Nos. 14-1430 & 14-1431

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Grace Schools, *et al.*,
Plaintiffs-Appellees,
v.
Kathleen Sebelius, in her official capacity as Secretary
of the United States Department of Health and Human Services, *et al.*,
Defendants-Appellants.

Diocese Of Fort Wayne-South Bend, Inc., *et al.*,
Plaintiffs-Appellees,
v.
Kathleen Sebelius, in her official capacity as Secretary
of the United States Department of Health and Human Services, *et al.*,
Defendants-Appellants.

On Appeal From The United States District
Court For The Northern District Of Indiana,
Nos. 1:12-cv-00159 and 3:12-cv-00459 (Hon. Jon E. DeGuilio)

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

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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court Nos.: 14-1430 & 14-1431

Short Caption: *Grace Schools, et al.* v. *Sebelius, et al.*, No. 14-1430 & *Diocese of Fort Wayne-South Bend, Inc., et al.* v. *Sebelius, et al.*, No. 14-1431

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(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:

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Attorney's Signature: /s/ Charles E. Davidow **Date:** May 19, 2014

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[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.

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 "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity" without cost-sharing requirements ("the contraception regulations"). 42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130 (2013); Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines ("HRSA Guidelines") (last visited May 12, 2014). Implementing regulations exempt certain religious employers from this requirement. *Id.* The regulations also accommodate other non-profit entities that meet certain criteria, by requiring the insurance issuer or third-party administrator to provide payments for contraceptive services separate from the group health insurance policy. 45 C.F.R. § 147.131 (2013).

The plaintiffs in these consolidated cases, Grace Schools *et al.* and Diocese of Fort Wayne-South Bend *et al.* (together, "Plaintiffs") qualify for either the exemption or the accommodation for non-profit entities. Yet, despite the fact that Plaintiffs are not required to cover contraceptive services in their group health insurance plans, they bring various challenges to the contraception regulations. These challenges include a claim under the Religious Freedom Restoration Act ("RFRA"), which 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. Plaintiffs claim that the accommodation violates their RFRA rights.

This Court should find that Plaintiffs' RFRA claim fails. As a panel in the Seventh Circuit has already held in a similar proceeding, the contraception regulations impose no substantial burden on Plaintiffs' religious exercise.[2] *See Notre Dame v. Sebelius*, 743 F. 3d

[2] *Amici*, like the Government, recognize that this Court's decision in *Korte* controls with respect to plans offered by for-profit corporations. *See Korte* v. *Sebelius*, 735 F.3d 654, 687 (7th Cir. 2013).

547, 559 (7th Cir. 2014). Thus, the Court need not reach the additional questions of whether the regulations further compelling interests and use the least restrictive means in advancing those interests. If the Court were to reach those questions, however, it must find that the regulations directly further at least two compelling governmental interests: promoting public health and equality for women. Indeed, even the District Court found that these governmental interests are "important," and assumed for the sake of its decisions that these interests are compelling. *See Diocese of Fort Wayne-South Bend, Inc.* v. *Sebelius*, No. 1:12-CV-159 JD, 2013 WL 6843012, at *15 (N.D. Ind. Dec. 27, 2013); *Grace Schools* v. *Sebelius*, No. 3:12-CV-459 JD, 2013 WL 6842772, at *15 (N.D. Ind. Dec. 27, 2013). As *amici* demonstrate below, the District Court's assumption was correct.

First, contraception is critical to women's health, and providing it with no cost-sharing 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 contraception regulations, the

high costs of contraception affected whether women who sought to avoid pregnancy used contraceptives consistently and whether women used the most appropriate and effective forms of contraception for their circumstances.

Second, by addressing gender gaps in health insurance and helping to remedy the sex-based disparities inherent in failing to provide health insurance coverage for contraception and related services, the contraception regulations advance the compelling governmental interest in ending gender discrimination and promoting gender equality. Indeed, in passing the ACA, Congress recognized that excluding coverage of women's preventive health services constituted discrimination against women. Before the ACA went into effect, women disproportionately bore the costs of health care, and these high costs negatively affected women's health and well-being, as women often lacked access to or forewent necessary health care to keep costs down. The contraception regulations address this disparity and advance equal opportunity in other aspects of women's lives, thus improving women's social and economic outcomes more generally.

