Nos. 14-12890, 14-13239

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

THE ROMAN CATHOLIC ARCHDIOCESE OF ATLANTA, an association of churches and schools; THE MOST REVEREND WILTON D. GREGORY, and his successors, Archbishop of the Roman Catholic Archdiocese of Atlanta; CATHOLIC CHARITIES OF THE ARCHDIOCESE OF ATLANTA, INC., a Georgia non-profit corporation; THE ROMAN CATHOLIC DIOCESE OF SAVANNAH, an ecclesiastical territory; THE MOST REVEREND JOHN HARTMAYER, and his successors, Bishop of the Roman Catholic Diocese of Savannah,

Plaintiffs-Appellees,

v.

SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF LABOR; U.S. DEPARTMENT OF THE TREASURY; SECRETARY, U.S. DEPARTMENT OF LABOR; SECRETARY, U.S. DEPARTMENT OF THE TREASURY,

Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Georgia

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

PAUL, WEISS, RIFKIND,
WHARTON & GARRISON LLP

NATIONAL WOMEN'S LAW CENTER
Marcia D. Greenberger

Charles E. Davidow
Amelia Frenkel, *Not yet admitted*
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Danielle Polebaum
Rebecca Orel
Abel McDonnell, *Not yet admitted*
1285 Avenue of the Americas
New York, New York 10019
(212) 373-3000

Judith G. Waxman
Emily J. Martin
Gretchen Borchelt
Leila Abolfazli
11 Dupont Circle, NW #800
Washington, D.C. 20036
(202) 588-5180

Counsel for Amici Curiae

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Eleventh 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:

Abolfazli, Leila

American Federation of State, County and Municipal Employees

Borchelt, Gretchen

Davidow, Charles E.

Frenkel, Amelia

Florida Association of Planned Parenthood Affiliates, Inc.

Greenberger, Marcia D.

Legal Momentum

Martin, Emily J.

McDonnell, Abel

NARAL Pro-Choice America

National Family Planning and Reproductive Health Association

National Latina Institute for Reproductive Health

National Women's Health Network

National Women's Law Center

Orel, Rebecca

Paul, Weiss, Rifkand, Wharton & Garrison LLP

Planned Parenthood Southeast, Inc.

Polebaum, Danielle

Population Connection

Service Employees International Union

Waxman, Judith G.

Amici curiae National Women's Law Center; American Federation of State, County and Municipal Employees; Florida Association of Planned Parenthood Affiliates, Inc.; Legal Momentum; NARAL Pro-Choice America; National Family Planning and Reproductive Health Association; National Latina Institute for Reproductive Health; National Women's Health Network; Planned Parenthood Southeast, 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: October 31, 2014

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

RULES AND REGULATIONS

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

INTEREST OF AMICI CURIAE

The National Women's Law Center; American Federation of State, County and Municipal Employees; Florida Association of Planned Parenthood Affiliates, Inc.; Legal Momentum; NARAL Pro-Choice America; National Family Planning & Reproductive Health Association; National Latina Institute for Reproductive Health; National Women's Health Network; Planned Parenthood Southeast, 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

[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.

regulations" or "regulations"). Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines (last visited Oct. 27, 2014); *see also* 42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130 (2014).

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. *See* Coverage of Certain Preventative Services Under the Affordable Care Act, 79 Fed. Reg. 51092, 51094-95 (Aug. 27,

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

2014) (to be codified at 45 C.F.R. § 147).[3] In either case, the organization's insurance issuer or third party administrator will then be required to provide payments for contraceptive services separate from the group health insurance policy.[4] 45 C.F.R. § 147.131 (2014). Any eligible organization that acts in accord with the accommodation is not required to provide contraceptive coverage to its employees.

The Plaintiffs in this case, the Roman Catholic Archdiocese of Atlanta, Catholic Charities of the Archdiocese of Atlanta, Catholic Education of North Georgia, the Roman Catholic Diocese of Savannah, the Archbishop of the Atlanta Archdiocese, and the Bishop of the Savannah Diocese, qualify for either the exemption or the accommodation for non-profit entities. Yet, despite the fact that they are not required to cover contraceptive services in their group health insurance plans, Plaintiffs claim that the regulations violate their rights under the

---

[3] In *Wheaton College* v. *Burwell*, 134 S. Ct. 2806, 2807 (2014), the Supreme Court enjoined HHS from requiring that Wheaton, an eligible non-profit organization, send the certification form directly to its third party insurer or third party administrator and stated that Wheaton was required only to inform HHS in writing that "it is a non-profit organization that holds itself out as religious and has religious objections to providing coverage for contraceptive services." HHS subsequently released the new interim final regulations cited above, allowing all eligible non-profit organizations to object in writing directly to HHS rather than submit the certification form to their insurer. Plaintiffs continue to object to the accommodation in spite of the new regulations.

