No. 12-3357

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FRANK O'BRIEN JR., O'BRIEN INDUSTRIAL HOLDINGS, LLC,

Plaintiffs-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, KATHLEEN SEBELIUS, in her official capacity as Secretary of the United States Department of Health and Human Services, UNITED STATES DEPARTMENT OF THE TREASURY, TIMOTHY GEITHNER, in his official capacity as Secretary of the United States Department of the Treasury, UNITED STATES DEPARTMENT OF LABOR, and HILDA SOLIS, in her official capacity as Secretary of the United States Department of Labor,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI-EASTERN DIVISION
CASE NO. 12-CV-0476 CEJ

BRIEF OF THE NATIONAL WOMEN'S LAW CENTER AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES AND AFFIRMANCE

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

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

Counsel for Amicus Curiae

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, the National Women's Law Center discloses that it has no parent corporation and is a nonprofit entity that issues no stock. Accordingly, no publicly held corporation owns 10% of its stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

RULES AND REGULATIONS

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

INTEREST OF AMICUS CURIAE

The National Women's Law Center ("NWLC") is a nonprofit legal advocacy organization dedicated to the protection of women's legal rights and the advancement of women's opportunities since its founding in 1972. Women have long faced great difficulty obtaining comprehensive, affordable health coverage due to harmful and discriminatory health insurance industry practices. The Patient Protection and Affordable Care Act ("ACA") remedies many of these practices, expanding women's access to health care and health insurance coverage. In particular, the Women's Health Amendment and the regulations promulgated pursuant to it, which require coverage of preventive care and screenings for women's health without cost-sharing, ensures broad access to contraception, a critical component of preventive care for women. NWLC is profoundly concerned about the impact that the Court's decision may have on women's ability to access this necessary, preventive care.[1]

BACKGROUND AND SUMMARY OF ARGUMENT

Contraceptive services are a key component of preventive health care for women. To further its goals of bettering the health and welfare of all Americans, the ACA includes a preventive health services coverage provision,

[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 amicus or its counsel, contributed money that was intended to fund the preparation or submission of this brief.

which requires all new insurance plans to cover certain preventive care and screenings with no cost-sharing requirement. 42 U.S.C. § 300gg-13(a). Because women have unique health needs, particularly with respect to their reproductive capacities, Congress passed the Women's Health Amendment to ensure adequate coverage of preventive health services for women. *Id.* at § 300gg-13(a)(4). With the help of independent experts who studied issues relating to women's health, the Health Resources and Services Administration ("HRSA"), an agency within the U.S. Department of Health and Human Services ("HHS"), recommended coverage of eight preventive services for women with no cost-sharing requirement, including "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." Health Res. & Servs. Admin., Dep't of Health & Human Servs., *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines ("HRSA Guidelines"), *implemented by* 77 Fed. Reg. 8,725 (Feb. 15, 2012) (requiring compliance for all plan years beginning on or after Aug. 1, 2012).

Plaintiffs challenge the regulations that require contraception coverage with no cost-sharing requirement (the "contraception regulations") on several grounds, including an alleged violation of the Religious Freedom Restoration Act ("RFRA"). This challenge must fail. The contraception

regulations do not violate RFRA because they do not substantially burden Plaintiffs' exercise of religion. Moreover, as *Amicus* will demonstrate herein, even if the regulations did substantially burden religious exercise, they do not run afoul of RFRA because they further the compelling governmental interests of safeguarding public health and promoting gender equality in the least restrictive means possible.

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

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

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

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

Twenty-eight states have passed legislation mandating contraceptive coverage. None of these laws has been found to burden religious exercise. The highest courts in both California and New York rejected challenges to such laws, holding that the laws advance the governmental interests in women's health and gender equality. *See Catholic Charities of the Diocese of Albany* v. *Serio*, 859 N.E.2d 459, 461 (N.Y. 2006), *cert. denied* 552 U.S. 816 (2007) (holding that a contraceptive coverage law did not violate the establishment or free exercise clauses of the federal or state constitutions); *Catholic Charities of Sacramento, Inc.* v. *Super. Ct.*, 85 P.3d 67, 73-74 (Cal. 2004), *cert denied* 543 U.S. 816 (2004)

(same). This Court, too, should find that the inclusion of contraception as a required component of preventive health services with no cost-sharing requirement withstands Plaintiffs' challenge.