In this case, Plaintiffs, who need not provide any coverage for contraception in their group health plans, seek to deny their employees and employees' covered family members the contraceptive coverage benefit to which they are entitled pursuant to the accommodation. Plaintiffs' actions threaten real harm to their employees and employees' covered family members. This harm to the rights and interests of third parties must bear heavily in the analysis of Plaintiffs' claims, as precedent makes clear that the right of religious exercise does not grant a license to harm the rights and interests of third parties.

Because the regulations forward compelling interests and because allowing Plaintiffs to abrogate their employees' rights to this coverage—particularly where Plaintiffs themselves do not have to provide the coverage—would harm third parties, Plaintiffs' claims must fail.

ARGUMENT

I. The Legislative History Of The ACA Demonstrates That The Contraception Regulations Were Enacted To Further Compelling Governmental Interests.

A key component of the ACA is the preventive health services coverage provision, which is designed to enable individuals 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 (2011), *available at* http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx ("IOM Rep."). This provision requires new health insurance plans to provide coverage for certain preventive services with no cost-sharing component. 42 U.S.C. § 300gg-13(a).

The bill as originally introduced in the Senate provided coverage for (1) items or services recommended by the U.S. Preventive Services Task Force ("USPSTF"); (2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and (3) with respect to children, preventive care and screenings recommended by the Health Resources

and Services Administration ("HRSA"). *See* H.R. 3590, 111th Cong. § 2713(a) (as reported Nov. 19, 2009). The USPSTF recommendations, however, "d[id] 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 problem is, several crucial women's health services are omitted" from USPSTF recommendations).

Recognizing this limitation for what it was—a significant gap in coverage that threatened women's health and discriminated against women—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 May 12, 2014).

In relevant part, the Amendment proposed a fourth category of preventive coverage:

> (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.

155 Cong. Rec. S11,985, S11,986 (daily ed. Nov. 30, 2009) (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 (daily ed. Dec. 3, 2009) (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" and to "end the punitive practices of the private insurance companies in their gender discrimination." 155 Cong. Rec. S12,021, S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski); *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."). In enacting the Amendment, 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, and in some instances were unable to obtain this care at all because of 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 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 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 S12,027 (statement of Sen. Gillibrand) (emphases added).

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) ("[A]ffordable 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."). The Senate adopted the Women's Health Amendment by a vote of 61 to 39. *See* 155 Cong. Rec. S12,265, S12,277.

To meet the Women's Health Amendment's objectives, HRSA commissioned the Institute of Medicine ("IOM")[3] to "convene a diverse 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 the Department of Health and Human Services ("HHS")] to consider in order to fill those gaps." IOM Rep. at 20-21. IOM assembled a committee of independent experts in the subject fields, which employed a rigorous methodology to analyze the relevant evidence. *See id.* at 20-21, 67. The IOM panel articulated the need to focus on the distinct preventive health needs of women because "women not only have different health care needs than men (because of

[3] The IOM is an independent, nonprofit organization that provides unbiased evidence to help those in government and the private sector make informed health decisions. *See About the IOM*, Inst. of Med., http://www.iom.edu/About-IOM.aspx (last visited May 12, 2014).

reproductive differences) but also manifest different symptoms and responses to treatment modalities." *Id.* at 18.

After conducting its analysis, the IOM panel recommended eight preventive services for women, including "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." *Id.* at 109-10. On August 1, 2011, HRSA adopted the recommendations set forth in the IOM Report. *See* HRSA Guidelines.

While the ACA's inclusion of contraceptive coverage was significant, it was not groundbreaking. For years, "[n]umerous health care professional associations and other organizations [have] recommend[ed] the use of family planning services as part of preventive care for women . . . ." IOM Rep. at 104. Additionally, various state and federal laws have recognized the compelling interest in providing such coverage. For example, twenty-eight states require health plans to cover contraception, and the Equal Employment Opportunity Commission ("EEOC") interprets Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act ("PDA"), to require

employers that provide health coverage for other prescription drugs and devices or other preventive health services also to provide coverage for contraception. Decision on Coverage of Contraception, at 5 (EEOC Dec. 14, 2000) ("EEOC Decision"). In its decision, the EEOC made clear that "Because the health needs of women may change—and because different women may need different prescription contraceptives at different times in their lives—[employers] must cover each of the available options for prescription contraception." *Id.* Moreover, since 1972, Medicaid has required coverage for family planning in all state programs with no cost-sharing requirements. IOM Rep. at 108. The objectives of Medicaid's family planning policy were "to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families." U.S. Dep't of Health, Education, & Welfare, Handbook of Public Assistance Administration, Supplement D (1966). The policy also recognized the importance of providing women with a range of contraceptive methods, explaining that "[t]here shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences." *Id.*

