No. 12-3841

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

CYRIL B. KORTE, et al.,

Plaintiffs-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ILLINOIS, CASE NO. 12-CV-1072-MJR-PMF

BRIEF OF THE NATIONAL WOMEN'S LAW CENTER AND THIRTEEN OTHER NATIONAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES AND AFFIRMANCE

Charles E. Davidow
Ilana D. Waxman
Andrée J. Goldsmith
Kimberley K. Allen
PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Marcia D. Greenberger
Judith G. Waxman
Emily J. Martin
Gretchen Borchelt
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle, NW #800
Washington, D.C. 20036
(202) 588-5180

Counsel for Amici Curiae

CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No.: 12-3841

Short Caption: Cyril B. Korte, et al. v. United States Department of Health and Human Services, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

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National Women's Law Center; American Academy of Nursing; American Association of University Women (AAUW); American Federation of State, County and Municipal Employees; Asian & Pacific Islander American Health Forum; Ibis Reproductive Health; Law Students for Reproductive Justice; MergerWatch; NARAL Pro-Choice America; National Partnership for Women & Families; National Organization for Women Foundation; Planned Parenthood Federation of America; Population Connection; and Raising Women's Voices for the Health Care We Need, as *amici curiae*.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Paul, Weiss, Rifkind, Wharton & Garrison LLP

(3) If the party or amicus is a corporation:

(i) Identify all its parent corporations, if any; and

Raising Women's Voices for the Health Care We Need is a collaborative project of three non-profit organizations: the Black Women's Health Imperative, the MergerWatch project of Community Catalyst, and the National Women's Health Network. None of these organizations has any parent company.

All other *amici* have no parent company.

(ii) List any publicly held company that owns 10% or more of the party's or amicus' stock:

N/A

Attorney's Signature: /s/ Charles E. Davidow **Date:** March 8, 2013

Attorney's Printed Name: Charles E. Davidow

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). Yes

Address: Paul, Weiss, Rifkind, Wharton & Garrison LLP
2001 K Street NW
Washington, D.C. 20006

Phone Number: (202) 223-7300 **Fax Number:** (202) 223-7420

Email Address: cdavidow@paulweiss.com

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N/A

Attorney's Signature: /s/ Gretchen Borchelt **Date:** March 8, 2013

Attorney's Printed Name: Gretchen Borchelt

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). No

Address: National Women's Law Center
11 Dupont Circle, NW #800
Washington, D.C. 20036

Phone Number: (202) 588-5180 **Fax Number:** (202) 588-5185

Email Address: gborchelt@nwlc.org

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The National Women's Law Center; American Academy of Nursing; American Association of University Women (AAUW); American Federation of State, County and Municipal Employees; Asian & Pacific Islander American Health Forum; Ibis Reproductive Health; Law Students for Reproductive Justice; MergerWatch; NARAL Pro-Choice America; National Partnership for Women & Families; National Organization for Women Foundation; Planned Parenthood Federation of America; Population Connection; and Raising Women's Voices for the Health Care We Need are national 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

Contraceptive services are a key component of preventive health care for women. To further its goals of bettering the health and welfare of all Americans, the ACA includes a preventive health services coverage provision, which requires all new insurance plans to cover certain preventive care and

[1] All parties have consented to the filing of this brief. 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.

screenings with no cost-sharing requirement. 42 U.S.C. § 300gg-13(a). Because women have unique health needs, particularly with respect to their reproductive capacities, Congress passed the Women's Health Amendment to ensure adequate coverage of preventive health services for women. *Id.* at § 300gg-13(a)(4). With the help of independent experts who studied women's health issues, the Health Resources and Services Administration ("HRSA"), an agency within the U.S. Department of Health and Human Services ("HHS"), recommended coverage of eight preventive services for women with no cost-sharing requirement, including "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." Health Res. & Servs. Admin., HHS, *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines ("HRSA Guidelines"), *implemented by* 77 Fed. Reg. 8,725 (Feb. 15, 2012) (requiring compliance for all plan years beginning on or after Aug. 1, 2012).

Plaintiffs challenge the regulations that require contraception coverage with no cost-sharing requirement (the "contraception regulations") on several grounds, including an alleged violation of the Religious Freedom Restoration Act ("RFRA"). This challenge must fail. The contraception regulations do not violate RFRA because they do not substantially burden

Plaintiffs' exercise of religion. Moreover, as *Amici* will demonstrate herein, even if the regulations did substantially burden religious exercise, they do not run afoul of RFRA because they further the compelling governmental interests of safeguarding public health and promoting gender equality in the least restrictive means possible. The regulations further ensure an individual's ability to access medically recommended preventive services free from employer interference.

First, contraception is critical to women's health, and providing it with no cost-sharing requirement advances the compelling governmental interest in public health. Contraception is highly effective at reducing unintended pregnancy, which, as countless studies have shown and experts agree, can have severe negative health consequences for both women and children. Yet, prior to the enactment of the contraception regulations, the high costs of contraception—including cost-sharing requirements—affected whether women used contraceptives consistently and whether women used the most appropriate or effective forms of contraception for their circumstances.

