* or their counsel, contributed money that was intended to fund the preparation or submission of this brief.

& Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines (last visited May 14, 2015); *see also* 42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130 (2014); Cntrs. for Medicare & Medicaid Servs., *FAQs About Affordable Care Act Implementation (Part XXVI)* (May 11, 2015), *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

The regulations exempt certain religious employers from this requirement. *See* 45 C.F.R. § 147.131 (2014). The regulations also accommodate non-profit entities that hold themselves out as religious and have religious objections to some or all forms of contraception (the "accommodation"). *See id*. Under the accommodation, a non-profit entity may certify via an Employee Benefits Security Administration ("EBSA") form[2] that it meets the eligibility criteria for the accommodation and share a copy of that form with its insurance issuer or third-party administrator. *Id.* Or, it may simply inform the Department of Health and Human Services ("HHS") of its objection in writing, stating "the basis on which it qualifies for an accommodation" and provide HHS with its insurance plan name and type and the name and contact information for the plan's third party administrators and health insurance issuers. *Id.* In either case, the organization's insurance issuer or third party administrator will then be required to provide

[2] U.S. Dep't of Labor, *EBSA Form 700* (Aug. 2014), *available at* http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf.

payments for contraceptive services separate from the group health insurance policy.[3] *Id*. Any eligible organization that acts in accord with the accommodation is not required to provide contraceptive coverage to its employees.

The Plaintiff-Appellant in this case, Wheaton College, qualifies for the accommodation as a non-profit religious organization. Yet, despite the fact that it is not required to cover contraceptive services in its group health insurance plans, Appellant claims that the regulations violate its rights under the Religious Freedom Restoration Act ("RFRA").[4] RFRA provides that the Government "shall not substantially burden a person's exercise of religion" unless the burden "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1.

This Court should affirm the district court and reject Appellant's claims. The contraception regulations impose no substantial burden on Appellant's religious exercise. *See, e.g.*, *Geneva College* v. *U.S. Secretary of Health and Human Services*, 778 F.3d 422, 427 (3rd Cir. 2015) (holding that the challenged accommodation poses no substantial burden); *Priests for Life* v. *U.S. Dep't. of Health and Human Servs.*, 772 F.3d 229, 237 (D.C. Cir. 2014); *see also Michigan*

[3] However, administrators of "church plans" are exempt from this requirement. *See* 29 U.S.C. § 1003(b)(2) (exempting church plans from regulation under ERISA).

[4] Appellant objects to certain forms of contraception as contrary to Christian doctrine and objects to the accommodation on that basis. Compl. ¶ 1-3, 67-69, 164-166.

Catholic Conference & Catholic Family Servs. v. *Burwell*, 755 F.3d 372, 390 (6th Cir. 2014*)*, *vacated sub nom.* No. 14-701, 2015 WL 1879768 (U.S. Apr. 27, 2015); *Univ. of Notre Dame* v. *Sebelius*, 743 F.3d 547, 559 (7th Cir. 2014), *vacated sub nom.* 135 S. Ct. 1528 (2015).[5] The Third Circuit recently recognized in *Geneva College* that the very accommodation challenged here did not pose a substantial burden. 778 F.3d at 427. The Court explained that it is federal law, and not the submission of the relevant form, that triggers the provision of the contraceptive services. *Id.* at 437. "[T]he eligible organization has *no role whatsoever* in the provision of the objected-to contraceptive services." *Id.* (emphasis added).

As the contraception regulations impose no substantial burden on religious exercise, this Court need not reach the additional questions of whether the regulations further compelling governmental interests and use the least restrictive means to advance those interests. But if the Court were to reach those questions, it should hold, as *amici* demonstrate below: First, that the contraception regulations serve the Government's compelling interests in protecting women's health and furthering women's equality, and second, that none of Appellant's proposed alternatives to the contraception regulations can be considered a less restrictive means of furthering the Government's compelling interests.

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[5] While both *Michigan Catholic Conference* and *Notre Dame* were remanded (GVR) for further consideration in light of *Hobby Lobby*, neither was vacated on the merits. *See Diaz* v. *Stephens*, 731 F.3d 370, 378 (5th Cir. 2013) ("A GVR makes no decision as to the merits of a case[.]").