Therefore, various governmental and non-governmental actors have recognized that contraceptive coverage advances compelling interests. However, none of these incremental steps have been able to accomplish what the contraception regulations will—an across-the-board requirement that all FDA-approved contraceptive methods and related education and counseling be made available to women through their health insurance without any cost-sharing. Comprehensive contraceptive coverage is no longer dependent on a woman's income level, the state in which she resides, or the health plan she chooses.[4] It is this fundamental shift in coverage of contraception—applicable across the nation—that makes the contraception regulations so critical to forwarding the Government's compelling interests.

[4] For example, twenty-two states do not have laws requiring contraception coverage; in the states that have contraceptive equity laws, the laws do not reach "self-funded" plans, which are considered to be employer benefit plans that are governed by federal law. In addition, Title VII and the PDA do not reach employers with fewer than 15 employees, and Medicaid is only available for low-income women; in fact, many state Medicaid programs do not reach their entire low-income population.

II. The Contraception Regulations Further Compelling Governmental Interests.

A. Safeguarding Public Health Is a Compelling Governmental Interest.

"[T]he 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)), *aff'd by Seven-Sky* v. *Holder*, 661 F.3d 1 (D.C. Cir. 2011). As the IOM Report makes clear, access to FDA-approved contraceptive methods and patient education and counseling 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. Indeed, the health of Plaintiffs' female employees and Plaintiffs' employees' covered family members is at stake in these cases.

1. *Unintended Pregnancies Are Highly Prevalent in the United States and Have Serious Health Consequences for Women and Children.*

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). Unintended pregnancy is associated with a wide range of negative health consequences for the woman and the resulting child. Addressing the high unintended pregnancy rate is of great interest to the Government and has been deemed a national objective by HHS. *See* U.S. Dep't of Health & Human Servs., *Healthy People 2020: Family Planning*, http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=13 (last visited May 12, 2014) ("*Healthy People 2020*"). *See also Notre Dame*, 743 F. 3d at 548-49 ("The health concerns that motivated the inclusion of contraception in the guidelines on needs of women for preventive care begin with the fact that about half of all pregnancies in the United States are unintended, and 40 percent of them end in abortion and many others in premature births or other birth problems.")

While unintended pregnancy is highly prevalent in the United States—significantly more so than in comparably-developed countries[5]—this need not be the case. *See* IOM Rep. at 102.

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

Contraception is highly effective in preventing unintended pregnancy. Failure rates of FDA-approved contraception are negligible with proper use. For example, 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.* at 105.

Studies document 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 during pregnancy, and to suffer from domestic violence during pregnancy. *See* IOM Rep. at 103; *Healthy People 2020*. Moreover, some women rely on contraception to avoid pregnancy due to other medical conditions.[6] 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* IOM Rep. at 103.

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

[6] 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* IOM Rep. at 107.

An unintended pregnancy may also cause negative health consequences for the children resulting from unintended pregnancy. 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 id.* These children are more likely to experience poor mental and physical health during childhood, and have lower educational attainment and more behavioral issues in their teen years. *See* Logan et al., *The Consequences Of Unintended Childbearing: A White Paper*, at 5-6 (Child Trends, Inc., ed. 2007).

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, alongside vaccinations and control of infectious diseases, noting:

> 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. 241-43 (1999), http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm (last visited May 12, 2014) ("*Ten Great Public Health Achievements*").

2. *Providing Access to the Full Range of FDA-Approved Contraceptive Methods and Counseling and Education Services Without Cost-Sharing Forwards Women's Health.*

By requiring coverage of the full range of FDA-approved contraceptive methods without cost-sharing, including IUDs and emergency contraception, the contraception regulations ensure that women can choose the contraceptive method that fits their needs "depending upon their life stage, sexual practices, and health status." IOM Rep. at 105. 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.