Second, the provision of contraceptive coverage without cost sharing addresses gender gaps in the provision of health care and advances the compelling governmental interest in promoting gender equality. Before the ACA went into effect, costs associated with women's health care—and specifically contraception—disproportionately burdened women. These high costs negatively

affected women's health and well-being, as women often lacked access to or forewent necessary health care in order to keep costs down. Moreover, access to contraception is key to progress and equal opportunity in other aspects of women's lives, thus improving women's social and economic outcomes more generally.

The contraception regulations are the least restrictive means of advancing these compelling governmental interests. Plaintiffs have not identified any feasible modifications that would be equally effective. Instead, their proposed alternative schema would be difficult if not impossible to implement and/or would be ineffective in achieving the goal of providing broader and more ready access to contraception.

Twenty-eight states mandate contraceptive coverage. The highest courts in both California and New York rejected challenges to such laws, holding that the laws advance the governmental interests in women's health and gender equality. *See Catholic Charities of the Diocese of Albany* v. *Serio*, 859 N.E.2d 459, 461 (N.Y. 2006), *cert. denied* 552 U.S. 816 (2007) (holding that a contraceptive coverage law did not violate the establishment or free exercise clauses of the federal or state constitutions); *Catholic Charities of Sacramento, Inc.* v. *Super. Ct.*, 85 P.3d 67, 73-74 (Cal. 2004), *cert denied* 543 U.S. 816 (2004) (same); *but see Yep* v. *Ill. Dep't of Ins.*, No. 2012 CH 5575 (Cir. Ct. Jan. 15, 2013) (finding a challenge to the Illinois state contraception coverage mandate to present

a "fair question as to the likelihood of success on the merits" and granting a preliminary injunction in light of the Illinois Health Care Right of Conscience Act and the Illinois Religious Freedom Restoration Act). This Court, too, should find that the inclusion of contraception as a required component of preventive health services with no cost-sharing requirement withstands Plaintiffs' challenge.

ARGUMENT

Defendants, acting within the scope of their authority to regulate the health insurance market, have issued regulations setting forth the minimum requirements for the provision of preventive care and screenings for women. Plaintiffs challenge the contraception regulations under RFRA, which provides generally 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.

The contraception regulations do not "substantially burden" Plaintiffs' exercise of religion, so this Court need not reach the question of whether the regulations are the least restrictive means of furthering a compelling governmental interest. In the event that it does, however, as this brief demonstrates, the contraception regulations clearly further the compelling governmental interests of

public health and equal opportunity for women, in the least restrictive means possible.

I. THE CONTRACEPTION REGULATIONS WERE ENACTED TO ADDRESS A GAP IN WOMEN'S HEALTH COVERAGE

A key component of the ACA is the preventive health services coverage provision, which is designed to avoid preventable conditions and improve health overall by increasing access to preventive care and screenings. *See* Inst. of Med., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS, at 16-18, 168 (2011), *available at* http://cnsnews.com/sites/default/files/documents/PREVENTIVE%20SERVICES-IOM%20REPORT_0.pdf ("IOM REP."). This provision requires all new health insurance plans to provide coverage for certain preventive services with no cost-sharing requirement. 42 U.S.C. § 300gg-13(a).

The bill as originally introduced in the Senate provided coverage for three categories of preventive health services:

> (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force [("USPSTF")];
>
> (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
>
> (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

H.R. 3590, 111th Cong. (as of Nov. 19, 2009).

As drafted, this provision primarily relied on the existing USPSTF recommendations to determine the scope of non-immunization coverage for adults. However, these recommendations "do not include certain recommendations that many women's health advocates and medical professionals believe are critically important." 155 Cong. Rec. S12,021, S12,025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer); *see also* 155 Cong. Rec. S12,265, S12,271 (daily ed. Dec. 3, 2009) (statement of Sen. Franken) ("The current bill relies solely on the [USPSTF] to determine which services will be covered at no cost. The problem is, several crucial women's health services are omitted.").

Recognizing this limitation for what it was—a significant gap in coverage that threatened women's health—Senator Mikulski sponsored the Women's Health Amendment to ensure "essential protection for women's access to preventive health care not currently covered in other prevention sections of the [ACA]." *Mikulski Amendment Improves Coverage of Women's Preventive Health Services and Lowers Costs to Women*, http://www.mikulski.senate.gov/_pdfs/Press/MikulskiAmendmentSummary.pdf (last visited Mar. 7, 2013); *see also* 155 Cong. Rec. S11,985, S11,986 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski) ("[A]s I reviewed the bill, I felt we could do more to be able to enhance and improve women's health care. . . . The essential aspect of my amendment is

that it guarantees women access to lifesaving preventive services and screenings.").