While a divided panel of this Court held in *Korte* v. *Sebelius* that the contraception regulations did not further a compelling governmental interest, *see* 735 F.3d 654 at 685-86, that holding pre-dated *Hobby Lobby*, in which a majority of the Supreme Court concluded that the regulations advance a compelling government interest. *See Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2786 (Kennedy, J., concurring) ("It is important to confirm that a premise of the Court's opinion is its assumption that the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees."); *id.* at 2799 (Ginsburg, J., dissenting) ("[T]he Government has shown that the contraceptive coverage for which the ACA provides furthers compelling interests in public health and women's well being."). The D.C. Circuit also recently recognized that the contraceptive coverage requirement "specifically advances" the Government's "compelling interests in promoting public health and gender equality." *Priests for Life*, 772 F.3d at 263-64. As *amici* demonstrate below, the regulations serve the Government's compelling interests in protecting women's health and furthering women's equality.

Cases like this one differ from *Hobby Lobby* in a "crucial respect." *Id.* at 245. In *Hobby Lobby*, the Supreme Court identified the accommodation as a less restrictive means of furthering the Government's compelling interests because it "ensur[ed] that the employees of these entities have *precisely the same access* to

all FDA-approved contraceptives as employees of companies whose owners have no religious objection to providing such coverage." 134 S. Ct. at 2759 (emphasis added). Thus "in holding that Hobby Lobby must be accommodated, the Supreme Court repeatedly underscored that the effect on women's contraceptive coverage of extending the accommodation to the complaining businesses would be precisely zero." *Priests for Life* 772 F.3d at 245 (quoting *Hobby Lobby*, 134 S. Ct. 2751 at 2760).

By contrast, the relief sought by Appellant here "would hinder women's access to contraception." *Id.* (internal citations omitted). All of Appellant's proposed alternatives in this case would force its female employees and their dependents into a separate system of care delivery or payment for their contraceptive health needs. By imposing additional financial, administrative, and logistical burdens on these women, Appellant's alternatives ensure that the affected women would *not* have precisely the same access to contraceptive care as women working for non-objecting employers, who would be able to access no-cost birth control alongside their other health care needs from their regular provider and insurance plan.

Leaving the affected women with lesser, more difficult, and more costly contraceptive access is not the result the Court approved in *Hobby Lobby*. Rather, it is a result that threatens women's health and equality and thus undercuts

the Government's efforts to achieve its compelling interests. Because none of Appellant's proposed alternatives can be considered a less restrictive method of furthering the Government's compelling interests, the Court should deny Appellant's requested relief.

ARGUMENT

I. THE CONTRACEPTION REGULATIONS FURTHER THE COMPELLING GOVERNMENTAL INTERESTS OF IMPROVING WOMEN'S HEALTH AND EQUALITY.

If the Court finds that the contraception regulations substantially burden Appellant's exercise of religion, Appellant's claims should still fail because the contraception regulations are carefully drawn to further the Government's compelling interests: promoting women's health and furthering women's equality.[6] As the Centers for Disease Control explained when it named "family planning" one of ten great public health achievements of the twentieth century, alongside vaccinations and control of infectious diseases:

> Access to family planning and contraceptive services has altered social and economic roles of women. Family planning has provided health benefits such as smaller family size and longer interval[s] between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier

[6] *Amici* are aware that a divided panel of this Court rejected "public health" and "gender equality" as compelling government interests in *Korte*. *See* 735 F.3d at 685-86. Since that decision, five members of the Supreme Court concluded that the Government's interests in the contraception regulations are compelling. *See* Br. of Appellees at 34.

> contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other SSTDs.

Cntrs. for Disease Control & Prevention, *Ten Great Public Health Achievements–United States, 1900-1999*, 48 Morbidity & Mortality Wkly. Rep. 241-43 (1999), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm.

A. The Contraception Regulations Forward the Compelling Governmental Interest of Protecting Women's Health.

As Justice Kennedy emphasized in his *Hobby Lobby* concurrence, "[i]t is important to confirm that a premise of the Court's opinion is its assumption that the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees." 134 S. Ct. at 2786 (Kennedy, J., concurring); *see also id.* at 2799 (Ginsburg, J., dissenting) ("[T]he Government has shown that the contraceptive coverage for which the ACA provides furthers compelling interests in public health and women's well being."); *Priests for Life*, 772 F.3d at 264 (holding that the contraceptive coverage requirement "specifically advances" the government's "compelling interests in promoting public health and gender equality").

Nearly half of all pregnancies in the United States each year are unintended (*i.e.*, unwanted or mistimed at the time of conception). *See* Finer & Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 Contraception 478, 480 (2011). Because unintended pregnancy is

associated with a wide range of negative health consequences for women and any resulting children, HHS has made reducing the proportion of pregnancies that are unintended a national objective. *See* U.S. Dep't of Health & Human Servs., *Healthy People 2020: Family Planning*, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning (last visited May 14, 2015) ("*Healthy People 2020*").