[4] 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). The district court has concluded that the plaintiffs offer health coverage through such church plans. *See Roman Catholic Archdiocese of Atlanta v. Sebelius, 2014 U.S. Dist. LEXIS 73624, *16 (N.D. Ga. May 30, 2014)*

Religious Freedom Restoration Act ("RFRA").[5] 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 find that Plaintiffs' RFRA claims fail. The contraception regulations impose no substantial burden on Plaintiffs' religious exercise. Therefore, 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 equal opportunity, and second, that none of Plaintiffs' proposed alternatives to the contraception regulations can be considered a less restrictive means of furthering the Government's compelling interests.

In *Hobby Lobby*, the Supreme Court of the United States 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

[5] Both Plaintiffs object to all forms of contraception and sterilization as contrary to Catholic doctrine and object to the accommodation on that basis. Second Am. Compl. ¶ 9.

precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objection to providing such coverage." *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2759 (2014) (emphasis added). By contrast, each of Plaintiffs' proposed alternatives in this case would force their female employees and the female dependents of their employees 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, Plaintiffs' 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. To the contrary, Plaintiffs' alternatives would put the affected women in a worse position and make it less likely that they would be able to obtain the best form of contraception for them. Leaving the affected women with lesser, more difficult, and more costly contraceptive access is not the result approved by the Court 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.

For these reasons, none of the alternatives proposed by the Plaintiffs can be considered a less restrictive method of forwarding the Government's compelling interests, and the Court should deny Plaintiffs' 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 Plaintiffs' exercise of religion, Plaintiffs' 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. 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 contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs.

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 ("*Ten Great Public Health Achievements*").

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." *Hobby Lobby*, 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.").

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 Oct. 27, 2014) ("*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 Oct. 27, 2014) ("IOM Rep"); *see also Healthy People 2020* (describing the above and additional risks of unintended pregnancy). An unintended pregnancy may also cause the child or the children resulting from the pregnancy to suffer negative health consequences. Without contraception, 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).

While unintended pregnancy is highly prevalent in the United States—significantly more so than in comparably-developed countries[6]—this need not be the case. *See* IOM Rep. at 91-92. Contraception is highly effective in

[6] 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).

preventing unintended pregnancy. For example, intrauterine devices (IUDs), female sterilization, and contraceptive implants have a failure rate at 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 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 Plaintiffs' female employees and the employees' female dependents is directly at stake in these cases.

B. The Contraception Regulations Forward the Compelling Governmental Interest of Promoting Equal Opportunity for Women.

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, 107 S. Ct. 1940, 1948 (1987); *Roberts* v. *U.S. Jaycees*, 468 U.S. 609, 626, 104 S.Ct. 3244, 3253 (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 id.* at 623; *United States* v. *Virginia*, 518 U.S. 515, 532, 116 S.Ct. 2264, 2275 (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.").[7] In enacting that

[7] Prior to the reforms made possible by the ACA, 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

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 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).

When insurance 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, this 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

---

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").

costs of pregnancy and childbirth, and women who often face barriers to employment and educational opportunities as a result of pregnancy.

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, 112 S.Ct. 2791, 2809 (1992). 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). For example, 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 better take care of themselves or their families, support themselves financially, complete their education, or get or keep a job. . . ." Sonfield, *What Women Already Know*, 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 barriers to access 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 lead 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 $1000. *See* Planned Parenthood Fed'n of Am., *IUD*, http://www.plannedparenthood.org/health-topics/birth-control/iud-4245.htm (last visited Oct. 27, 2014).

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 of any kind, the contraception 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. PLAINTIFFS' 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.*[8] 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.

---

[8] 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).

All of Plaintiffs' 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. Specifically, Plaintiffs' proposals range from tax credits and deductions, to compelling "manufacturers or distributors of contraceptives to provide them for free or at reduced rates," to expanding Medicaid or other existing programs. Pl.'s Opp. to Mot. to Dismiss 32-36. These proposals would deny women health insurance coverage of contraception 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 their existing employer-based insurance plan, Plaintiffs' alternatives would make it more difficult for affected women to access basic preventive medicine. Indeed, Plaintiffs' proposals would require affected women to take on significant personal costs—monetary and otherwise—just to access care fundamental to women's health. As such, none of the proposed alternatives meet 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

Plaintiffs' 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).[9] If proposed 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) (holding that prohibition of marijuana use as a condition of supervised release does not violate RFRA).

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

[9] 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. Flores*, 521 U.S. 507, 515, 117 S.Ct. 2157, 2162 (1997) (Congress's "stated purpose" in passing RFRA was to "restore the compelling interest test").

