14-427

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

The Roman Catholic Archdiocese of New York, Catholic Health Care System, Catholic Health Services of Long Island, Cardinal Spellman High School, Monsignor Farrell High School, The Roman Catholic Diocese of Rockville Centre, New York,

Plaintiffs-Appellees,

Catholic Charities of the Diocese of Rockville Centre,

Plaintiff,

v.

Kathleen Sebelius, in her official capacity as Secretary of the U.S. Department of Health and Human Services, U.S. Department of Health and Human Services, U.S. Department of Labor, Thomas Perez, U.S. Department of Treasury, Jacob L. Lew, in his official capacity as Secretary of the U.S. Department of Treasury,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK, NO. 1:12-cv-02542 (HON. BRIAN M. COGAN)

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

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, *amici curiae* the National Women's Law Center; American Association of University Women (AAUW); American Federation of State, County, and Municipal Employees (AFSCME); Ibis Reproductive Health; Legal Momentum; MergerWatch; NARAL Pro-Choice America; NARAL Pro-Choice Connecticut; NARAL Pro-Choice New York; National Organization for Women (NOW) Foundation; National Partnership for Women and Families; Planned Parenthood of Central and Western New York, Inc.; Planned Parenthood Hudson Peconic, Inc.; Planned Parenthood of the Mid-Hudson Valley, Inc.; Planned Parenthood Mohawk Hudson, Inc.; Planned Parenthood of Nassau County, Inc.; Planned Parenthood of New York City, Inc.; Planned Parenthood of the North County New York, Inc.; Planned Parenthood of Northern New England; Planned Parenthood of the Southern Finger Lakes, Inc.; Planned Parenthood of Southern New England; Population Connection; Raising Women's Voices for the Health Care We Need; Service Employees International Union (SEIU); and Upper Hudson Planned Parenthood, Inc. disclose that they have no parent corporations, and are nonprofit entities that issue no stock. Accordingly, no publicly held corporation owns 10% of their stock.

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INTEREST OF AMICI CURIAE

The National Women's Law Center; American Association of University Women (AAUW); American Federation of State, County, and Municipal Employees (AFSCME); Ibis Reproductive Health; Legal Momentum; MergerWatch; NARAL Pro-Choice America; NARAL Pro-Choice Connecticut; NARAL Pro-Choice New York; National Organization for Women (NOW) Foundation; National Partnership for Women and Families; Planned Parenthood of Central and Western New York, Inc.; Planned Parenthood Hudson Peconic, Inc.; Planned Parenthood of the Mid-Hudson Valley, Inc.; Planned Parenthood Mohawk Hudson, Inc.; Planned Parenthood of Nassau County, Inc.; Planned Parenthood of New York City, Inc.; Planned Parenthood of the North County New York, Inc.; Planned Parenthood of Northern New England; Planned Parenthood of the Southern Finger Lakes, Inc.; Planned Parenthood of Southern New England; Population Connection; Raising Women's Voices for the Health Care We Need; Service Employees International Union (SEIU); and Upper Hudson Planned Parenthood, Inc. are national, regional, and state organizations committed to protecting and advancing women's health, with a particular interest in ensuring

that women receive the full benefits of access to no-cost contraceptive coverage as intended by the Affordable Care Act.[1]

BACKGROUND AND SUMMARY OF ARGUMENT

Contraceptives are a key component of preventive health care for women. To further the goals of bettering the health and welfare of all Americans, the Patient Protection and Affordable Care Act ("ACA") and implementing regulations require all new insurance plans to cover "[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 June 3, 2014). Implementing regulations exempt certain religious employers from this requirement. *Id.* The regulations also accommodate other non-profit entities that meet certain criteria. Under the regulations, the non-profit entity need only certify that it meets the eligibility criteria and share a copy of the certification with its insurance issuer or third-party administrator, which is then required to provide

[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.

payments for contraceptive services separate from the group health insurance policy. 45 C.F.R. § 147.131 (2013).