Many studies document the negative health consequences of unintended pregnancy. For example, during an unintended pregnancy, a woman is more likely to receive delayed or no prenatal care, to be depressed, and to suffer from domestic violence. *See* Inst. Of Med., *Clinical Preventive Services for Women: Closing the Gaps* 90 (2011), *available at* http://www.iom.edu/reports/2011/clinical-preventive-services-for-women-closing-the-gaps.aspx (last visited May 14, 2015) ("IOM Rep"); *see also Healthy People 2020* (describing the above and additional risks of unintended pregnancy). An unintended pregnancy may also cause any resulting children to suffer negative health consequences. Women are more likely to have short inter-pregnancy intervals, which are associated with preterm birth, low birth weight, and small-for-gestational-age births. *See* IOM Rep at 90. As they grow, children born of unintended pregnancies are likely to be in poorer physical health than children of planned pregnancies, may be less likely to succeed in school, and may be more

likely to struggle with behavioral issues during their teen years. *See* Logan et al., *The Consequences Of Unintended Childbearing: A White Paper*, at 5-7 (Child Trends, Inc. ed., 2007). For these reasons, "[p]ermitting women to control the timing and spacing of their pregnancies improves the health and welfare of women, children, and infants." *Priests for Life*, 772 F.3d at 262.

While unintended pregnancy is highly prevalent in the United States—significantly more so than in comparably-developed countries[7]—this need not be the case. *See* IOM Rep. at 91-92. Contraception is highly effective in preventing unintended pregnancy. For example, intrauterine devices (IUDs), female sterilization, and contraceptive implants have a failure rate of 1% or less in the first 12 months—as compared with an 85% chance of pregnancy within 12 months with no contraception. *See id.*

Moreover, some women rely on contraception to avoid pregnancy due to other medical conditions. For example, it may be advisable for women with chronic medical conditions, such as diabetes and obesity, to postpone pregnancy until their health stabilizes. *See id*. at 90. Contraception can also have independent health benefits, including treating menstrual disorders; reducing risks of

[7] For example, "[w]hile 49% of pregnancies in the United States are unintended, the corresponding percentage in France is only 33%, and in Edinburgh, Scotland, it is only 28%." James Trussell & L.L. Wynn, *Reducing Unintended Pregnancy in the United States*, 77 Contraception 1, 4 (2008).

endometrial cancer; protecting against pelvic inflammatory disease; and, potentially, preventing ovarian cancer. *See id.* at 92.

For all of these reasons, increasing access to contraception is a matter of public health, and the health of Appellant's female employees and their female dependents is directly at stake in this case.

B. The Contraception Regulations Forward the Compelling Governmental Interest of Promoting Women's Equality.

Eliminating gender discrimination and promoting women's equality are compelling state interests. *Bd. of Dirs. of Rotary Int'l* v. *Rotary Club of Duarte*, 481 U.S. 537, 549 (1987); *Roberts* v. *U.S. Jaycees*, 468 U.S. 609, 625-26 (1984). The Supreme Court has specifically recognized "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," and has thus found that "[a]ssuring women equal access to . . . goods, privileges, and advantages clearly furthers compelling state interests." *U.S. Jaycees*, 468 U.S. at 626; *see also United States* v. *Virginia*, 518 U.S. 515, 532 (1996) (noting that fundamental principles are 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").

Congress passed the provision that led to the contraception regulations to help alleviate the "punitive practices of insurance companies that charge women more and give [them] less in a benefit" and to "end the punitive practices of the private insurance companies in their gender discrimination." 155 Cong. Rec. 28,842 (2009) (statement of Sen. Mikulski); *see also id.* at 28,846 (statement of Sen. Dodd) ("I support the effort by Senator Mikulski on her efforts to see to it that women are treated equally, and particularly in preventive care.").[8] In enacting that provision, Congress recognized that the failure to cover women's preventive health services meant that women paid more in out-of-pocket costs than men for basic and necessary preventive care, or were simply unable to obtain preventive care at all because of high cost barriers:

> Women must shoulder the worst of the health care crisis, including *outrageous discriminatory practices in care and coverage*. Not only do we pay more for the coverage we seek . . . but. . . . [i]n America today, too many women are delaying or skipping preventive care because of the costs of copays and

[8] Prior to the ACA's passage, women paid substantially more to access basic health care than did men and were significantly more likely to be burdened with high medical costs. Women of childbearing age spent 68% more in out-of-pocket health care costs than men. Rachel Benson Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, 1 Guttmacher Rep. on Pub. Pol'y 5 (Aug. 1998); *see also* IOM Rep. at 18-19 (noting that "women are consistently more likely than men to report a wide range of cost-related barriers to receiving or delaying medical tests and treatments and to filling prescriptions for themselves and their families"); Elizabeth M. Patchias & Judy Waxman, The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* 4 (Apr. 2007), *available at* http://www.commonwealthfund.org/usr_doc/1020_Patchias_women_hlt_coverage_affordability_gap.pdf (noting that 9% of men but 16% of women in a 2005-06 survey were "underinsured").

