STATE OF MINNESOTA
COURT OF APPEALS
A23-0374, A23-0484

Andrea Anderson,

Appellant,

v.

Aitkin Pharmacy Services, LLC d/b/a Thrifty White Pharmacy; George Badeaux,

Respondents.

BRIEF OF *AMICUS CURIAE* NATIONAL WOMEN'S LAW CENTER

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INTEREST OF *AMICUS CURIAE*

The National Women's Law Center is a non-profit legal advocacy organization that fights for gender justice—in the courts, in public policy, and in our society—working across the issues that are central to the lives of women and girls—especially women of color, LGBTQ people, and low-income women and families. Since its founding in 1972, NWLC has worked to advance educational opportunities, workplace justice, health and reproductive rights, and income security. Because the ability to decide whether to become pregnant or bear children is of tremendous significance to gender equality and the lives of women and all who can become pregnant,[1] NWLC seeks to ensure access to contraception and has participated as *amicus* in numerous cases involving denials of reproductive health care across the country.

INTRODUCTION

When Plaintiff Andrea Anderson needed prescription emergency contraception, time was of the essence. So, she called her local pharmacy—

[1] *Amicus* recognizes it is both true that transgender men and nonbinary individuals can become pregnant, and pregnancy is a sex-related condition. Pregnancy is something that only people assigned female at birth and some intersex individuals experience, and social stereotypes about pregnancy are inextricably linked to sex stereotypes that result in discrimination.

Defendant Thrifty White—to make sure it was in stock. Despite initially being assured by a technician that the store would order it and have it available for her the next day, she was then contacted by the pharmacist-in-charge, who volunteered that if he was working tomorrow, he would not dispense the prescription. Thrifty White's policy not only allowed the pharmacist to refuse to dispense the prescription; it also failed to provide a mechanism for a different pharmacist at the store to dispense the prescription, to arrange for a different pharmacy to fill it, or to otherwise ensure that the customer could access her necessary medication. [2] Instead, Thrifty White permitted its pharmacists to obstruct customers from accessing time-sensitive medications.

Pharmacies may not obstruct customers' access to sex-specific prescriptions like emergency contraception, regardless of the personal views of their employees. Emergency contraception is an essential aspect of health care that is uniquely needed by people capable of pregnancy. It assists people to decide if, and when, to become pregnant, and how they want to live their

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[2] Federal and state employment non-discrimination law allows employees to request reasonable accommodations based on religion unless this creates an undue burden. *See, e.g.*, *Groff v. DeJoy*, No. 22-174, 2023 WL 4239256, at *11 (U.S. June 29, 2023). However, Defendants did not raise any affirmative defense based on the pharmacist's religious beliefs. *See* Order Denying Pl.'s Mot. for J. as a Matter of Law at 13 [hereinafter Order]. And *Amicus* notes that employers' decisions regarding religious accommodations must consider harms to patients or customers.

lives. It is an essential good that individuals capable of pregnancy often need to access from their local pharmacy under crucial time constraints.

The Minnesota Human Rights Act (MHRA) protects against discrimination based on sex, including pregnancy. Thrifty White's policy, which obstructed customers' access to emergency contraception, was facially discriminatory based on sex, including pregnancy, because it singled out for unequal access a medication needed solely by individuals capable of pregnancy. Many people, particularly those in rural areas, will be unable to obtain emergency contraception altogether if their local pharmacy refuses to dispense it and is not obligated to make other arrangements for the customer to access it. Many may also suffer shame or humiliation and be reluctant to seek emergency contraception elsewhere. Even those who do ultimately obtain the emergency contraception they need may be delayed in doing so, which could diminish the medication's efficacy and threaten their health, including by putting them at risk for unintended pregnancy.

Where, as here, a policy is facially discriminatory based on a protected characteristic, a civil-rights plaintiff carries no additional burden to prove that the policy was enacted or enforced with discriminatory intent. Nor must the plaintiff establish that they were ultimately unable to obtain the good or

service they were seeking. Because Thrifty White's policy was facially discriminatory on the basis of sex, including pregnancy, in violation of the MHRA, Ms. Anderson was entitled to judgment as a matter of law.