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 Plaintiffs' proposed alternatives would have the effect of undermining the Government's efforts to protect women's health and promote equal opportunity for women by eliminating barriers to contraception.[10] The barriers to contraceptive access imposed by each of Plaintiffs' proposals in comparison to the accommodation refute the possibility that they may be considered less restrictive alternatives of achieving the Government's compelling interests.

Plaintiffs' suggestion that the Government offer a tax credit or deduction based on the costs of contraception would require women to pay up front for their contraceptive needs. It would thus reinstate the very cost barriers that can

[10] This is so even assuming Plaintiffs' proposals were enacted into law. However, each of Plaintiffs' proposals would require congressional action prior to taking effect. Prior to such action, Plaintiff Catholic Charities' female employees and the employees' female dependents would only have access to contraception via the options available to them prior to the enactment of the ACA. *See* Def.'s Opp. to Mot. for Prelim. Inj. 25 (noting that Plaintiffs' proposals constitute "an entirely new legislative and administrative scheme").

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 their contraceptive costs over the course of the year and substantiating these costs in their tax returns. Finally, for those women who will not owe taxes at the end of the year, the proposal might offer no benefit at all.[11]

Plaintiffs' suggestion that the Government compel providers or distributors of contraceptives to provide their products for free or at subsidized rates, potentially through a grant program, would not guarantee women the ability to access the specific method of contraception they need—or the ability to access any method at all without cost-sharing. Moreover, even if a woman were able to obtain the particular contraceptive method she needs from a distributor at no cost, this program would impose logistical and administrative burdens on her—she would need to locate the distributor and would likely need to prove her eligibility while working for an employer who presumably objects to any method of certification that would allow her to receive contraceptive care.

---

[11] 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 Serv., *Publ'n 501, Exemptions, Standard Deduction, and Filing Information* 3 (2013), *available at* http://www.irs.gov/pub/irs-pdf/p501.pdf. If the tax credit were nonrefundable, women who did not make sufficient income to file taxes would not receive the tax credit at all. If the tax credit were refundable, it would provide 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).

Plaintiffs' suggestion that the "Government could simply extend contraception coverage through the Medicaid program to women whose employers do not provide the required coverage[]" is equally flawed. Pl.'s Opp. to Mot. to Dismiss 33. First, Plaintiffs' suggestion would require women to take on the significant administrative burden of enrolling in an entirely separate insurance system. Enrollment would likely require proof of eligibility on the basis that the enrollee lacks contraceptive access through an insurance plan offered by an objecting employer. There is no reason to believe that Plaintiffs would be any more amenable to verifying enrollees' claims under these circumstances—and thus empowering women to obtain the contraceptive care—than Plaintiffs are willing to certify their religious objections to the Government in accord with the accommodation.

After enrolling, many women would need to take the additional step of locating a new contraceptive provider who accepts Medicaid.[12] And those women willing to take on that task might be unsuccessful. Each Medicaid program has its own limited set of providers, and those providers may be inaccessible to women living in certain areas. *See* 42 U.S.C. § 1396a (giving states' broad

[12] Private providers that accept employer-sponsored insurance coverage do not necessarily accept Medicaid. According to a 2014 study, about 46 percent of physicians accept Medicaid, a 10% drop from 2010. See John Tozzi, *Losing Patience, and Patients, with Medicaid*, Bloomberg Businessweek (Apr. 10, 2014), http://www.businessweek.com/articles/2014-04-10/doctors-shun-patients-who-pay-with-medicaid (last visited Oct. 27, 2014).

discretion in designing Medicaid programs). Even if women were able to locate a local Medicaid provider, the traditional Medicaid program does not guarantee that every method of contraceptive will be covered for every eligible person.[13] Rather, each state decides for itself which contraceptives it will cover.[14] As a result, female employees provided with Medicaid coverage might still lack coverage for the form of contraception most appropriate for their individual circumstances.

Finally, Plaintiffs' proposal would require State governments to develop an entirely new administrative system to determine eligibility for participation in the program and enrollment. In addition, because Medicaid is a joint state-federal program, the viability of Plaintiffs' Medicaid proposal would depend upon the ability of the federal government to require states to participate in and contribute financially to the implementation of this Medicaid expansion—

---

[13] *See* Cntrs. for Medicare & Medicaid Servs., *The State Medicaid Manual* 4-270, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (last visited Oct. 27, 2014) ("[States] are free to determine the specific services and supplies which will be covered as Medicaid family planning services so long as those services are sufficient in amount, duration and scope to reasonably achieve their purpose.").