> limited access. In fact, more than half of women delay or avoid preventive care because of its cost. *This fundamental inequity in the current system is dangerous and discriminatory and we must act*.

Id. at 28,844 (statement of Sen. Gillibrand) (emphases added).

Insurance that covers basic preventive health care for men without requiring an out-of-pocket payment, but requires women to draw upon their personal savings for their basic preventive care, discriminates on the basis of sex. Moreover, when effective contraception is not used, and unintended pregnancy results, it is women who incur the attendant physical burdens and medical risks of pregnancy, women who disproportionately bear the health care costs of pregnancy and childbirth, and women who often face barriers to employment and educational opportunities as a result of pregnancy. The D.C. Circuit noted: "An unintended pregnancy is virtually certain to impose substantial, unplanned-for expenses and time demands on any family, and those demands fall disproportionately on women." *Priests for Life*, 772 F.3d at 263.

As the Supreme Court has recognized, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 856 (1992); *see also Priests for Life*, 772 F.3d at 263 ("For most women, whether and under what circumstances to bear a child is the most important economic decision of their lives."). Indeed, a majority of women report

the ability to better control their lives as a very important reason for using birth control. Frost & Lindberg, Guttmacher Inst., *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics*, 87 Contraception 465, 467 (2013). Increased control over reproductive decisions provides women with educational and professional opportunities that have advanced gender equality over the decades since birth control's effectiveness has improved and access to birth control has expanded. In fact, "[e]conomic analyses have found clear associations between the availability and diffusion of oral contraceptives, particularly among young women, and increases in U.S. women's education, labor force participation, and average earnings, coupled with a narrowing in the wage gap between women and men." *Id.* at 465. Another study concludes that the advent of oral contraceptives contributed to an increase in the number of women employed in professional occupations, including as doctors and lawyers. *See* Goldin & Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730, 758-62 (2002). And in a study that specifically asked women why they use contraceptives, a "majority of women reported that, over the course of their lives, access to contraception had enabled them to take better care of themselves or their families, support themselves financially, complete their education, or get or keep a job. . . ."

Sonfield, *What Women Already Know: Documenting the Social and Economic Benefits of Family Planning*, 16 Guttmacher Pol'y Rev. 8, 8 (Winter 2013).

In enacting the provision that led to the contraception regulations, Congress understood that covering women's preventive health services without cost-sharing alongside other preventive services in existing employer-based insurance would be "a huge step forward for justice and equality in our country." 155 Cong. Rec. 28,869 (2009) (statement of Sen. Franken).

C. The Contraception Regulations Further the Government's Compelling Interests By Eliminating Barriers to Contraception.

Eliminating access barriers to contraception, including up-front costs, is essential to achieving the compelling interests in protecting women's health and equal opportunity. Studies show that the high costs of contraception leads women to forego contraception completely, to choose less effective contraception methods, or to use contraception inconsistently or incorrectly. *See, e.g.*, Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* 5 (Sept. 2009), *available at* http://www.guttmacher.org/pubs/RecessionFP.pdf (finding that, to save money, women forewent contraception, skipped birth control pills, delayed filling prescriptions, went off the pill for at least a month, or purchased fewer birth control packs at once). Oral contraception costs women, on average, $2,630 over five years. James Trussell et al., *Cost Effectiveness of Contraceptives in the United*

States, 80 Contraception 229, 299 (2009). Other hormonal contraceptives—including injectable contraceptives, transdermal patches, and the vaginal ring—cost women between $2,300 and $2,800 over a five-year period. *Id.* Moreover, some of the most highly effective methods of birth control carry large up-front costs. For example, the up-front costs of the IUD can be as much as $1,000. *See* Planned Parenthood Fed'n of Am., *IUD*, http://www.plannedparenthood.org/health-topics/birth-control/iud-4245.htm (last visited May 15, 2015).

Evidence and practical experience show that eliminating barriers to contraception access and providing education and counseling about the available methods can greatly reduce the incidence of unintended pregnancy. For example, one study found a "clinically and statistically significant reduction" in unintended pregnancies when at-risk women received contraceptive counseling and reversible contraceptive methods of their choice at no cost. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1291 (2012).