Plaintiffs the Roman Catholic Archdiocese of New York, *et al.* qualify for either the exemption or the accommodation for non-profit entities. Yet, despite the fact that they are not required to cover contraceptive services in their group health insurance plans, 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.[2]

This Court should find that Plaintiffs' RFRA claim fails. The contraception regulations pose no substantial burden on Plaintiffs' religious

[2] The Government acknowledges that it lacks the authority to require third party administrators of Plaintiffs' plans to provide contraceptive coverage because Plaintiffs provide health insurance through self-insured "church plans," which are exempt from regulation under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1003(b)(2). However, the Administration has offered financial incentives to third party administrators to provide that coverage. Therefore, despite the fact that the plans at issue here are "church plans," the employees and their covered beneficiaries could receive the coverage under the accommodation. Additionally, some of Plaintiffs' employees already receive the contraceptive coverage through their health plans funded by Plaintiffs and administered by a third party. *See* Government's Brief, at 9.

exercise. Thus, this 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, as *amici* demonstrate below, it must find that the regulations directly further at least two compelling governmental interests: promoting public health and equality for women.

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 themselves provide any coverage for contraceptive benefits in their group health plans, seek to deny their employees and covered family members the contraceptive coverage benefit to which they are entitled pursuant to the accommodation. This threatens real harm to their employees and employees' covered family members. This harm 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 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 June 2, 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

[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 June 2, 2014).

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 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 164-67, 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 contraceptive equity in health insurance plans, 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, Educ., & 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 are in the process of accomplishing—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.

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

[4] For example, twenty-two states do not have laws requiring contraceptive 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.

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 June 2, 2014) ("*Healthy People 2020*").

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. 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

[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, 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.

with chronic medical conditions, such as diabetes and obesity, to postpone pregnancy until their health stabilizes. *See* IOM Rep. at 103.

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 June 2, 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 methods without cost-sharing, 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 June 3, 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, 299 (2009). Other hormonal

contraceptives – including injectable contraceptives, transdermal patches, and the vaginal ring – cost women between $2,300 and $2,800 over a five-year period. *Id.*

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.*, Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* 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 also* Nat'l Bus. Grp. on Health, *Investing in Maternal and Child Health: A Toolkit*, (2007) Part 4, at 12 (Advising employers to cover "comprehensive contraceptive options" and 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 the 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.

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.

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

[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 contraceptive 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).

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 did men and were significantly more likely to be burdened with high medical costs. Women of childbearing age spent 68% more in out-of-pocket health care costs than men. 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 (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

[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

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 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* at 2.

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.,

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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.

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 465. 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 this possibility of access to contraceptives 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 the 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 *Emp't Div., Dep't of Human Res. 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.[10] RFRA did not overturn this basic principle. *See* S. Rep. No. 103-111, at 9 ("This

[10] As the District Court itself acknowledged "[t]he potential burden that granting an exemption would impose upon third parties is certainly a relevant consideration in Free Exercise cases." *Roman Catholic Archdiocese of New York* v. *Sebelius*, No. 12-cv-02542, at 36 (E.D.N.Y. Dec. 16, 2013). However, the court was incorrect to conclude that "this not a case where, for example, plaintiffs claim a religious right to engage in invidious discrimination that Congress has sought to remedy." *Id.* Granting the requested exemption permits Plaintiffs to engage in the very discrimination in health coverage that Congress sought to remedy when it enacted the Women's Health Amendment.

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 threaten harm to a significant number of third parties: the female employees and the employees' covered family members. Granting the relief would completely deny these women the possibility of accessing the contraceptive coverage benefit to which they are entitled under the accommodation, thereby inflicting upon the women the very harms Congress meant to eliminate. To grant relief would also deny these women any possibility of receiving 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 ruling.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(d) because it contains 6,458 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 3rd day of June, 2014, I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Second 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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