[14] *See id.* While the Medicaid expansion population receives coverage for the full range of FDA-approved contraceptives without cost-sharing, expanding Medicaid is optional for states, and 23 states have chosen not to expand Medicaid. *See* Cntrs. for Medicare & Medicaid Servs., *State Medicaid and CHIP Eligibility Standards, available at* http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf. Existing Medicaid beneficiaries in non-expansion states are not entitled to preventative services under the ACA. *See* Sara E. Wilensky and Elizabeth A. Gray, *Existing Medicaid Beneficiaries Left Off The Affordable Care Act's Prevention Bandwagon*, 32 Health Affairs 1188, 1188-89 (2013).

Plaintiffs would be asking the federal government *and the state* to pay for their religious exercise.[15]

Similarly, Plaintiffs' suggestion that the Government expand existing "programs established by duly enacted law"—Title X being the most recognizable such program—is also 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. *See* Second Am. Compl. ¶130.

First, like Plaintiffs' proposal to expand Medicaid, Plaintiffs' suggestion that women could rely on an expanded Title X program would require many women to take on the burden of locating a new provider just for contraceptive service, losing the benefit provided by continuity of care with her preferred doctor.[16] Additionally, as with Medicaid providers, women may have difficulty locating a Title X-funded provider within a reasonable distance.[17]

---

[15] See Cntrs. for Medicare & Medicaid Servs., *Financing and Reimbursement*, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html (last visited Oct. 27, 2014).

[16] 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 Oct. 27, 2014). Grantees include state, county, and local health departments, community health centers, Planned Parenthood Centers, and private nonprofits. *Id.*

[17] 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.

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.[18]

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").[19] 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.[20] *See* 42 CFR § 59.5(a)(8) (2014).

---

[18] The problem of access is also implicated by Plaintiffs' suggestions that the Government work to "increase public awareness of contraceptives available for free or reduced rates." Pls. Opp. to Mot. to Dismiss 36. The issue for many women may not be a lack of awareness, but rather may be lack of local access. *See supra* note 19 and accompanying text.

[19] $19,790 is the 2014 Poverty Guideline for a family of three in the 48 contiguous states and the District of Columbia. 79 Fed. Reg. 3593 (Jan. 22, 2014).

[20] In 2014, 250 percent of the Poverty Guideline for a family of three in the 48 contiguous states and the District of Columbia is $49,475. *See id.*

Above that income level, women pay "the reasonable cost of providing services." *Id.*

Finally, like Medicaid providers, 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, *Program Requirements for Title X Funded Family Planning Projects* (Apr. 2014), *available at* http://www.nationalfamilyplanning.org/document.doc?id=1462.[21]

A few examples demonstrate the impact Plaintiffs' proposals would have on the affected women, and make inescapably clear the defects in those proposals 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,

---

[21] 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).

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.[22] If her hospital is not Title X-funded, Plaintiffs' 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*, http://www.plannedparenthood.org/health-topics/birth-control/iud-4245.htm (last visited Oct. 27, 2014) (noting that insertion of an IUD and related follow-up visits can cost as much as $1000). For a woman in a low-wage job, the up-front cost of the IUD could be nearly a month's salary.[23] Yet Plaintiffs would suggest that she

---

[22] 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.

[23] 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

pay that amount up front, and seek reimbursement the following calendar year through a tax credit or deduction. Even assuming that the full cost of the IUD would ultimately be reimbursed this way—which might not be the case, depending on her income tax liability—the up-front costs may be prohibitive, eliminating the IUD as an option for her. Plaintiffs' 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 best for her and most effective in preventing unwanted pregnancy.

In summary, all of Plaintiffs' 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 burdensome administrative requirements in order to demonstrate eligibility to participate in any such program proposed by Plaintiffs, which represent a further obstacle to gaining access to contraceptives without out-of-pocket cost. In other words, Plaintiffs' proposals would impose significant costs, administrative burdens, and logistical obstacles on Plaintiffs'

Rosenbaum as Amici Curiae in Support of the Government at 17 n.37, *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

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[24]—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 equal opportunity for women.

Because these proposals would have a detrimental effect on the Plaintiffs' 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

[24] Guttmacher Inst., *Contraceptive Use in the United States* (June 2014), http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Oct. 27, 2014).

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 would continue to guarantee such access. *See Hobby Lobby*, 134 S. Ct. at 2759-60. Plaintiffs' 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 reverse the District Court's rulings.

Dated: October 31, 2014

Respectfully submitted,

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

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 6,835 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.

Dated: October 31, 2014

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

By: /s/ Charles E. Davidow
Charles E. Davidow
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on this 31st day of October, 2014, I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit. All participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

Dated: October 31, 2014

By: /s/ Charles E. Davidow
Charles E. Davidow
2001 K Street, NW
Washington, D.C. 20006
(202) 223-7300

Counsel for Amici Curiae