ARGUMENT

Defendants, acting within the scope of their authority to regulate the health insurance market, have issued regulations setting forth the minimum requirements for the provision of preventive care and screenings for women. Plaintiffs challenge the contraception regulations under RFRA, which provides generally that the Government shall not "substantially burden a person's exercise of religion" unless the burden "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1.

The District Court properly found that the contraception regulations do not "substantially burden" Plaintiffs' exercise of religion, so it did not reach the question of whether the regulations are the least restrictive means of furthering a compelling governmental interest. This Court, too, need not reach this question. In the event that it does, however, as this brief demonstrates, the contraception regulations clearly further the compelling governmental interests of public health and equal opportunity for women, in the least restrictive means possible.

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

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

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

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

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

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

Recognizing this limitation for what it was—a significant gap in coverage that threatened women's health—Senator Mikulski sponsored the Women's Health Amendment to ensure "essential protection for women's access to preventive health care not currently covered in other prevention sections of the [ACA]." *Mikulski Amendment Improves Coverage of Women's Preventive Health Services and Lowers Costs to Women*, http://www.mikulski.senate.gov/_pdfs/Press/MikulskiAmendmentSummary.pdf (last visited Jan. 2, 2013); *see also* 155 Cong. Rec. S11,985, S11,986 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski) ("[A]s I reviewed the bill, I felt we could do more to be able to enhance and improve women's health care. . . . The essential aspect of my amendment is

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

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

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

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

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

> Women must shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage. Not only do we pay more for the coverage we seek for the same age and the same coverage as men do, but in general women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. . . . In America today, too many women are delaying or skipping preventive care because of the costs and copays and limited access.

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

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

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

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

[2] The IOM is an independent, nonprofit organization that provides unbiased, authoritative evidence to help those in government and the private sector make

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

The IOM's inclusion of contraceptive services in standard preventive care for women is significant, but not groundbreaking. "Numerous health care professional associations and other organizations recommend the use of family

---

informed health decisions. *See* Inst. of Med., *About the IOM*, http://www.iom.edu/About-IOM.aspx (last visited Jan. 2, 2013).

planning services as part of preventive care for women . . . ." *Id.* at 104. Twenty-eight states require contraceptive coverage. *Id.* at 108. Moreover, contraceptive coverage has become standard practice for most private and federally-funded insurance programs, and, since 1972, Medicaid has required coverage for family planning in all state programs with no cost-sharing requirements. *Id.*

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

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

A. Safeguarding Public Health Is a Compelling Governmental Interest.

"[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)); *see also Catholic Charities of the Diocese of Albany*, 859 N.E.2d at 468 (rejecting a challenge to contraceptive

coverage, in part in consideration of "the State's substantial interest in fostering equality between the sexes, and in providing women with better health care"). Courts have long recognized public health as a matter of compelling governmental interest. *See, e.g.*, *Fla. Bar* v. *Went For It, Inc.*, 515 U.S. 618, 625 (1995) ("[A]s part of their power to protect the public health, safety, and other valid interests [States] have broad power to establish standards for licensing practitioners and regulating the practice of professions.") (internal quotations omitted); *Crow* v. *Gullet*, 706 F.2d 856, 858 (8th Cir. 1983) (per curiam) (affirming district court's holding that state interest in protecting the health and welfare of park visitors was a compelling interest in the face of a free exercise clause challenge).

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

As the IOM Report and HRSA Guidelines make abundantly clear, access to contraception without cost sharing is a critical component of preventive care for women that has demonstrable benefits for the health of women and children. Simply put, increasing access to contraception is a matter of public health.