ARGUMENT

The district court erred in three respects in denying Plaintiff's motion for judgment as a matter of law. First, the district court improperly concluded that policies permitting businesses to obstruct prescriptions for emergency contraception cause a disparate impact based on sex but are not *per se* discriminatory. (Order at 12.) Second, the district court erred as a matter of law in holding that a jury could absolve the pharmacy entirely if the pharmacist's actions were "motivated by his personal beliefs and not unlawful discriminatory intent." (Order at 13.) Finally, the district court erred in holding that a reasonable jury could conclude that Thrifty White's policy did not deprive Ms. Anderson of "full and equal enjoyment" of the pharmacy's services. (Order at 11.)

I. PHARMACY POLICIES THAT OBSTRUCT ACCESS TO EMERGENCY CONTRACEPTION ARE FACIALLY DISCRIMINATORY BASED ON SEX, INCLUDING PREGNANCY.

Under the MHRA, it is unlawful discrimination to deny someone "full and equal enjoyment of the goods [and] services . . . of a place of public

accommodation because of . . . sex." Minn. Stat. § 363A.11, subd. 1(a)(1). "Sex" under the MHRA "includes, but is not limited to, pregnancy, childbirth, and disabilities related to pregnancy or childbirth." Minn. Stat. § 363A.03, subd. 42. As the district court acknowledged, only people capable of pregnancy can be prescribed emergency contraception. (Order at 12.) Even so, the district court concluded that Thrifty White's policy of failing to guarantee a customer's ability to fill emergency contraception prescriptions had a disparate impact based on sex but was not *per se* discriminatory. This conclusion is contrary to state and federal court precedent, which makes clear that singling out for unfavorable treatment sex-based characteristics like pregnancy or the need to prevent it constitutes *per se* sex discrimination.

a. The Minnesota Supreme Court has long held that singling out a health risk or need of only one sex, such as the risk of pregnancy or the need for pregnancy-related health care, constitutes *per se* sex discrimination. For example, in *Minnesota Mining and Manufacturing Co. v. State*, 289 N.W. 2d 396, 397 (Minn. 1979), the Minnesota Supreme Court determined that excluding only pregnancy-related disabilities from an otherwise comprehensive employer income-maintenance plan was "per se sex discrimination" within the meaning of the MHRA. The Court reasoned that

"[s]ince only women face the risk of becoming pregnant, excluding only pregnancy-related disabilities from an otherwise comprehensive income maintenance plan is per se sex discrimination." *Id.* at 400.

The Minnesota Supreme Court's reasoning is consistent with other state courts' interpretations of state laws barring discrimination based on sex. For example, two state courts interpret their states' equal rights amendments as barring their state Medicaid programs from singling out for exclusion a sex-based medical procedure—abortion care. *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 856 (N.M. 1999); *Doe v. Maher*, 515 A.2d 134, 159 (Conn. Super. Ct. 1986). The New Mexico and Connecticut courts reasoned that where a state offers comprehensive Medicaid benefits, excluding abortion coverage "undoubtedly singles out for less favorable treatment" a sex-based procedure and thus is facially discriminatory. *Johnson*, 975 P.2d at 856; *see also Doe*, 515 A.2d at 443–44. Like abortion care, the need for emergency contraception is sex-specific, and following the reasoning of these cases, when health care needs are generally served, it is discriminatory to selectively deny care that is needed based on sex.

Other states' attorneys general have applied similar reasoning to determine that their states' anti-discrimination laws bar employers from

excluding coverage for contraceptives from otherwise comprehensive employee benefits plans. In Montana and Wisconsin, the state attorneys general have interpreted their state laws to require contraceptive coverage.[3] In Michigan, the ruling came from the Michigan Civil Rights Commission, before the state enacted contraceptive coverage legislation in 2009.[4] Although these opinions arise from the insurance context, their reasoning—that differential treatment related to the need for contraception is facially discriminatory based on sex—is equally applicable to the public-accommodations context.