In relevant part, the Amendment proposed a fourth category of preventive coverage for women's unique health needs:

> (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

Id. (Amend. No. 2791). The Amendment "require[d] coverage of women's preventive services developed by women's health experts to meet the unique needs of women." 155 Cong. Rec. S12,265, 12,273 (statement of Sen. Stabenow).

Congress intended the Amendment to help alleviate the "punitive practices of insurance companies that charge women more and give [them] less in a benefit." 155 Cong. Rec. S12,021, S12,026 (statement of Sen. Mikulski); *see also id.* at S12,030 (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."). Of particular concern was that cost posed a unique barrier to women's ability to access basic and necessary care.

> 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 for the same age and the same coverage as men do, but in general women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. . . . In America today, too many women are delaying or skipping preventive care because of the costs and copays and limited access.

> . . . This fundamental inequity in the current system is dangerous and discriminatory and we must act.

Id. at S12,027 (statement of Sen. Gillibrand).

In considering the Amendment, Congress expressed its expectation that the HRSA Guidelines would incorporate family planning services. *See, e.g.*, *id.* ("With Senator Mikulski's amendment, even more preventive screening will be covered, including . . . family planning."); 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 1, 2009) (statement of Sen. Franken) ("I believe that affordable family planning services must be accessible to all women in our reformed health care system."); 155 Cong. Rec. S12,106, S12,114 (daily ed. Dec. 2, 2009) (statement of Sen. Feinstein) ("[The amendment] will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women's health screenings."). Following three days of debates, the Senate adopted the Women's Health Amendment by a vote of 61 to 39. *See* 155 Cong. Rec. S12,265, S12,277; 42 U.S.C. § 300gg-13(a)(4).

To meet the objectives of the Women's Health Amendment, the HRSA commissioned the Institute of Medicine ("IOM")[2] to "convene a diverse

[2] The IOM is an independent, nonprofit organization that provides unbiased, authoritative evidence to help those in government and the private sector make informed health decisions. *See* Inst. of Med., *About the IOM*, http://www.iom.edu/About-IOM.aspx (last visited Mar. 7, 2013).

committee of experts in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines to review existing guidelines, identify existing coverage gaps, and recommend services and screenings for HHS to consider in order to fill those gaps." IOM REP. at 20-21. The IOM assembled a committee of independent experts in the subject fields, which employed a rigorous methodology to thoroughly analyze the relevant evidence. *See id.* at 67. IOM's Report, issued at the conclusion of its review, articulated the need to focus on preventive health needs of women independently from those of men because women suffer from chronic disease and disability at rates disproportionate to those of men, women have different health needs and manifest different symptoms and responses to treatment modalities from men, and women face unique health risks due to their reproductive capacities. *Id.* at 18. The Report recommended eight preventive services for women, including "the full range of Food and Drug Administration-approved contraception methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." *Id.* at 8-12, Table S-1.

The IOM's inclusion of contraceptive services in standard preventive care for women is significant, but not groundbreaking. "Numerous health care professional associations and other organizations recommend the use of family planning services as part of preventive care for women . . . ." *Id.* at 104. Twenty-

eight states require contraceptive coverage, and contraceptive coverage has become standard practice for most private and federally-funded insurance programs. *Id.* at 108. Since 1972, Medicaid has required coverage for family planning in all state programs with no cost-sharing requirements. *Id.* Moreover, since 2000, the Equal Employment Opportunity Commission ("EEOC") has required, pursuant to Title VII, as amended by the Pregnancy Discrimination Act ("PDA"), that employers that provide health coverage for preventive health services also provide coverage for contraception. EEOC, Decision on Coverage of Contraception, at 2-4 (Dec. 14, 2000) ("EEOC Decision").

On August 1, 2011, HRSA adopted the recommendations set forth in the IOM Report. *See* HRSA Guidelines. In response to public comments, HRSA exempted certain religious employers from the requirement to cover contraception. *See id.*; 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011). Defendants implemented the HRSA Guidelines to apply to all non-grandfathered health insurance plans with plan years beginning on or after August 1, 2012. *See* 77 Fed. Reg. 8,725, 8,725-26 (Feb. 15, 2012).

II. THE CONTRACEPTION REGULATIONS SIGNIFICANTLY ADVANCE THE COMPELLING GOVERNMENTAL INTEREST OF SAFEGUARDING PUBLIC HEALTH

A. Safeguarding Public Health Is a Compelling Governmental Interest.

Courts in this Circuit have long recognized public health as a compelling governmental interest. *See*, *e.g.*, *U.S.* v. *Israel*, 317 F.3d 768, 771-72 (7th Cir. 2003) (rejecting a RFRA challenge to revocation of supervised release where the government demonstrated its "compelling interest" in "prevent[ing] harm to the public health and safety"); *Johnson* v. *McCann*, No. 08 C 4684, 2010 WL 2104640, at *5 (N.D. Ill. May 21, 2010) ("Health and safety are also compelling governmental interests."). Moreover, "the Government clearly has a compelling interest in safeguarding the public health by regulating the health care and insurance markets." *Mead* v. *Holder*, 766 F. Supp. 2d 16, 43 (D.D.C. 2011) (citing *Olsen* v. *Drug Enforcement Admin.*, 878 F.2d 1458, 1462 (D.C. Cir. 1989)); *see also Catholic Charities of the Diocese of Albany*, 859 N.E.2d at 468 (rejecting a challenge to contraceptive coverage, in part in consideration of "the State's substantial interest in fostering equality between the sexes, and in providing women with better health care").