By requiring health insurance plans to include coverage of the full range of FDA-approved methods without co-payments or cost-sharing, the regulations ensure that each woman can choose the contraceptive method that fits her needs "depending upon [her] life stage, sexual practices, and health status,"

IOM Rep. at 91, and guarantee that she can obtain her contraception through the same providers and systems from which she otherwise obtains health care, thus reducing barriers to access. *See* 45 C.F.R. § 147.130(a)(1)(iv) (2014). Moreover, by covering patient education and counseling, the regulations help ensure that each woman has the information she needs to identify the form of contraception that is most appropriate for her. *See id.* In so doing, the regulations substantially further the Government's compelling interests in women's health and equality.

II. APPELLANT'S PROPOSED ALTERNATIVES ARE INSUFFICIENT AND IMPRACTICAL AND WOULD HARM THE WOMEN FORCED TO RELY UPON THEM.

In *Hobby Lobby*, the Supreme Court held that the accommodation was a less restrictive means of achieving the Government's compelling interests in protecting women's health than mandating that an employer provide coverage because:

> Under the accommodation, the plaintiffs' female employees would continue to receive contraceptive coverage without cost sharing for all FDA-approved contraceptives, and they would continue to face minimal logistical and administrative obstacles, because their employers' insurers [are] responsible for providing information and coverage.

134 S. Ct. at 2782 (citations omitted) (internal quotation marks omitted); *see also id*. at 2786 (Kennedy, J., concurring) (the accommodation is an "existing, recognized, workable, and already-implemented framework to provide [insurance] coverage" of birth control to women who work for employers seeking exemptions

from the contraception regulations). Specifically, the Supreme Court reasoned that the accommodation guarantees that employees of objecting entities "have *precisely the same access* to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing such coverage." *Id.* at 2759 (emphasis added). The Court held that the accommodation "constitutes an alternative that achieves all of the Government's aims." *Id.*[9] The Court, in reaching this conclusion, emphasized that there is "no reason why this accommodation would fail to protect the asserted needs of women as effectively as the [contraception regulations]." *Id.* at 2782. It was significant to the Court's calculus that females who work for objecting companies would not be put in a worse position than women working for non-objecting employers. *Id.* at 2759.

Appellant's proposed alternatives, by contrast, would require women who access their health care through the insurance plan of an objecting employer—and only those women—to navigate a difficult, distinct process in order to obtain preventive contraceptive care without cost-sharing. Indeed, these alternatives "would . . . at a minimum, make [contraceptive] coverage no longer seamless from

[9] In so holding, the Court also emphasized: "The effect of the HHS-created accommodation on the women employed by Hobby Lobby and the other companies involved in these cases would be ***precisely zero***." *Hobby Lobby*, 134 S. Ct. at 2760 (emphasis added); *see also id.* at 2781 n. 37 ("Our decision in these cases need not result in any detrimental effect on any third party."). The D.C. Circuit recently explained that this language was significant to the Court's decision in *Hobby Lobby*. *See Priests for Life*, 772 F.3d at 245 (noting that the Supreme Court "repeatedly underscored" that the effect on women's contraceptive coverage "would be precisely zero").

the beneficiaries' perspective, instead requiring them to take additional steps to obtain contraceptive coverage elsewhere" or "would . . . deny the contraceptive coverage altogether." *See Priests for Life*, 772 F.3d at 245.

Although the burden is on Appellant to propose and address alternatives available to the Government, Appellant's four vague proposals fail to satisfy the standard under *Hobby Lobby*. Appellant proposes that the Government could "pay for the objectionable services itself through its existing network of family planning services funded under Title X, through direct government payments, or through tax deductions, refunds, or credits[,]" or that the Government "simply exempt all religious employers." Compl. ¶ 181-82. None of these proposals is a least restrictive means of furthering the Government's compelling interests, because none would ensure women contraception coverage without cost-sharing and within the same system of care and coverage in which they address their other health needs.

By separating women's reproductive health care from all of the other health care needs addressed by its existing employer-based insurance plan, Appellant's alternatives would make it more difficult for affected women to access basic preventive medicine. Indeed, Appellant's proposals would require affected women to take on significant personal costs—monetary and otherwise—just to access care fundamental to women's health, undermining the Government's

compelling interests. As the Court of Appeals for the District of Columbia recently held:

> Providing contraceptive services seamlessly together with other health services, without cost sharing or additional administrative or logistical burdens and within a system familiar to women, is necessary to serve the government's interest in effective access. Imposing even minor added steps would dissuade women from obtaining contraceptives and defeat the compelling interests in enhancing access to such coverage.

Priests for Life, 772 F.3d at 265.

None of the proposed alternatives meets the needs of women "as effectively" as the contraception regulations. *See Hobby Lobby*, 134 S. Ct. at 2782 (noting that the accommodation does so). Therefore none can be considered a less restrictive means of achieving the Government's compelling interests in women's health—including the health of Appellant's employees and their eligible dependents—and promoting equal opportunity for women.