Moreover, another state public-accommodations law has been interpreted to prohibit refusals to provide services related to contraception. In 2020, the Illinois Human Rights Commission (IHRC) determined that a hospital's refusal to remove and replace a contraceptive device supported a charge of discrimination based on sex and pregnancy in violation of the state's human rights law. *See In re the Matter of the Request for Review by Darolyn*

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[3] *See* Montana Attorney General Opinion Vol. No. 51, Op. No. 16, https://bit.ly/3XoKMqD; Letter from Wisconsin Attorney General Peggy A. Lautenschlager to State Senator Gwendolynne Moore, Oct. 17, 2003 (on file with the National Women's Law Center).

[4] Michigan Civil Rights Commission, Declaratory Ruling on Contraceptive Equity, Aug. 21, 2006, https://bit.ly/3NDrevh.

Lee, Charge No. 2018CP2109, 2020 WL 13724340 (Ill. Hum. Rts. Com. Mar. 6, 2020). Ms. Lee was initially denied contraceptive services because her first doctor stated that "all women should be required to have children." *Id.* at *3. She was again denied at a second appointment under a blanket policy prohibiting "birth control services," and offered a pap smear instead. *Id.* at *4. The IHRC determined that these facts established a *prima facie* case of sex discrimination. *Id.*

b. The Minnesota Supreme Court's reasoning in *Minnesota Mining and Manufacturing*—that singling out sex-specific medical needs for unfavorable treatment constitutes sex discrimination—is also consistent with Title VII precedent, which serves as the floor of legal rights that the MHRA protects. *See Kenneh v. Homeward Bound*, 944 N.W.2d 222, 229 n.2 (Minn. 2020). Under Title VII, the U.S. Supreme Court has long recognized as facially discriminatory policies that single out for unfavorable treatment sex-specific characteristics like child-bearing capacity. *See Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 197–99 (1991). Extending this principle, multiple federal courts, as well as the U.S. Equal Employment Opportunity Commission (EEOC), have determined that comprehensive employee health benefit plans

that exclude prescription contraceptive coverage facially discriminate based on some employees' ability to become pregnant, and therefore violate Title VII. *See Cooley v. DaimlerChrysler Corp.*, 281 F. Supp. 2d 979, 986 (E.D. Mo. 2003), *overruled by In re Union Pac. R.R. Emp. Practices Litig.*, 479 F.3d 936 (8th Cir. 2007)[5]; *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1276–77 (W.D. Wash. 2001); *E.E.O.C. v. United Parcel Serv., Inc.*, 141 F. Supp. 2d 1216, 1220 (D. Minn. 2001).

These decisions recognize that "[t]he special or increased health care needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other health care needs." *Erickson*, 141 F. Supp. 2d at 1271. The same holds true in the public-accommodations context. A refusal to fill an emergency contraception prescription in a pharmacy that continues to fill other prescriptions is analogous to an employer's refusal to cover prescription contraceptives in its health plan while providing coverage for other medications. In both cases, the

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[5] As the EEOC has explained, the Eighth Circuit's decision in *In re Union Pac. R.R.*., 479 F.3d at 942, that contraception is not "related to pregnancy" is not persuasive because it is contrary to the Supreme Court's holding in *Johnson Controls* that the Pregnancy Discrimination Act of 1978, which amended Title VII, applies to potential pregnancy. *See* EEOC, *Enforcement Guidance: Pregnancy Discrimination and Related Issues*, at *7 n.38 (June 25, 2015).

refusal diminishes the relative comprehensiveness of the goods and services offered to customers who can become pregnant, and thus denies them equal access to services on the basis of their sex.