B. Contraception Is Critical to Comprehensive Preventive Health Care for Women.

As the IOM Report and HRSA Guidelines make abundantly clear, access to contraception without cost sharing is a critical component of preventive

care for women that has demonstrable benefits for the health of women and children. Simply put, increasing access to contraception is a matter of public health.

1. *Unintended Pregnancies Are Highly Prevalent in the United States*.

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 & Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPS. ON SEXUAL & REPROD. HEALTH 90, 92 (2006). Unintended pregnancy is associated with a wide range of negative health consequences for the woman and any resulting child. Addressing this public health crisis is of great interest to the government. The HHS program that sets national objectives for improving U.S. public health seeks to increase the proportion of pregnancies that are intended, specifically from 51% as reported in 2002 to 56% by 2020. *See* HHS, *Healthy People 2020: Family Planning*, http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=13 (last visited Mar. 7, 2013) ("*Healthy People 2020*").

While unintended pregnancy is highly prevalent in the United States—significantly more so than in comparably-developed countries[3]—this need

[3] For example, "[w]hile 49% of pregnancies in the United States are unintended, the corresponding percentage in France is only 33%, and in Edinburgh,

not be the case. *See* IOM REP. at 104. Contraception is highly effective in preventing unintended pregnancy. Failure rates of FDA-approved contraception are negligible with proper use, as compared with an 85% chance of pregnancy within 12 months with no contraception. *See id.* at 105. Studies show that as rates of contraceptive use increase, rates of unintended pregnancy and abortion decline. For example, one study found that between 1982 and 2002, an increase in contraceptive use among unmarried women contributed significantly to a decrease in unintended pregnancy and abortion rates. *See* Boonstra et al., Guttmacher Inst., ABORTION IN WOMEN'S LIVES, at 18 (2006), *available at* http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf. A study of teen pregnancy rates found that a significant decline from 1991 to 2005 and moderate increase in 2006 and 2007 could be explained by a corresponding increase and then decline in teen contraceptive use over the same period. *See* Santelli & Melnikas, *Teen Fertility in Transition: Recent and Historic Trends in the United States*, 31 ANN. REV. OF PUB. HEALTH 371, 379 (2010) (finding also that lower levels of teen contraceptive use accounted for greater rates of teen pregnancies in the United States than in other developed countries). A research project in Iowa implementing several programs to increase knowledge and access to contraception found significant increases in contraceptive use and corresponding decreases in unintended

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Scotland, it is only 28%." Trussell & Wynn, *Reducing Unintended Pregnancy in the United States*, 77 CONTRACEPTION 1, 4 (2008).

pregnancy and abortion over the five year period from 2007 through 2012. *See* Iowa Initiative to Reduce Unintended Pregnancies, *Preliminary Findings*, http://www.iowainitiative.org/uploads/pdf/iiclinicresearch.pdf (last visited Mar. 7, 2013).

2. Unintended Pregnancies Have Real Health Consequences for Women and Children.

The negative health consequences of unintended pregnancy are well-documented. Women who experience unintended pregnancy are more likely to receive delayed or no prenatal care, to be depressed during pregnancy, and to suffer from domestic violence during pregnancy. *See* IOM REP. at 103; *Healthy People 2020*. Contraception allows a woman to avoid risks that pregnancy may pose due to other medical conditions. For example, it may be advisable for women with certain chronic medical conditions, such as diabetes and obesity, to postpone pregnancy until their health stabilizes. *See* IOM REP. at 103. Women with certain serious medical conditions, such as pulmonary hypertension and cyanotic heart disease, may need to avoid pregnancy altogether or risk serious medical consequences. *See id.* at 103-104.

The negative health consequences extend to children resulting from unintended pregnancy.[4] Without contraception, women are more likely to have

[4] This, of course, assumes that the unintended pregnancy results in a live birth. 42% of unintended pregnancies end in abortion. *See* IOM REP. at 102.

short inter-pregnancy intervals, which are associated with preterm birth, low birth weight, and small-for-gestational-age births. *See id.* at 103. Once born, children of unintended pregnancy are less likely to be breastfed, depriving them of the known benefits of breastfeeding to early development. *See id*. These children are more likely to experience poor mental and physical health during childhood, have lower educational attainment and more behavioral issues in their teen years, and have lower quality relationships with their mothers throughout childhood and even into adulthood. *See* Logan et al., *The Consequences Of Unintended Childbearing: A White Paper*, at 11 (Child Trends, Inc., 2007), *available at* http://www.childtrends.org/Files/Child_Trends-2007_05_01_FR_Consequences.pdf.