In evaluating whether proposed alternatives constitute a less restrictive means of achieving the Government's compelling interests, the question for the Court is whether "the state can be assured its interest will be attained if [challengers'] religious beliefs are accommodated" via their proposed alternatives. *Murphy* v. *Arkansas*, 852 F.2d 1039, 1043 (8th Cir. 1988).[10] If proposed

[10] While *Murphy* involved a challenge under the Free Exercise Clause of the First Amendment, the case reflects the pre-*Smith* standard Congress enshrined in RFRA. *See City of Boerne* v.

alternatives are "impractical" or "insufficient" to advance the Government's compelling interests, the Government's existing regulatory scheme must prevail. *See United States* v. *Lafley*, 656 F.3d 936, 942 (9th Cir. 2011).

Moreover, the analysis does not require the Government to "do the impossible"—that is, it need not "refute each and every conceivable alternative regulation scheme." *United States* v. *Wilgus*, 638 F.3d 1274, 1289 (10th Cir. 2011); *see also May* v. *Baldwin*, 109 F.3d 557, 564-65 (9th Cir. 1997) (calling on the government only to "identif[y] the failings in the alternatives" proposed by the plaintiff); *Hamilton* v. *Schriro*, 74 F.3d 1545, 1556 (8th Cir. 1995) (noting that requiring the government to "refute every conceivable option" would impose a "herculean burden" on the government and calling on the plaintiff to "demonstrate what, if any, less restrictive means remain unexplored"). Rather, the Government must "support its choice of regulation [and] refute the alternative schemes offered by the challenger." *Wilgus*, 638 F.3d at 1289. Thus, the judicial inquiry is a limited one—RFRA "is not an open-ended invitation to the judicial imagination." *Id.*

Each of Appellant's proposed alternatives would undermine the Government's efforts to protect women's health and promote women's equality by eliminating barriers to contraception. The barriers to contraceptive access imposed

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Flores, 521 U.S. 507, 515 (1997) (Congress's "stated purpose" in passing RFRA was to "restore the compelling interest test[.]").

by each of Appellant's proposals in comparison to the accommodation illustrate that they are not less restrictive alternatives. Because "[t]he evidence shows that contraceptive use is highly vulnerable to even seemingly minor obstacles," the significant obstacles imposed by Appellant's alternatives are especially troubling. *See Priests for Life*, 772 F.3d at 265.

First, if the Government were, at the Appellant's urging, to create a broader "exemption for religious employers," this would simply leave more women without the comprehensive insurance coverage for preventive health services that Congress deemed compelling, increasing the likelihood that women's personal family planning decisions would be subject to an effective veto by their employer. *See Coverage of Certain Preventative Services Under the Affordable Care Act*, 78 Fed. Reg. 39870, 39887 (July 2, 2013), *available at* http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf (noting that women employed in accommodation-eligible organizations "are less likely than individuals in plans of [exempt] religious employers to share their employer's . . . faith and objection to contraceptive coverage on religious grounds" and that the accommodation thus preserves their ability to make autonomous family planning decisions). Unlike employees of entities subject to the accommodation, the employees of entities falling within a broader exemption would be responsible for procuring and paying for their own contraceptive care and that of their family

members. Moreover, for some women the contraceptive care could be prohibitively expensive. *See infra* pages 26-27.

Appellant's suggestion that the Government simply expand Title X is not a workable alternative and would fall short of ensuring that the affected women have the same seamless access to contraception without cost-sharing as women who benefit from the contraception regulations. It would require many women to take on the burden of locating a new provider just for contraceptive services, losing the benefit provided by continuity of care with her preferred health care provider.[11] Additionally, women may have difficulty locating a Title X-funded provider within a reasonable distance.[12] Women working at the objecting employers are scattered across fifty states, living in both rural and urban areas, with various health and financial needs. Requiring that these women receive their contraceptive care only from a Title X-funded provider could force them to travel long distances just to receive contraceptive care, potentially leading them to forgo such care completely.

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[11] Title X is a federal grant program overseen by the U.S. Department of Health and Human Services' Office of Population Affairs dedicated to providing low-income individuals with family planning and related preventive health services. *See* Office of Population Affairs, *Title X Family Planning*, http://www.hhs.gov/opa/title-x-family-planning/ (last visited May 15, 2015). Grantees include state, county, and local health departments, community health centers, Planned Parenthood Centers, and private nonprofits. *Id.*

[12] In fact, approximately one in four U.S. counties does not have a Title X-funded provider. *See* U.S. Dept. of Health & Human Servs., *Fact Sheet: Title X Family Planning Program* (Jan. 2008), *available at* http://www.hhs.gov/opa/pdfs/title-x-family-planning-fact-sheet.pdf.