This coverage without cost-sharing is especially critical because the most highly effective methods of birth control carry large up-front costs. For example, the up-front costs of the IUD can range between $500 and $1000. *See IUD*, Planned Parenthood Fed'n of Am., http://www.plannedparenthood.org/

health-topics/birth-control/iud-4245.htm (last visited May 12, 2014). 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.*

Studies show that these high costs lead women to forego contraception completely, to choose less effective contraception methods, or to use contraception inconsistently or incorrectly. *See, e.g.*, *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions*, Guttmacher Inst., 5 (Sept. 2009), 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). Accordingly, the costs of contraception can pose significant risks of unintended pregnancy, as "even a brief gap in [contraceptive] method use can have a major impact." Gold, *The Need for and Cost of Mandating Private Insurance*

Coverage of Contraception, 1 Guttmacher Rep. on Pub. Pol'y 5, 6 (Aug. 1998) ("Gold").

Evidence shows that eliminating cost barriers to contraception and providing education and counseling about the available methods can greatly reduce the incidence of unintended pregnancy. 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); *see* Nat'l Bus. Grp. on Health, *Investing in Maternal and Child Health: A Toolkit*, (2007) Part 4, at 12, 37-38 (advising employers to cover "comprehensive contraception options" and reduce or eliminate cost sharing to "help prevent unintended pregnancies").

In another study, Kaiser Permanente found that when out-of-pocket costs for contraceptives were eliminated or reduced, their use—particularly of the most effective forms of contraception—increased and the estimated annual contraceptive failure rate decreased. *See* Postlethwaite et al., *A Comparison of Contraceptive*

Procurement Pre- and Post-Benefit Change, 76 Contraception 360, 360, 363 (2007).

By removing cost barriers to contraceptive methods and the education and counseling that help women identify the most effective methods of contraception appropriate for them, the contraception regulations forward compelling health interests, including those of Plaintiffs' female employees and employees' covered family members.

B. The Contraception Regulations Forward the Compelling Governmental Interest of Promoting Gender Equality.

The Government has a compelling interest in providing access to contraception without cost-sharing, in order to help remedy the longstanding practice of denying insurance coverage for reproductive health care, a practice that imposes costs primarily on women. In addition, by improving women's ability to control whether and when they will have a child, contraceptive access also fosters women's ability to participate in education and the workforce on equal footing with men. The regulations forward this compelling interest in women's equality both among the broader public and for the Plaintiffs' female employees and employees' covered family members.

1. *Promoting Gender Equality, Including Equal Access to Health Care, Is a Compelling Governmental Interest.*

Eliminating gender discrimination and promoting women's equality are compelling state interests. *Bd. of Dirs. of Rotary Int'l* v. *Rotary Club of Duarte*, 481 U.S. 537, 549 (1987); *Roberts* v. *U.S. Jaycees*, 468 U.S. 609, 626 (1984). Specifically, the Supreme 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; *United States* v. *Virginia*, 518 U.S. 515, 532 (1996) (noting that fundamental principles are violated when "women, simply because they are women" are denied the "equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities"); *Catholic Charities of Sacramento, Inc.* v. *Superior Court of Sacramento Cnty.*, 85 P.3d 67, 92 (Cal. 2004) ("The [contraceptive coverage law] serves the compelling state interest of eliminating gender discrimination.").

2. *Excluding Contraceptive Coverage Discriminates Against Women.*

Making basic preventive health care available without cost to men, but not to women, discriminates on the basis of sex. Moreover, when effective contraception is not used, and unintended pregnancy results, it is women who incur the attendant physical burdens and medical risks of pregnancy, women who disproportionately bear the health care costs of pregnancy and childbirth, and women who often face barriers to employment and educational opportunities as a result of pregnancy.

Indeed, the EEOC, in considering a Title VII challenge to an employer's failure to include contraceptive coverage in its health insurance policy that provided otherwise comprehensive coverage of prescription drugs and other preventive services, found that Congress, in passing the PDA, sought to "equalize employment opportunities for men and women" and to "address discrimination against female employees that was based on assumptions that they would become pregnant." EEOC Decision at 1-3. Noting that "[c]ontraception is a means by which a woman controls her ability to become pregnant," the EEOC accordingly held 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.[7]

Congress, in passing the Women's Health Amendment, was acting on the same principle as the EEOC: that increased access to contraception promotes equality for women. By ensuring that women and men are equally able to access basic preventive health care services without cost-sharing, the contraception regulations advance the compelling interest in remedying sex discrimination in the provision of health care.