For all these reasons, the Centers for Disease Control and Prevention identified "family planning" as one of ten great public health achievements of the twentieth century, noting:

> 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 between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs.

Ctrs. for Disease Control & Prevention, *Ten Great Public Health Achievements–United States, 1900-1999*, 48 MORBIDITY & MORTALITY WKLY. REP. 241 (1999), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm.

3. Cost Poses a Substantial Barrier to Effective Contraceptive Use.

Despite its effectiveness at preventing unintended pregnancy, many women misuse or fail to use contraception because of cost. Studies show that high costs lead women to forego contraception altogether, 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, at 5 (2009), *available at* http://www.guttmacher.org/pubs/ RecessionFP.pdf ("A REAL-TIME LOOK") (finding that, in order 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). These responses to contraception's costs pose significant risks of unintended pregnancy, as "even a brief gap in [birth control] method use can have a major impact." Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, GUTTMACHER REP. ON PUB. POL'Y, Aug. 1998, at 6 ("Gold").

Eliminating cost barriers to contraception can greatly reduce the incidence of unintended pregnancy. A study conducted by the Washington University in St. Louis School of Medicine found a "clinically and statistically significant reduction" in unintended pregnancies where at-risk women received contraceptive counseling and reversible contraceptive methods of their choice at no

cost. *See* Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291, 1291 (2012). In another recent study, Kaiser Permanente found that when out-of-pocket costs for contraceptives were eliminated or reduced, women were more likely to rely on more effective, long-acting contraceptive methods. *See* Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 CONTRACEPTION 360, 363 (2007). [5]

III. THE CONTRACEPTION REGULATIONS SIGNIFICANTLY ADVANCE THE COMPELLING GOVERNMENTAL INTEREST OF PROMOTING GENDER EQUALITY

A. Promoting Gender Equality, Including Equal Access to Health Care, Is a Compelling State Interest.

The Supreme Court has held promoting women's equality and eliminating gender discrimination to be compelling state interests, justifying state

[5] Plaintiffs ignore the abundant evidence demonstrating that cost impedes access to contraception, and instead make misleading arguments based on out-of-context statistics. For example, Plaintiffs state that only 2.3% of women not using contraception said it was due to contraception being "too expensive." (App. Br. 54.). Plaintiffs fail to note that, according to the study they cite, the most common reasons for not using contraception were sexual inactivity, infertility, or otherwise not needing it. *See* Contraception in America, *Unmet Needs Survey, Executive Summary*, http://www.contraception inamerica.com/downloads/executive_summary.pdf (last visited Mar. 7, 2013). That factors other than cost weigh heavily in a woman's decision regarding contraception hardly undermines conclusive evidence linking high costs to reduced access. And, the study supports that conclusive evidence by showing that cost is a significant factor for those women who actually seek to use birth control.

action burdening First Amendment interests through the least restrictive means available. *Roberts* v. *U.S. Jaycees*, 468 U.S. 609 (1984) (finding that a state law forbidding gender discrimination in public accommodations did not unconstitutionally burden First Amendment right of expressive association). Specifically, the Court has 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." *Id.* at 626; *see also id.* at 623 (holding that the state's "compelling interest in eradicating discrimination against its female citizens" justified the statute's impact on associational freedoms); *id.* at 624 (stating that state's goal of "eliminating discrimination and assuring its citizens equal access to publicly available goods and services . . . . plainly serves compelling state interests of the highest order"); *U.S.* v. *Virginia*, 518 U.S. 515, 532 (1996) (noting the 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"); *Equal Emp't Opportunity Comm'n* v. *Fremont Christian Sch.*, 781 F.2d 1362, 1368-69 (9th Cir. 1986) (rejecting a school's free exercise challenge to the application of Title VII to its health

insurance plan, which was offered only to "heads of households"—defined as single persons and married men—based on the government's compelling interest in eliminating employment discrimination); *Catholic Charities of Sacramento, Inc.*, 85 P.3d at 92-93 ("The [contraceptive coverage law] serves the compelling state interest of eliminating gender discrimination.").

B. Women Are Uniquely Affected by Gaps in Health Care, Including a Lack of Access to Affordable Contraceptives.

Pervasive gender inequalities exist in the provision of health care.[6] Women's unique health needs, particularly as related to reproductive health, generate additional costs, causing health care expenditures to disproportionately burden women. *See* IOM REP. at 19. A primary contributing factor to these cost disparities is the high cost of contraception. And improving access to contraception promotes gender equality generally, as it improves the social and economic status of women.

1. Women are disproportionately burdened by health care costs.

Women pay substantially more to access basic health care than do men, and are significantly more likely to be burdened with high medical costs. "Compared with men, women require more health care services during their

[6] This section discusses disparities existing prior to the passage and full implementation of the ACA. Of course, when fully implemented, that legislation—in particular, the contraception regulations promulgated thereunder—will take great steps towards eradicating these disparities.

reproductive years (ages 18 to 45), have higher out-of-pocket medical costs, and have lower average incomes." Rustgi et al., The Commonwealth Fund, WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE, at 1 (2009), *available 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 ("Rustgi et al."). Women of childbearing age spend 68% more in out-of-pocket health care costs than men. Gold at 5; *see also* Women's Research and Educ. Inst., WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES, at 2 (1994).