This interpretation of the scope of protections against sex discrimination is in line with other federal law as well. Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, prohibits recipients of federal financial assistance from discriminating on the basis of sex, including pregnancy, in their health programs or activities. The U.S. Department of Health and Human Services recently issued guidance instructing that a pharmacy may violate Section 1557 by refusing to fill an emergency contraception prescription.[6]

c. Collectively, these precedents confirm that the relevant inquiry is not whether a policy causes actual harm to every single customer of any particular sex; rather, this court should assess the pharmacy's policy to determine whether it diminishes the relative *comprehensiveness* of the goods or services offered based on sex or pregnancy status. *See Minn. Mining & Mfg. Co.*, 289

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[6] *See* U.S. Dep't of Health & Human Servs., Off. for Civ. Rts., *Guidance to Nation's Retail Pharmacies: Obligations Under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services* (July 13, 2022), https://bit.ly/3r8T75P.

N.W. 2d at 400 (holding that it was unlawful to exclude pregnancy-related disabilities in an "otherwise comprehensive" income-maintenance plan), *Erickson*, 141 F. Supp. 2d at 1271 ("The fact that equality under Title VII is measured by evaluating the relative comprehensiveness of coverage offered to the sexes has been accepted and amplified by the Supreme Court.").

Further, this focus on relative comprehensiveness means that a sex-based exclusion will be discriminatory even if the excluded product is not the sole good or service that the public accommodation refuses to provide. A pharmacy need not guarantee access to *all* prescription medications for a policy that effectively blocks the distribution of emergency contraception to be discriminatory. *See Erickson*, 141 F. Supp. 2d at 1274–75 (rejecting the argument that exclusion of prescription contraceptives was not discriminatory because the plan excluded other drugs, reasoning that "[t]he additional exclusion of prescription contraceptives . . . reduce[d] the comprehensiveness of the coverage offered to female employees while leaving the coverage offered to male employees unchanged."). What matters is that the exclusion reduces the comprehensiveness of the goods or services for customers with a sex-specific need as compared to those without it.

Thrifty White's policy leaves access to emergency contraception—a good that is sex-specific and needed based on pregnancy status—obstructed. Thrifty White cannot allow its pharmacists to block customers from accessing goods and services needed because of their protected characteristics, and for that reason the pharmacy's policy facially discriminates based on sex, including pregnancy.

II. Where, As Here, There Is a Facially Discriminatory Policy, a Plaintiff Need Not Also Prove Discriminatory Intent.

The district court erroneously instructed the jury that in order to determine whether Thrifty White's policy violated the MHRA, it must consider whether the pharmacist acted with unlawful animus against women or lawfully in accordance with "his personal, religious beliefs." Order at 13. Setting aside that Defendants did not raise the pharmacist's religious convictions as an affirmative defense, it was the *pharmacy's* policy that failed to guarantee access to the needed medication. And this instruction was in error because it is well-established that when a policy is facially discriminatory, a plaintiff need not prove discriminatory intent.

A facially discriminatory policy, on its own, demonstrates discriminatory intent. "[T]he absence of a malevolent motive does not convert a facially discriminatory policy into a neutral policy with a discriminatory

effect." *Johnson Controls*, 499 U.S. at 199. When a policy is "discriminatory on its face," "intent to discriminate can be presumed." *Jankovitz v. Des Moines Indep. Cmty. Sch. Dist.*, 421 F.3d 649, 653 (8th Cir. 2007). In other words, when a policy injures a person based on a protected characteristic—like the ability to become pregnant—no further showing of intent is needed. *See Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1745–46 (2020) ("[N]othing in Title VII turns on the employer's labels or any further intentions (or motivations) for its conduct beyond sex discrimination."). The policy itself is evidence enough of intent.

Because Thrifty White's policy facially discriminated by failing to guarantee customers' ability to fill emergency contraception prescriptions, the district court erred in instructing the jury that additional evidence of discriminatory intent on the part of an individual pharmacist was necessary.

III. WHEN PHARMACY POLICIES OBSTRUCT ACCESS TO EMERGENCY CONTRACEPTION, PEOPLE SUFFER SUBSTANTIAL HARMS.

Ms. Anderson was injured as a matter of law by the pharmacy's facially discriminatory policy because she was denied full and equal access to the pharmacy's services. But the jury instructions required Ms. Anderson to prove an additional element: that the facially discriminatory policy caused a "material disadvantage" or a "tangible change in conditions." Order at 10. The

district court instructed the jury that it needed to find Ms. Anderson suffered "more than minor differences in service or access to goods." Jury Instructions at 13.