[7] Several federal courts have agreed with the EEOC. *See, e.g., Erickson* v. *Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1276 (W.D. Wash. 2001) (adopting EEOC reasoning that "the exclusion of prescription contraceptives from a generally comprehensive insurance policy constitutes sex discrimination under Title VII"); *Mauldin* v. *Wal-Mart Stores, Inc.*, No. 01-cv-2755, 2002 WL 2022334, at *19 (N.D. Ga. Aug. 23, 2002) (certifying class of female employees alleging that a lack of coverage of prescription contraception violated Title VII and the PDA); *but see In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 943 (8th Cir. 2007) (disagreeing with the EEOC's conclusion that the PDA requires employers to provide contraception coverage). Moreover, several states have interpreted their laws prohibiting sex discrimination to require health insurance coverage of contraception and related medical services. *See, e.g.*, Mich. Civil Rights Comm'n, *Declaratory Ruling on Contraceptive Equity*, at 1 (Aug. 21, 2006); 51 Mont. Op. Att'y Gen. 16, at 7 (Mar. 28, 2006); Office of the Wisc. Att'y Gen., OAG-1-04, 2004 WL 3078999, at 1-2 (Aug. 16, 2004).

3. *Women's Disproportionate Share of Health Care Costs, Including the Cost of Contraceptives, Harms Women's Health and Economic Status.*

Prior to the ACA, pervasive gender inequalities existed in the provision of health care. The historical failure to cover women's health needs to the same extent as men's has meant that women have paid more out-of-pocket costs and disproportionately borne the burden of health care expenditures. *See* IOM Rep. at 18-19.

Prior to the reforms made possible by the ACA, women paid substantially more to access basic health care than do men and are significantly more likely to be burdened with high medical costs. Women of childbearing age spend 68% more in out-of-pocket health care costs than men. Gold at 5; *see also* Women's Research & Educ. Inst., *Women's Health Insurance Costs and Experiences*, at 2 (1994). The cost of contraception contributes to this disparity. *See* Liang et al., *Women's Out-Of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills Between 1996 and 2006*, 83 Contraception 528, 531 (2011).

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. Women of color earn even less.[8] Moreover, women, particularly women of color, are more likely to be poor than men,[9] thus increasing the likelihood that women will face cost barriers to accessing needed health care. Requiring insurance coverage of birth control without cost-sharing thus helps to ensure that women do not continue to face a health insurance gap alongside this income gap.

4. *Promoting Women's Access to Contraception Leads to Greater Social and Economic Opportunities for Women.*

Contraception puts women in control of their fertility, allowing them to decide whether, and when, to bear children. As the Supreme Court has recognized, "[t]he ability of women to participate

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[8] For every dollar earned by white, non-Hispanic men, African American women earn just 64 cents, while Hispanic women earn just 54 cents. Nat'l Women's Law Ctr., *FAQ About the Wage Gap*, at 2 (2013), *available at* http://www.nwlc.org/sites/default/files/pdfs/wage_gap_faqs_sept_2013.pdf.

[9] In 2011, the poverty rate for women in the U.S. was 14.6%, compared with 10.9% for men. For African American women, the rate was 25.9% and 23.9% for Hispanic women. 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.

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). Similarly, the Centers for Disease Control and Prevention recognized that "[a]ccess to family planning and contraceptive services has altered social and economic roles of women." *Ten Great Public Health Achievements*.

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) ("Frost & Lindberg"). 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. 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. One study looking at the effect of access to birth control on women's education and employment in the 1970s reports that "women in states with easier and earlier pill access were 10% to 20% more likely to be enrolled in college at age 21 and had higher earnings trajectories that persisted even into their 40s—a finding that remained robust even after netting out the influence of other factors." The Nat'l Campaign to Prevent Teen and Unplanned Pregnancy, *Getting the Facts Straight on the Benefits of Birth Control in America: Summary*, Nov. 2013, at 3.

In addition, 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* 26 (Nat'l Bureau of Econ. Research, Working Paper No. 17922, Mar. 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. *See id.* at 27. 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). 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 Women's Health Amendment, Congress understood that the Amendment—including its broadening of access to family planning services—would be "a huge step forward for justice and equality in our country." 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 1, 2009) (statement of Sen. Franken).

III. The Rights And Interests Of The Employees And Family Members Covered By The Contraception Regulations Bear Heavily On The Plaintiffs' RFRA Claims.