The impact of these higher health care costs is magnified by women's lower incomes. Women earn, on average, just 77 cents for every dollar earned by men. *See* DeNavas-Walt et al., U.S. Census Bureau, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 7 (2012), *available at* http://www.census.gov/prod/ 2012pubs/p60-243.pdf. Moreover, women are more likely to be poor than men,[7] thus increasing the likelihood that women will face cost barriers to accessing needed health care.

Indeed, in 2007, 62% of women, compared with 48% of men, reported trouble paying medical bills, cost barriers to needed health care, or both.

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[7] In 2011, the poverty rate for women in the U.S. was 14.6%, compared with 10.9% for men. Nat'l Women's Law Ctr., INSECURE AND UNEQUAL: POVERTY AND INCOME AMONG WOMEN AND FAMILIES 2000-2011, at 3 (2012), *available at* http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_povertyreport.pdf.

Rustgi et al. at 2. In addition, women are more likely to spend a significant share of their income on out-of-pocket health care costs than men—in 2007, 35% of women, compared with 31% of men, spent 10% or more of their income on such costs. *Id.* at 3. This same study showed even starker results among low-income women: 55% of women earning less than $20,000 spent more than 10% of their income on out-of-pocket health care costs in 2007. *Id.* Studies also show that women more so than men—32% of women versus 24% of men—are unable to pay for basic necessities, such as food, heat, or rent, or take on a loan or credit card debt due to medical bills. *Id.* at 5.

The financial barriers to health care, and the significant income disparities between men and women, in turn lead women to forego necessary medical care at a higher rate than men. A 2007 survey showed that 52% of women did not fill a prescription; skipped a recommended medical test, treatment or follow-up; did not visit a doctor when they had a medical problem; or did not get necessary specialist care due to cost, compared with 39% of men. Rustgi et al. at 3. Moreover, 79% of women with medical debt or problems paying medical bills reported not pursuing necessary health care because of cost. *Id.* at 5. And, although women are more-frequent users of preventive health care services, a 2010 study showed that only 46% of women were up-to-date on recommended preventive screenings, including blood pressure, cholesterol, cervical cancer, colon

cancer and breast cancer. Robertson & Collins, The Commonwealth Fund, WOMEN AT RISK: WHY INCREASING NUMBERS OF WOMEN ARE FAILING TO GET THE HEALTH CARE THEY NEED AND HOW THE AFFORDABLE CARE ACT WILL HELP, at 8-9 (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1502_Robertson_women_at_risk_reform_brief_v3.pdf. Another study reported that "[n]early one out of four women report having put off a gynecological or birth control visit to save money in the past year." A REAL-TIME LOOK at 6.

Given these statistics, it is beyond dispute that the disproportionately high health care costs borne by women create "financial barriers [] that prevent women from achieving health and well-being for themselves and their families." IOM REP. at 20.

2. The high cost of contraception is a primary contributor to gender inequality in health care.

A significant portion of the health care cost disparities faced by women result from reproductive and gender-specific conditions, including the costs of contraception. IOM REP. at 19. Oral contraception costs women, on average, $2,630 over five years. Trussell et al., *Erratum to* "*Cost Effectiveness of Contraceptives in the United States*," 80 CONTRACEPTION 229, 229 (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.*

3. Promoting women's access to contraception leads to greater social and economic opportunities for women.

Access to contraception promotes equal opportunities far beyond the health care realm by improving women's social and economic status. Contraception puts women in control of their fertility, allowing them to decide whether, and when, to become parents. In one study, 60% of women reported 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, at 9 (2012), *available at* http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf ("Frost & Lindberg"). Indeed, the U.S. Supreme Court has found that "[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 Erickson* v. *Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) ("[T]he adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the marketplace and the world of ideas.") (internal quotations omitted).

Increased control over reproductive decisions, in turn, has provided women with educational and professional opportunities that have increased gender equality over the decades since birth control was introduced. Indeed, "[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." Frost & Lindberg at 3. A number of analyses have connected the advent of oral contraception to significant augmentation of women's wages. One study found that "the Pill-induced effects on wages amount to roughly one-third of the total wage gains for women in their forties born from the mid-1940s to early 1950s." Bailey et al., THE OPT-IN REVOLUTION? CONTRACEPTION AND THE GENDER GAP IN WAGES, at 26-27 (2012), *available at* http://www-personal.umich.edu/~baileymj/Opt_In_Revolution.pdf. That same study estimates that approximately 10% of the narrowing of the wage gap during the 1980s and 31% during the 1990s can be attributed to access to oral contraceptives prior to age 21. *Id.* at 27; *see also* Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply*, 121 Q. J. OF ECON. 289, 317 (2006) ("[C]ohorts with earlier legal access to the pill . . . worked more for pay during their late twenties and early thirties."). 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, 759-62 (2002).