This instruction was in error. It is well established under Minnesota law that "[w]hen an individual or a company has been held to have violated the provisions of a specific civil rights law, the act of discrimination itself constitutes sufficient injury for the law to provide a remedy, in the absence of statutory language requiring more." *Potter v. LaSalle Court Sports & Health Club*, 384 N.W.2d 873, 875 (Minn. 1986); *see also Krueger v. Zeman Const. Co.*, 781 N.W.2d 858, 862 (Minn. 2010).

Nonetheless, the harm caused by Thrifty White's policy meets even the unnecessarily high bar set by the district court.

A. Pharmacy refusals are a form of sex—including pregnancy—discrimination that are especially burdensome for those who already face discrimination based on other identities or characteristics.

Discrimination comes in many forms. In public accommodations, it can look like paying increased and unwanted attention to Black customers or other customers of color, based on harmful racial stereotypes. *Cf. Aromashodu v. Swarovski N. Am. Ltd.*, 981 N.W.2d 791, 797–98 (Minn. Ct. App. 2022) (reversing summary judgment on MHRA public accommodations claim for

allegedly racially-motivated shoplifting report). Or, as with the Civil Rights Era lunch-counter protests, it can look like refusing to provide services to members of a protected class. Such discrimination often arises in the form of institutional policies that harm members of protected classes. *See Potter v. LaSalle Sports & Health*, 368 N.W.2d 413, 417 (Minn. Ct. App. 1985) upholding finding that club's policy prohibiting LGBTQ+ individuals "from socializing with one another" violated MHRA). Just like the restaurant that posts a "whites only" sign, or the bakery that refuses to make wedding cakes for same-sex couples, pharmacies, hospitals, and other medical institutions that permit refusals of medical services that only a protected class needs are engaging in blatant, facial discrimination in a place of public accommodation.

Across the country, examples abound of individuals being denied critical health services, information, and referrals because a hospital or other entity refused the service or because it did not have a protocol in place to ensure patients receive necessary care in cases where an individual employee has an objection to providing the standard of care.[7] This includes, among other examples, individuals experiencing emergency pregnancy complications or

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[7] *See Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (May 15, 2023), https://bit.ly/3PEGAkS.

miscarriage denied time-sensitive, life- and health-saving emergency medical care,[8] transgender individuals denied critical gender-affirming care,[9] and patients with medical conditions for which pregnancy is contraindicated denied sterilization.[10] Hospital, pharmacy, and other health care entity policies that ultimately block access to certain goods or services run afoul of legal requirements and fail to live up to the required standard of care, thereby putting health and lives in jeopardy.

When medical entities block access to reproductive health care by not having policies that guarantee patient care even if an individual employee objects, the harms caused by existing, pervasive patterns of discrimination in health care are exacerbated, particularly for those who already face multiple and intersecting barriers to care. Women, who are most often the subjects of refusals of reproductive health care, have long been the victims of

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[8] *See, e.g.*, *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 223 (3d Cir. 2000) (describing patient experiencing placenta previa who was "standing in a pool of blood" but delayed in obtaining emergency caesarean section due to nurse's refusal to participate); *New York et al. v. HHS*, No. 19-4254, Dkt No. 323, Brief of *Amici Curiae* Rachael Lorenzo et al. (2d Cir. Aug. 3, 2020) (detailing stories of three individuals who were denied essential, stabilizing treatment because medical professionals refused to provide emergency abortions).

[9] *See Hammons v. Univ. of Md. Med. Sys. Corp.*, No. CV DKC 20-2088, 2023 WL 121741, at *4 (D. Md. Jan. 6, 2023).