The Government's compelling interests in advancing public health and gender equality make clear that granting Plaintiffs the relief they seek would threaten real harm to third parties—the female employees and their employees' covered family members who are entitled to contraceptive coverage under the accommodation. Plaintiffs want to deny these women access to contraceptive coverage and related education and counseling without cost sharing, even though they are not required to provide the coverage in their own group insurance plan. In the absence of this coverage, these women could be forced to forgo the most effective and most appropriate method of contraception for them and will bear costs in accessing basic preventive health care that men need not shoulder. This harm to third parties is highly relevant in considering Plaintiffs' RFRA claims.

In enacting RFRA, Congress was clear that it intended to restore the full breadth of Free Exercise jurisprudence as it existed prior to *Employment Division, Dep't of Human Resources of Oregon* v. *Smith*, 494 U.S. 872 (1990). *See, e.g.*, S. Rep. No. 103-111, at 12,

reprinted in 1993 U.S.C.C.A.N. 1892, 1902 ("[T]he purpose of this act is only to overturn the Supreme Court's decision in Smith . . ."); *id.* at 8-9 ("The committee expects that the courts will look to free exercise cases decided prior to Smith for guidance. . . ."). Thus, when applying RFRA's compelling interest test, this Court must consider how Free Exercise cases were decided prior to *Smith*.

As pre-*Smith* jurisprudence made clear, "[n]ot all burdens on religion are unconstitutional." *United States* v. *Lee*, 455 U.S. 252, 257 (1982). Indeed, when applying the balancing test set out in *Sherbert* v. *Verner*, 374 U.S. 398 (1963), that RFRA restored, the Supreme Court has routinely held that religious activities must give way to the administration of general public welfare legislation. *See Bowen* v. *Roy*, 476 U.S. 693, 708-12 (1986); *Lee*, 455 U.S. at 261; *Bob Jones Univ.* v. *United States*, 461 U.S. 574, 604 (1983); *Hernandez* v. *Comm'r of Internal Revenue*, 490 U.S. 680, 700-01 (1989). Prior to *Smith*, the Supreme Court generally protected the exercise of religion when the "sole conflict is between authority and rights of the individual" but permitted much less latitude when the plaintiff's religious practice "bring[s] them into collision with rights asserted by any other

individual. . . ." *W. Va. State Bd. of Educ.* v. *Barnette*, 319 U.S. 624, 630 (1943).

For example, in *United States* v. *Lee*, the Supreme Court rejected a challenge by an Amish employer with Amish employees who claimed that withholding social security taxes violated the employer's free exercise rights. 455 U.S. at 258. The Court distinguished *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972), which exempted an Amish family from a school attendance law despite the State's interest in ensuring children's educational opportunities, by noting that one employer's religious beliefs could not override a broad federal scheme to his employees' detriment:

> When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. Granting an exemption from social security taxes to an employer operates to impose the employer's religious faith on the employees.

Lee, 455 U.S. at 259-61; *see also Cutter* v. *Wilkinson*, 544 U.S. 709, 720 (2005) (reviewing the Religious Land Use and Institutionalized Persons Act and emphasizing that "courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries").

As these cases demonstrate, the Supreme Court has never held that religious exercise provides a license to harm others or violate third parties' rights. RFRA did not overturn this basic principle. *See* S. Rep. No. 103-111, at 9 ("This bill is … the restoration of the legal standard that was applied in [prior free exercise] decisions. Therefore, the compelling interest test generally should not be construed more stringently or more leniently than it was prior to *Smith*.").

Granting the relief Plaintiffs seek would harm a significant number of third parties: Plaintiffs' female employees and the employees' covered family members. Granting Plaintiffs relief would completely deny these women the contraceptive coverage benefit to which they are entitled, even though Plaintiffs do not have to provide that benefit, thereby inflicting upon the women the very harms Congress meant to eliminate. To grant Plaintiffs relief would also deny these women coverage for education and counseling about their birth control options, thus inappropriately interfering in the provider-patient relationship and women's ability to give fully-informed consent. The absence of contraceptive coverage jeopardizes the health of these women and any children they might conceive. It subjects them to financial burdens that

men in the same group health plan do not face. And it has long-term negative consequences for women's and their families' economic, educational, and employment opportunities. In short, granting relief to Plaintiffs would improperly "impose the employer's religious faith on the employees," to those employees' detriment. *See Lee*, 455 U.S. at 261.

CONCLUSION

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

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(d) because it contains 5,869 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of May, 2014, 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.

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