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

Nearly half of all pregnancies in the United States each year are unintended (i.e. unwanted or mistimed at the time of conception). *See* Finer &

Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPS. ON SEXUAL & REPROD. HEALTH 90, 92 (2006). Unintended pregnancy is associated with a wide range of negative health consequences for the woman and any resulting child. Addressing this public health crisis is of great interest to the government. The HHS program that sets national objectives for improving U.S. public health seeks to increase the proportion of pregnancies that are intended, specifically from 51% as reported in 2002 to 56% by 2020. *See* Dep't of Health & Human Servs., *Healthy People 2020: Family Planning*, http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=13 (last visited Jan. 2, 2013) ("*Healthy People 2020*").

While unintended pregnancy is highly prevalent in the United States—significantly more so than in comparably-developed countries[3]—this need not be the case. *See* IOM REP. at 104. Contraception is highly effective in preventing unintended pregnancy. Failure rates of FDA-approved contraception are negligible with proper use, as compared with an 85% chance of pregnancy within 12 months with no contraception. *See id.* at 105. Studies show that as rates of contraceptive use increase, rates of unintended pregnancy and abortion decline. For example, one study found that between 1982 and 2002, an increase in

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

contraceptive use among unmarried women contributed significantly to a decrease in unintended pregnancy and abortion rates. *See* Boonstra et al., Guttmacher Inst., ABORTION IN WOMEN'S LIVES, at 18 (2006), *available at* http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf. A study of teen pregnancy rates found that a significant decline from 1991 to 2005 and moderate increase in 2006 and 2007 could be explained by a corresponding increase and then decline in teen contraceptive use over the same period. *See* Santelli & Melnikas, *Teen Fertility in Transition: Recent and Historic Trends in the United States*, 31 ANN. REV. OF PUB. HEALTH 371, 379 (2010) (finding also that lower levels of teen contraceptive use accounted for greater rates of teen pregnancies in the United States than in other developed countries). A research project in Iowa implementing several programs to increase knowledge and access to contraception found significant increases in contraceptive use and corresponding decreases in unintended pregnancy and abortion over the five year period from 2007 through 2012. *See* Iowa Initiative to Reduce Unintended Pregnancies, *Preliminary Findings*, http://www.iowainitiative.org/uploads/pdf/iiclinicresearch.pdf (last visited Jan. 2, 2013).

Despite its effectiveness, many women misuse or fail to use contraception because of cost. Studies show that high costs lead women to forego contraception altogether, to choose less effective contraception methods, or to use

contraception inconsistently or incorrectly. *See, e.g.*, Guttmacher Inst., A REAL-TIME LOOK AT THE IMPACT OF THE RECESSION ON WOMEN'S FAMILY PLANNING AND PREGNANCY DECISIONS, at 5 (2009), *available at* http://www.guttmacher.org/pubs/RecessionFP.pdf ("A REAL-TIME LOOK") (finding that, in order to save money, women forewent contraception, skipped birth control pills, delayed filling prescriptions, went off the pill for at least a month, or purchased fewer birth control packs at once). These responses to contraception's costs pose significant risks of unintended pregnancy, as "even a brief gap in [birth control] method use can have a major impact." Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, GUTTMACHER REP. ON PUB. POL'Y, Aug. 1998, at 6 ("Gold").

Eliminating cost barriers to contraception can greatly reduce the incidence of unintended pregnancy. A study conducted by the Washington University in St. Louis School of Medicine found a "clinically and statistically significant reduction" in unintended pregnancies where at-risk women received contraceptive counseling and reversible contraceptive methods of their choice at no cost. *See* Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291, 1291 (2012). In another recent study, Kaiser Permanente found that when out-of-pocket costs for contraceptives were eliminated or reduced, women were more likely to rely on

more effective, long-acting contraceptive methods. *See* Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 CONTRACEPTION 360, 363 (2007).

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

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

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

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

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

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

> Access to family planning and contraceptive services has altered social and economic roles of women. Family planning has provided health benefits such as smaller family size and longer interval between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs.