The proponents of the ACA were not alone in recognizing that access to contraception would further gender equality. In considering a Title VII challenge to an employer's failure to include contraception coverage in its health insurance policy, the EEOC found that Congress, in passing the PDA, sought to "equalize employment opportunities for men and women" and "address discrimination against female employees that was based on assumptions that they would become pregnant." EEOC Decision at 2-3. Accordingly, it concluded that "the PDA's prohibition of discrimination in connection with a woman's ability to become pregnant necessarily includes the denial of benefits for contraception." *Id.* at 2; *see also Erickson*, 141 F. Supp. 2d at 1276 (agreeing with the EEOC and holding that "the exclusion of prescription contraceptives from a generally comprehensive insurance policy constitutes sex discrimination under Title VII").

Here, Congress similarly understood that the Women's Health Amendment—including its broadening of access to contraceptives—would be "a huge step forward for justice and equality in our country." 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 3, 2009) (statement of Sen. Franken); *see also supra* Section I.

IV. THAT THE ACA PROVIDES FOR CERTAIN EXEMPTIONS DOES NOT NEGATE THE COMPELLING GOVERNMENTAL INTERESTS

Plaintiffs argue that "exemptions" from the contraception regulations for employers with "grandfathered" group health plans and those with fewer than fifty employees "radically undermine[]" the government's assertion of compelling interests. (App. Br. 50.) This misconstrues the law. First, the exemption for grandfathered plans is not a true exemption at all. *See* 42 U.S.C. § 18011; 45 C.F.R. § 147.140. A health insurance plan relinquishes its grandfathered status if certain changes are made to the plan, such as a significant reduction in coverage or a significant increase in co-payments. 45 C.F.R. § 147.140. Rather than providing a true exemption, the grandfathering provision contemplates a gradual transition to the new, complex regulatory scheme as health plans lose their grandfathered status over time, a fact that in no way undermines the government's compelling interests. Indeed, as another court considering a challenge to the contraception regulations has stated, "[t]o find the Government's interests other than compelling only because of the grandfathering rule would perversely encourage Congress in the future to require immediate and draconian enforcement of all provisions of similar laws, without regard to pragmatic considerations, simply in order to preserve 'compelling interest' status." *Legatus* v. *Sebelius*, No. 12-12061, 2012 WL 5359630, at *9 (E.D. Mich. Oct. 31, 2012). In any event, the government

estimated that as many as 69% of all plans that had grandfathered status when the ACA was enacted will lose that status by the end of 2013. 75 Fed. Reg. 34,538, 34,552 (June 17, 2010). Additional plans can be expected to lose their grandfathered status in each subsequent year, thus bringing those plans within the scope of the contraception regulations.

Second, there is no exemption from the contraception regulations for employers with fewer than 50 full-time employees. Instead, these employers are exempt from the shared responsibility provision of the ACA, which requires certain employers who fail to provide health insurance to pay an assessable fee. *See* 26 U.S.C. § 4980H(a), (c)(2)(A). Even employers with fewer than 50 employees who provide non-grandfathered health insurance plans must comply with the contraception regulations.

Even were these provisions actually exemptions, it is not uncommon for federal statutes promoting equality interests to exempt certain actors. Even Title VII—the landmark federal statute prohibiting employment discrimination in the Civil Rights Act of 1964—exempts employers with fewer than 15 employees from its non-discrimination provisions. *See* 42 U.S.C. § 2000e(b). Yet no court has found or suggested that, as a result of this exemption, Title VII does not forward the government's compelling interest in eliminating employment discrimination.

Contrary to Plaintiffs' argument, the contraception regulations will have widespread effects. According to HHS, approximately 47 million American women were, at the time the mandate went into effect, enrolled in non-grandfathered health plans that were required to cover contraception and the other preventive services mandated by the new regulations. Simmons & Skopec, HHS, 47 MILLION WOMEN WILL HAVE GUARANTEED ACCESS TO WOMEN'S PREVENTIVE SERVICES WITH ZERO COST-SHARING UNDER THE AFFORDABLE CARE ACT (2012), *available at* http://aspe.hhs.gov/health/reports/2012/womensPreventiveServicesACA/ib.shtml. The contraception regulations will protect all 47 million of those women by guaranteeing them access to contraception without cost-sharing. Moreover, the regulations will guarantee contraception to millions of additional women as health plans lose their grandfathered status over time. Plaintiffs' assertion that regulations, which serve to protect millions of women, are somehow too underinclusive to pass muster under federal law cannot stand.