Second, Title X does not provide "free" contraceptives to all women. Rather, Title X-funded providers offer no-cost family planning and related preventive health services only to women whose income is below the federal poverty level. 42 C.F.R. § 59.5(a)(7) (2014) (providing that, in general, "no charge will be made for services provided to any persons from a low-income family"); 42 C.F.R. § 59.2 (2014) (defining a low-income family as "a family whose annual income does not exceed 100 percent of the most recent Poverty Guidelines").[13] Women from families with annual incomes of up to 250 percent of the federal Poverty Guidelines may purchase services from Title X-funded providers on a sliding scale based on their ability to pay.[14] *See* 42 C.F.R. § 59.5(a)(8) (2014). Above that income level, women pay "the reasonable cost of providing services." *Id.*

Finally, Title X-funded providers may not be able to offer every contraceptive product to their client populations—while Title X-funded providers offer a "broad range" of contraceptive methods, every method is not guaranteed at every Title X-funded provider. *See generally* Office of Population Affairs,

[13] $20,090 is the 2015 Poverty Guideline for a family of three in the 48 contiguous states and the District of Columbia. 80 Fed. Reg. 3236 (Jan. 22, 2015).

[14] In 2015, 250 percent of the Poverty Guideline for a family of three in the 48 contiguous states and the District of Columbia is $50,225. *See id.*

Program Requirements for Title X Funded Family Planning Projects (Apr. 2014), *available at* http://www.nationalfamilyplanning.org/document.doc?id=1462.[15]

Appellant's proposed provision of a tax credit or deduction based on contraception costs would require women to pay up front for their contraceptive needs. As such, the proposal would reinstate the very cost barriers that deter women from obtaining the most effective methods or prevent women from using contraception altogether. In addition, it would require women to take on the administrative burden of collecting documentation of contraceptive costs over the course of the year and substantiating these costs through their tax returns. For those women who will not have taxes due at the end of the year, the proposal might offer no benefit at all.[16] This proposal, therefore, would not only force women to pay for the upfront costs of their contraceptive care and shoulder significant

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[15] In addition, Title X is perpetually underfunded and overburdened. *See* NARAL Pro-Choice Am., *Title X: The Nation's Cornerstone Family-Planning Program* (Jan. 2010), *available at* http://www.prochoiceamerica.org/assets/files/birth-control-family-planning-titlex-cornerstone.pdf (noting that Title X is significantly underfunded compared to the fiscal year 1980 funding level on an inflation-adjusted basis even while the Title X caseload has grown).

[16] Whether an individual must file a federal income tax return depends on her gross income, filing status, age, and whether she is a dependent. *See* Internal Revenue Service, Publication 501, *Exemptions, Standard Deduction, and Filing Information* 3 (2013), *available at* http://www.irs.gov/pub/irs-pdf/p501.pdf. Under some tax credit schemes, women who do not make sufficient income to file taxes would not receive the tax credit at all. Under others, the refundable tax credit might provide some women with the opportunity to recover the costs of their contraception, but only after filing a tax return that they otherwise would not have had to file. *Compare* 26 U.S.C. § 32 (creating a refundable earned income credit), *with* 26 U.S.C. § 23 (establishing a nonrefundable adoption expense credit).

administrative burdens to obtain reimbursement long after the fact, but would not even guarantee that the women would receive the funds at a later date.

Lastly, if the Government were to initiate a new program to directly provide contraceptive coverage or services to women or to offer grants to contraceptive providers to expand delivery of their services, such programs would be subject to future appropriations.[17] A woman's only guaranteed contraceptive care would be the care she could pay for herself. Given that the average cost of a full year's worth of birth control pills for an uninsured woman is $344—the equivalent of 47 hours of work for someone making the federal minimum wage—and the up-front costs of the more effective birth control methods, such as the IUD, would be nearly a month's salary for her,[18] she might be forced to use less effective forms of birth control or none at all.

A few examples demonstrate how Appellant's proposals would impact affected women, and make inescapably clear the defects in those proposals

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[17] In contrast, the contraceptive regulations are not dependent upon appropriations, but guarantee Appellant's employees access to contraception without cost-sharing regardless of annual changes in the federal budget. *See* 45 C.F.R. § 147.130 (2014); 45 C.F.R. § 156.50 (2014) (providing that health insurance issuers who make payments for contraceptive services pursuant to the accommodation may qualify for a concomitant reduction in federally-facilitated Exchange user fees).