[10] Sandhya Somashekhar, *A Pregnant Woman Wanted Her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://bit.ly/3Joe3vP.

discrimination by health care providers.[11] Despite the historic achievements of the Affordable Care Act, which bars discrimination based on sex in federally funded health programs, women—particularly Black women—are still far more likely to be harassed by a provider.[12] Moreover, when women are able to see a provider, their pain is routinely undertreated and often dismissed.[13] And due to gender biases and disparities in research, doctors tend to offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.[14]

This discrimination is particularly dangerous for Black women, who experience compounding race- and sex-based discrimination in health care. For example, Black women are more likely than white women to rely upon religiously-affiliated medical institutions for care, where policies prohibiting providers from performing certain pregnancy-related procedures, or even

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[11] Prior to the Affordable Care Act, women were routinely charged more for health care on the basis of sex and were continually denied health insurance coverage for sex-specific health services. *See Turning to Fairness*, NAT'L WOMEN'S L. CTR. 1, 3–4 (2012), https://bit.ly/469Fxiz.

[12] *See Discrimination in America: Experiences and Views of American Women*, NPR & HARVARD T.H. CHAN SCH. PUB. HEALTH (Dec. 2017), https://bit.ly/3p4EKPn.

[13] *See, e.g.,* Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J. L., MED., & ETHICS 13, 13–27 (2001).

[14] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. AM. HEART ASS'N 1 (2015).

informing patients about them, are more common.[15] Indeed, in one report, Black women disclosed that their doctors failed to inform them of the full range of reproductive health options regarding labor or delivery, possibly due to stereotypes about Black women's sexuality.[16] The results of this compounding discrimination in health care are dire: Black women are more likely to experience pregnancy-related complications than white women and are 3.5 times more likely to die from pregnancy-related causes.[17]

Generally, medical practice guidelines and standards of care establish the boundaries of medical services that customers can expect to receive and that pharmacies should be expected to deliver. Yet, policies like the one at issue here allow a pharmacy—a place of public accommodation—to flout these guidelines and effectively block evidence-based, sex-specific care. The inability to obtain necessary and often time-sensitive care not only poses an immediate threat to customers' health, it also exacerbates the discrimination in

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[15] *See* Kira Shepherd et al., *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://bit.ly/44b7vct.
[16] *See The State of Black Women & Reproductive Justice*, IN OUR OWN VOICE (2017), https://bit.ly/3CGNQok.
[17] For example, Black women experience higher rates of preeclampsia and eclampsia than white women and are more likely to die from this complication. Marian F. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records*, 2016–2017, 111 AM. J. PUBLIC HEALTH 1673, 1676–77 (2021).

health care already faced by women—particularly Black women—and ultimately creates countless related harms while undermining individuals' trust in health care systems.[18]

B. A refusal to fill an emergency contraception prescription causes specific serious harms.

1. Emergency contraception is time sensitive.

Any delay in access to emergency contraception (EC) is harmful because the medication is time sensitive. Levonorgestrel emergency contraception (LNG-EC), sold as Plan B One-Step and generic forms, is the most common and easily accessible form of EC in the United States because it is available over-the-counter (OTC).[19] This medication works to prevent pregnancy by inhibiting or delaying ovulation if it is taken before luteinizing hormones trigger ovulation.[20] For this reason, this form of EC ideally should

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[18] *See, e.g.*, Mohsen Bazargan et al., *Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults*, 19 ANN. FAM. MED. 4 (2021).

[19] *See* American Society for Emergency Contraception, *Mechanism of Action of Levonorgestrel Emergency Contraceptive Pills* 1 (Jan. 2023), https://bit.ly/3NiSlug.

[20] *Id.* Several studies have indicated that this form of EC does not prevent pregnancy by preventing implantation of a fertilized egg in the uterus, *id.* at 1, nor does it effect a pregnancy after implantation has occurred, *id.* at 2.

be used as soon as possible after intercourse, although it may work three to five days after.[21]

Ulipristal acetate emergency contraception (UPA-EC), sold as ella, is available by prescription-only. It is the most effective EC pill,[22] and for those weighing over 165 pounds, like Ms. Anderson at the time she visited Thrifty White as well as 38.2% of Minnesotan women aged 18 to 54 in 2021,[23] it is the most effective EC pill.[24] Like LNG-EC, UPA-EC is also a time-sensitive drug, although it does have a longer efficacy period.