V. THE CONTRACEPTION REGULATIONS ARE THE LEAST RESTRICTIVE MEANS OF FURTHERING THE GOVERNMENT'S COMPELLING INTERESTS

The contraception regulations are the least restrictive means of furthering the government's compelling interests in women's health and equality. By guaranteeing women access to contraception without cost sharing within the existing framework of employer-provided health insurance plans, the regulations

present a seamless and efficient means of advancing the government's compelling interests. Moreover, the contraception regulations are highly effective at guaranteeing contraception without cost sharing to millions of women. Indeed, the regulations will affect not only women who cannot currently access birth control, but also women who are already enrolled in health plans that cover contraception, by ensuring that contraception costs no longer force women to choose less-effective methods of birth control, or to forego contraception altogether in favor of other necessary medical care.

Plaintiffs purport to identify four alternative means of furthering the compelling interests: (1) tax credits or deductions; (2) expanded eligibility for federal programs; (3) governmental reimbursement; and (4) incentives for pharmaceutical companies to provide contraceptives through pharmacies, doctor's offices, and clinics. (App. Br. 57.) Each fails as a feasible and equally-effective alternative to the contraception regulations. *See, e.g.*, *Fegans* v. *Norris*, 537 F.3d 897, 904-06 (8th Cir. 2008); *St. John's United Church of Christ* v. *City of Chicago*, 502 F.3d 616, 635-36 (7th Cir. 2007); *Graham* v. *Comm'r of Internal Revenue Serv.*, 822 F.2d 844, 852 (9th Cir. 1987), *overruled in part on other grounds by Navajo Nation* v. *U.S. Forest Serv.*, 479 F.3d 1024, 1033 (9th Cir. 2007) (en banc).

Expanding Title X or Medicaid to cover contraception for those with employer-provided insurance is neither feasible nor equally effective. The costs

and administrative burdens of doing so, and the difficulties of uprooting millions of women who already access contraception through their existing insurance plans, make this both infeasible and ineffective. *See St. John's*, 502 F.3d at 635 (finding the government's means the least restrictive where there was "no realistic, economically practical alternative") (internal quotations omitted); *New Life Baptist Church Acad.* v. *Town of E. Longmeadow*, 885 F.2d 940, 947 (1st Cir. 1989) ("[A]dministrative considerations play an important role in determining whether or not the state can follow its preferred means.").

Providing tax credits, deductions, or government reimbursements for contraceptive costs fails as ineffective. As discussed above, women earn less and face higher health care costs than men. *See supra* Section III.B.1. The promise of a tax credit or deduction in next year's tax return, or the promise of a reimbursement of contraceptive costs at a later date, does little to help a woman who cannot afford contraceptives today. Meanwhile, the consequences of lack of access to contraceptives are immediate and pressing. *See supra* Section II.B. For these reasons, this proposal "would not adequately serve the state's purposes." *Fellowship Baptist Church* v. *Benton*, 815 F.2d 485, 491 (8th Cir. 1987); *see also Williams* v. *Snyder*, 367 Fed. App'x. 679, 683 (7th Cir. 2010) (rejecting proposed alternative means as "inadequa[te]").

Providing incentives for pharmaceutical companies to offer contraceptives for free is similarly ineffective. Unlike a contraceptive coverage requirement, the mere provision of "incentives" for pharmaceutical companies does nothing to guarantee that women obtain the care they need. Pharmaceutical companies could freely decline to participate or, even when participating, could offer less than the full range of FDA-approved contraceptives. Moreover, women may be unable to determine where contraceptives are offered, and the clinics or pharmacies offering them may face greater demand than supply, leaving women with unpredictable access to contraceptives when needed. Such a measure would be, at best, a patchwork scheme that would not provide women with the guaranteed access of insurance coverage. As such, this is not an equally-effective alternative. *See Murphy* v. *State of Ark.*, 852 F.2d 1039, 1042-43 (8th Cir. 1988); *see also St. John's*, 502 F.3d at 636 (means are least restrictive where accommodation of religious concerns is not "possible without compromising [the government's] compelling interests").

Plaintiffs have not offered a feasible and equally-effective alternative to the contraception regulations, and so the regulations are the least restrictive means of furthering the government's compelling interests, and withstand scrutiny.

CONCLUSION

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

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Respectfully submitted,

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
Ilana D. Waxman
Andrée J. Goldsmith
Kimberley K. Allen
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Marcia D. Greenberger
Judith G. Waxman
Emily J. Martin
Gretchen Borchelt
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle, NW #800
Washington, D.C. 20036
(202) 588-5180

Counsel for Amici Curiae

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 6,996 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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 it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman font.

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PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
Ilana D. Waxman
Andrée J. Goldsmith
Kimberley K. Allen
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Marcia D. Greenberger
Judith G. Waxman
Emily J. Martin
Gretchen Borchelt
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle, NW #800
Washington, D.C. 20036
(202) 588-5180

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of March, 2013, 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 by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: March 8, 2013

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
Ilana D. Waxman
Andrée J. Goldsmith
Kimberley K. Allen
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Marcia D. Greenberger
Judith G. Waxman
Emily J. Martin
Gretchen Borchelt
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle, NW #800
Washington, D.C. 20036
(202) 588-5180

Counsel for Amici Curiae