[18] *See* Brief of the Guttmacher Institute and Professor Sara Rosenbaum as Amici Curiae in Support of the Government at 5, 17, *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

that render them inadequate means of achieving the Government's compelling interests.

Take, for example, a woman who determines in consultation with her provider that she would like a tubal ligation immediately after giving birth—a not uncommon scenario. Under the current health insurance system, that woman would get the care she needs in a seamless system, from her health care provider, ensuring that her care is integrated both during and after her pregnancy. But under an expanded Title X program, the woman would most likely not be able to obtain a sterilization immediately after giving birth, since her hospital or other birth setting may not be Title-X funded.[19] If her hospital is not Title X-funded, Appellant's proposal would force her into a dual system, requiring her to postpone her procedure, to transfer her records, and to follow-up with two different providers—all while recovering from a birth and managing the needs of a newborn infant.

Or take the example of a low-wage worker seeking to avoid unintended pregnancy by getting an IUD, one of the most effective forms of contraception, but also one of the most expensive. *See, e.g.*, IOM Rep. at 105 (noting that IUDs have a failure rate of 1% or less in the first twelve months); Planned Parenthood Fed'n of Am., *IUD*,

[19] In 2010, fewer than 200 hospitals across the United States received Title X grants. Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2010*, at 15 (2013), *available at* http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf. As of the same year, there were no Title X-funded hospitals in 24 states. *Id.* at 36-37.

http://www.plannedparenthood.org/health-topics/birth-control/iud-4245.htm (last visited May 18, 2015) (noting that insertion of an IUD and related follow-up visits can cost as much as $1,000). For a woman in a low-wage job, the up-front cost of the IUD could be nearly a month's salary.[20] Yet, by arguing for a broader religious employer exemption, Appellant suggests that more women be required to pay that amount up front—or be prevented from accessing effective care by an inability to pay. As such, Appellant's proposal would put this woman in the very position she was in before the ACA and the contraception regulations took effect—allowing cost to dictate whether she is able to use the method of contraception that is most appropriate for her and most effective in preventing unwanted pregnancy.

In summary, Appellant's proposals have serious flaws that render them impractical or insufficient to advance the Government's compelling interests. They would most likely require the affected women to find new providers and disrupt the continuity of care; could require them to shoulder the upfront costs for contraception and related education and counseling; and/or would not guarantee availability of the full range of contraceptive methods. In addition, women could be required to complete a series of administrative requirements in order to

[20] The federal minimum wage is $7.25 an hour. 29 U.S.C. § 206(a)(1). A woman who works 40 hours a week at the minimum wage earns $290 per week, or $1,160 per month, before taxes and deductions. *See also* Brief of the Guttmacher Institute and Professor Sara Rosenbaum as Amici Curiae in Support of the Government at 17 n.37, *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

demonstrate eligibility to participate in any such program proposed by Appellant, which represent a further obstacle to gaining access to contraceptives without out-of-pocket cost. In other words, Appellant's proposals would impose significant costs, administrative burdens, and logistical obstacles on Appellant's female employees and their covered family members, resulting in real harm to the affected women and rendering these alternatives less effective than the accommodation in forwarding the Government's compelling interests.

None of the alternatives would accomplish what the contraception regulations guarantee: seamless access to the full range of contraceptive methods and counseling without cost-sharing and within the existing employer-based insurance framework.

Moreover, each proposal seeks to deny women a part of their compensation from their employer—health insurance coverage of a basic preventive health care service that ninety-nine percent of sexually active women use at least one point in their lives[21]—while men with the same exact health insurance plan would not experience a similar carve out of their basic preventive health care needs. By introducing sex discrimination into health insurance packages, the proposals directly conflict with the Government's compelling interest in advancing women's equality.

[21] Guttmacher Inst., *Contraceptive Use in the United States* (June 2014), http://www.guttmacher.org/pubs/fb_contr_use.html (last visited May 15, 2015).

Because these proposals would have a detrimental effect on Appellant's female employees and covered family members, they do not leave these women with "precisely the same access" as other women working for non-objecting employers, and do not meet their needs as effectively as the contraception regulations. *See Hobby Lobby*, 134 S. Ct. at 2759. Therefore, they cannot be justified by *Hobby Lobby*, which approved of the accommodation as a less restrictive means after reasoning that the accommodation could provide such access. *See id.* at 2759-60. Appellant's proposals would undermine the Government's compelling interests in promoting women's health and equality, and they must be rejected.

CONCLUSION

For all of the foregoing reasons, this Court should affirm the District Court's rulings.

Dated: May 18, 2015

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(d) because it contains 6,987 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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Dated: May 18, 2015

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CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of May, 2015, I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit. All participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

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