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

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

A. Promoting Gender Equality, Including in the Provision of Health Care, Is a Compelling State Interest.

The United States Supreme Court has held promoting women's equality and eliminating gender discrimination to be compelling state interests, justifying state action burdening First Amendment interests through the least restrictive means available. *Roberts* v. *U.S. Jaycees*, 468 U.S. 609 (1984) (finding that a state law forbidding gender discrimination in public accommodations did not unconstitutionally burden First Amendment right of expressive association). Specifically, the Court has recognized "the importance, both to the individual and to society, of removing the barriers to economic advancement and political and social integration that have historically plagued certain disadvantaged groups, including women," and has thus found that "[a]ssuring women equal access to . . . goods, privileges, and advantages clearly furthers compelling state interests." *Id.* at 626; *see also id.* at 623 (holding that the state's "compelling interest in eradicating discrimination against its female citizens" justified the statute's impact on associational freedoms); *id.* at 624 (stating that state's goal of "eliminating discrimination and assuring its citizens equal access to publicly available goods and services . . . . plainly serves compelling state interests of the highest order"); *U.S.* v. *Virginia*, 518 U.S. 515, 532 (1996) (noting the fundamental principle that is

violated when "women, simply because they are women" are denied the "equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities"); *Equal Emp't Opportunity Comm'n* v. *Fremont Christian Sch.*, 781 F.2d 1362, 1368-69 (9th Cir. 1986) (rejecting a school's free exercise challenge to the application of Title VII to its health insurance plan, which was offered only to "heads of households"—defined as single persons and married men—based on the government's compelling interest in eliminating employment discrimination); *Catholic Charities of Sacramento, Inc.*, 85 P.3d at 92-93 ("The [contraceptive coverage law] serves the compelling state interest of eliminating gender discrimination.").

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

Pervasive gender inequalities exist in the provision of health care.[5] Women's unique health needs, particularly as related to reproductive health, generate additional costs, causing health care expenditures to disproportionately burden women. *See* IOM REP. at 19. A primary contributing factor to these cost disparities is the high cost of contraception. And improving access to

[5] This section discusses disparities existing prior to the passage of the ACA. Of course, that legislation—in particular, the contraception regulations promulgated thereunder—takes great steps towards eradicating these disparities.

contraception promotes gender equality generally, as it improves the social and economic status of women.

1. Women are disproportionately burdened by health care costs.

Women pay substantially more to access basic health care than do men. In 2007, 35% of working-age women spent 10% or more of their income on out-of-pocket health care costs, compared to 31% of men. Rustgi et al., The Commonwealth Fund, WOMEN AT RISK: WHY MANY WOMEN ARE FORGOING NEEDED HEALTH CARE, at 3 (2009), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf ("Rustgi et al."). This same study showed even starker results among low-income women: 55% of women earning less than $20,000 spent more than 10% of their income on out-of-pocket health care costs in 2007. *Id.* Furthermore, 62% of women, compared with 48% of men, reported trouble paying medical bills, cost barriers to needed health care, or both. *Id.* at 2; *see also* Robertson & Collins, The Commonwealth Fund, WOMEN AT RISK: WHY INCREASING NUMBERS OF WOMEN ARE FAILING TO GET THE HEALTH CARE THEY NEED AND HOW THE AFFORDABLE CARE ACT WILL HELP, at 21 (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1502_Robertson_women_at_risk_reform_brief_v3.pdf ("Robertson & Collins") (in 2010, 44% of women, compared to 35% of

men, reported problems paying medical bills in the previous year or reported that they were paying off medical debt over time). Studies also show that women more so than men—32% of women versus 24% of men—are unable to pay for basic necessities, such as food, heat, or rent, or take on a loan or credit card debt due to medical bills. Rustgi et al. at 5.

Magnifying the effects of these high costs is the fact that women earn, on average, just 77 cents for every dollar earned by men. 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. And women are more likely to be poor than men: in 2011, the poverty rate for women was 14.6%, compared with 10.9% for men. Nat'l Women's Law Ctr., INSECURE AND UNEQUAL: POVERTY AND INCOME AMONG WOMEN AND FAMILIES 2000-2011, at 3 (2012), *available at* http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_povertyreport.pdf.

These costs lead women, more than men, to forego necessary medical care. A 2007 survey showed that 52% of women did not fill a prescription; skipped a recommended medical test, treatment or follow-up; did not visit a doctor when they had a medical problem; or did not get necessary specialist care due to cost, compared with 39% of men. Rustgi et al. at 3. And, although women are more-frequent users of preventive health care services, a 2010 study showed that

only 46% of women were up-to-date on recommended preventive screenings, including blood pressure, cholesterol, cervical cancer, colon cancer and breast cancer. Robertson & Collins at 8-9. Another study reported that "[n]early one out of four women report having put off a gynecological or birth control visit to save money in the past year." A REAL-TIME LOOK at 6. In 2007, 79% of women with medical debt or problems paying medical bills reported not pursuing necessary health care because of cost. Rustgi et al. at 5.

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

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

A significant portion of the health care cost disparities faced by women result from reproductive and gender-specific conditions. IOM REP. at 19. "Compared with men, women require more health care services during their reproductive years (ages 18 to 45), have higher out-of-pocket medical costs, and have lower average incomes." Rustgi et al. at 1. Women of childbearing age spend 68% more in out-of-pocket health care costs than men. Gold at 5; *see also* Women's Research and Educ. Inst., WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES, at 2 (1994).

Contraception accounts for much of the disparity. Oral contraception costs women, on average, $2,630 over five years. Trussell et al., *Erratum to* "*Cost Effectiveness of Contraceptives in the United States*," 80 CONTRACEPTION 229, 229 (2009). Other hormonal contraceptives—including injectable contraceptives, transdermal patches and the vaginal ring—cost women between $2,300 and $2,800 over a five-year period. *Id.*

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

Access to contraception promotes equal opportunities far beyond the medical realm by improving women's social and economic status. Contraception puts women in control of their fertility, allowing them to decide whether, and when, to become parents. In one study, 60% of women reported the ability to better control their lives as a very important reason for using birth control. Frost & Lindberg, Guttmacher Inst., REASONS FOR USING CONTRACEPTION: PERSPECTIVES OF US WOMEN SEEKING CARE AT SPECIALIZED FAMILY PLANNING CLINICS, at 9 (2012), *available at* http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf ("Frost & Lindberg"). Indeed, the U.S. Supreme Court has found that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 856 (1992); *see also Erickson* v. *Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001)

("[T]he adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the marketplace and the world of ideas.") (internal quotations omitted).

Increased control over reproductive decisions, in turn, has provided women with educational and professional opportunities that have increased gender equality over the decades since birth control was introduced. Indeed, "[e]conomic analyses have found clear associations between the availability and diffusion of oral contraceptives particularly among young women, and increases in U.S. women's education, labor force participation, and average earnings, coupled with a narrowing in the wage gap between women and men." Frost & Lindberg at 3. A number of reports have connected the advent of oral contraception to significant augmentation of women's wages. One study found that "the Pill-induced effects on wages amount to roughly one-third of the total wage gains for women in their forties born from the mid-1940s to early 1950s." Bailey et al., THE OPT-IN REVOLUTION? CONTRACEPTION AND THE GENDER GAP IN WAGES, at 26-27 (2012), *available at* http://www-personal.umich.edu/~baileymj/Opt_In_Revolution.pdf. That same study estimates that approximately 10% of the narrowing of the wage gap during the 1980s and 31% during the 1990s can be attributed to early access to oral contraceptives. *Id.* at 27; *see also* Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply*, 121 Q. J. OF

ECON. 289, 317 (2006) ("[C]ohorts with earlier legal access to the pill . . . worked more for pay during their late twenties and early thirties."). Another study concludes that the advent of oral contraceptives contributed to an increase in the number of women employed in professional occupations, including as doctors and lawyers. *See* Goldin & Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. POL. ECON. 730, 759-62 (2002).

The Equal Employment Opportunity Commission ("EEOC") recognized the importance of contraception to gender equality in its Decision on Coverage of Contraception. There, in considering a challenge to an employer's failure to include contraception coverage in its health insurance policy, the EEOC found that the Pregnancy Discrimination Act ("PDA") was aimed at "equaliz[ing] employment opportunities for men and women" and "address[ing] discrimination against female employees that was based on assumptions that they would become pregnant." EEOC, Decision on Coverage of Contraception, at 2-3 (Dec. 14, 2000). Accordingly, it concluded that "the PDA's prohibition of discrimination in connection with a woman's ability to become pregnant necessarily includes the denial of benefits for contraception." *Id.* at 2.[6] Here, Congress understood that the

[6] In *In re Union Pacific Railroad Employment Practices Litigation*, this Court disagreed with the EEOC's conclusion that an employer's failure to provide contraception coverage violated the PDA. 479 F.3d 936, 943 (8th Cir. 2007). However, this is not a case concerning alleged gender discrimination under the PDA. Whether or not an employer's failure to provide insurance coverage for

Women's Health Amendment—including its broadening of access to contraceptives—addresses concerns beyond even those enshrined in the PDA by promoting gender equality, and specifically recognized the Amendment as "a huge step forward for justice and equality in our country." 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 3, 2009) (statement of Sen. Franken); *see also supra* Section I.

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

Plaintiffs argue that exemptions from the contraception regulations—specifically, the exemptions for employers with fewer than fifty employees and those with "grandfathered" group health plans—"undermines the government's assertion of compelling interests." (Brief of Appellants at 30.) This misconstrues the law. First, the exemption for employers with fewer than 50 full-time employees is not an exemption from the contraception regulations, but rather from the shared responsibility provision of the ACA, which requires certain employers who fail to provide health insurance to pay an assessable fee. *See* 26 U.S.C. § 4980H(a), (c)(2)(A). Even employers with fewer than 50 employees who provide

---

contraception constitutes a violation of the PDA, Congress, in passing the Women's Health Amendment, and like the EEOC in its Decision on Coverage of Contraception, recognized that increased access to contraception promotes equality for women. The coverage of contraception pursuant to the Women's Health Amendment thus furthers a compelling interest.

non-grandfathered health insurance plans must comply with the contraception regulations. Second, the exemption for grandfathered plans is not a true exemption at all. *See* 42 U.S.C. § 18011; 45 C.F.R. § 147.140. A health insurance plan relinquishes its grandfathered status if certain changes are made to the plan, such as a significant reduction in coverage or a significant increase in co-payments. 45 C.F.R. § 147.140. Rather than providing an exemption, the grandfathering provision allows for a smooth, gradual transition to the new, complex regulatory scheme as health plans lose their grandfathered status over time. In fact, the Government estimated that as many as 69% of all plans that had grandfathered status when the ACA was enacted will lose that status by the end of 2013. And additional plans can be expected to lose their grandfathered status in each subsequent year. 75 Fed. Reg. 34,538, 34,552 (June 17, 2010).

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

Plaintiffs draw attention to the fact that 89% percent of fertile, sexually active women were using some form of contraception as of June 2010 to argue that the contraception regulations do not further the government's interests because they may not guarantee access for the 11% of women not already using contraception. (Brief of Appellants at 33.) This statistic, however, fails to consider the high costs that women pay for contraception and whether cost precludes women from using contraception as prescribed or forces them to choose between contraception and other necessary medical care. By eliminating cost-sharing requirements, the contraception regulations benefit all women who choose to use contraception by guaranteeing their access and alleviating disproportionate costs. *See supra* Section III.B.

The contraception regulations will have widespread effects. According to HHS, approximately 47 million American women were, at the time the mandate went into effect, enrolled in non-grandfathered health plans that were required to cover contraception and the other preventive services mandated by the new regulations. Simmons & Skopec, Dep't of Health & Human Servs., 47 MILLION WOMEN WILL HAVE GUARANTEED ACCESS TO WOMEN'S PREVENTIVE SERVICES WITH ZERO COST-SHARING UNDER THE AFFORDABLE CARE ACT (2012), *available at* http://aspe.hhs.gov/health/reports/2012/womensPreventiveServices ACA/ib.shtml. The contraception regulations will protect all 47 million of those

women by guaranteeing them access to contraception without cost-sharing. Moreover, the regulations will guarantee contraception to millions of additional women as health plans lose their grandfathered status over time. Plaintiffs' assertion that regulations, which serve to protect millions of women, are somehow too underinclusive to pass muster under federal law cannot stand.

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

The contraception regulations are the least restrictive means of furthering the government's compelling interest in women's health and equality. Plaintiffs purport to identify three alternative means of furthering these compelling interests: (1) government-provided contraception; (2) tax credits or deductions; and (3) incentives for pharmaceutical companies to provide contraceptives through pharmacies, doctor's offices, and clinics. (Brief of Appellants at 36-37.) Yet each fails as a feasible and equally effective alternative to the contraception regulations. *See, e.g.*, *Fegans* v. *Norris*, 537 F.3d 897, 904-06 (8th Cir. 2008); *Fellowship Baptist Church* v. *Benton*, 815 F.2d 485, 491 (8th Cir. 1987); *Graham* v. *Comm'r of Internal Revenue Serv.*, 822 F.2d 844, 852 (9th Cir. 1987), *overruled in part on other grounds by Navajo Nation* v. *U.S. Forest Serv.*, 479 F.3d 1024, 1033 (9th Cir. 2007) (en banc).

The first proffered alternative, government-provided contraception, is neither feasible nor equally effective. The contraception regulations reflect HHS's determination that covering contraceptives through employer-provided insurance is the best way to achieve the ACA's goals. Working within the existing framework of employer-provided health insurance plans—90% of which already cover contraceptives[7]—offers a seamless means of providing comprehensive coverage. In contrast, Plaintiffs' proposed alternative would require creating an entirely new federal program. The costs and administrative burdens of establishing such a program and the difficulties of uprooting millions of women who already access contraception through their existing insurance plans would make this both infeasible and ineffective. *See Gooden* v. *Crain*, 353 F. App'x 885, 888 (5th Cir. 2009) (affirming trial court's decision that the least restrictive means requirement was satisfied where the "suggested alternative was not administratively or financially feasible"); *New Life Baptist Church Acad.* v. *Town of E. Longmeadow*, 885 F.2d 940, 947 (1st Cir. 1989) ("[A]dministrative considerations play an important role in determining whether or not the state can follow its preferred means.").

The second proffered alternative, tax credits and deductions, fails as ineffective. As discussed above, women earn less and face higher health care costs

[7] Guttmacher Inst., *Fact Sheet: Contraceptive Use in the United States*, http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Jan. 2, 2013).

than men. *See supra* Section III.B.1. Moreover, 62% of women have reported difficulty accessing health care or paying medical bills due to high costs, barriers which in turn lead women to forego necessary health care. *See* Rustgi et al. at 2. The promise of a tax credit or deduction in next year's tax return does nothing to help a woman who cannot afford contraceptives today. Meanwhile, the consequences of lack of access to contraceptives are immediate and pressing. *See supra* Section II.B. For these reasons, this proposal, too, "would not adequately serve the state's purposes." *Fellowship Baptist Church*, 815 F.2d at 491.

The third proffered alternative, providing incentives for pharmaceutical companies to offer contraceptives for free, is similarly ineffective. Unlike a contraceptive coverage mandate, the mere provision of "incentives" for pharmaceutical companies does nothing to guarantee that women obtain the care they need. Pharmaceutical companies could freely decline to participate. Even where these services would be available, companies may offer less than the full range of FDA-approved contraceptives. Moreover, women may be unable to determine where contraceptives are offered, and the clinics or pharmacies offering them may face greater demand than supply, leaving women with unpredictable access to contraceptives when needed. Although such a measure might *expand* women's access to contraceptive care, it would be, at best, a patchwork scheme that would not provide women with the guaranteed access of insurance coverage.

As such, this is not an equally-effective alternative. *See Murphy* v. *State of Ark.*, 852 F.2d 1039, 1042-43 (8th Cir. 1988).

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

CONCLUSION

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

Dated: January 3, 2013

Respectfully submitted,

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

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

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

Counsel for Amicus 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 6,863 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: January 3, 2013

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

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

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

Counsel for Amicus Curiae

CERTIFICATE OF VIRUS CHECK

The electronic version of the brief has been scanned for viruses and is virus free.

Dated: January 3, 2013

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

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

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

Counsel for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of January, 2013, I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: January 3, 2013

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP

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

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

Counsel for Amicus Curiae