2. People seeking emergency contraception will have difficulty accessing alternative care once refused.

Once a pharmacy refuses to fill an individual's EC prescription or provide it over the counter, that individual is less likely to ultimately receive

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[21] *See* American Society for Emergency Contraception, *Emergency Contraception: A Guide for Pharmacies and Retailers* 1 (Aug. 2020), https://bit.ly/3PjAOVu; *see also* Chelsey Yang, *The Inequity of Conscientious Objection: Refusal of Emergency Contraception*, 27 NURSING ETHICS 1408, 1412 (2020).

[22] *See* Elena Rosato et al., *Mechanism of Action of Ulipristal Acetate for Emergency Contraception: A Systemic Review*, 6 FRONTIERS IN PHARMACOLOGY 1, 21 (2016), https://bit.ly/3JlPcIY.

[23] NWLC calculations based on 2021 Behavioral Risk Factor Surveillance System (BRFSS). Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

[24] *See* American Society for Emergency Contraception, *Efficacy of Emergency Contraception and Body Weight: Current Understanding and Recommendations* 1 (June 2022), https://bit.ly/445dxuH. UPA-EC's effectiveness has been questioned for those weighing more than 194 pounds. *See id.* at 3.

the care they need. For some, the discriminatory experience may be so off-putting that they do not pursue alternatives. Others may face insurmountable barriers—due to their inability to transfer their prescription to another pharmacy, find another pharmacy with EC in stock, increased costs, or other hurdles—to accessing alternatives.

First, it is important to recognize that contraception use is particularly sensitive to barriers. *See Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 265 (D.C. Cir. 2014) ("The evidence shows that contraceptive use is highly vulnerable to even seemingly minor obstacles."). If an individual is refused the EC they need at a pharmacy, they may delay trying to get it again or even believe they will never be able to access it and simply give up.

When searching for alternatives, individuals may be deterred because EC is limited in availability and accessibility at pharmacies, and it may not be possible to find another pharmacy with EC in stock in time. Barriers to accessing EC are varied and include suboptimal stocking due to perceived low demand, personal objections by pharmacy staff, or individual pharmacy decisions to place OTC EC behind the counter or in a locked box due to

concerns about theft.[25] A recent study of more than 300 pharmacies in 21 states, including Minnesota, revealed that 18% of pharmacies did not stock OTC EC at all, another 9% did not have any in stock, and more than one-quarter (28%) stocked OTC EC behind the counter at either the pharmacy or front cashier.[26] Further, of stores with OTC EC on the shelves (54%), about half (48%) kept the medication in a portable plastic box that requires a store employee to unlock at time of purchase, which customers reported was "intimidating."[27] Access is further limited for prescription EC products like ella; only 13% of pharmacies surveyed had ella in stock.[28]

Further, access to EC is particularly limited in certain geographic areas. For example, pharmacies in low-income areas are more likely to create barriers to EC, including by stocking all forms of EC behind the counter.[29] In rural areas, pharmacies are less likely to maintain late hours, which can make EC harder to obtain for individuals who have work or childcare duties during

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[25] *See* Alia Moore et al., *Seeking Emergency Contraception in the United States: A Review of Access and Barriers*, 59 WOMEN & HEALTH 364 (2018).
[26] *See* American Society for Emergency Contraception, *2022 Emergency Contraception Access Report* 1, 4–6 (Feb. 2023), https://bit.ly/3NCaSTN.
[27] *See id* at 7.
[28] *Id.* at 10.
[29] *See* Yen P. Doan et al., *Effects of Neighborhood-Level Income on Access to Emergency Contraception*, 112 CONTRACEPTION 120, 122 (2022).

the daytime.[30] This is particularly important in Minnesota, where one in ten women live in rural areas.[31] And more generally, rural areas have limited health care facilities, especially for reproductive health care. A recent study found that only 68.1% of the population lived within 10 miles of a pharmacy in rural areas.[32] Moreover, rural areas are predominantly served by independent pharmacies and franchises as opposed to chains, and pharmacy closures in recent years have disproportionately affected independent pharmacies, making it even more difficult for rural residents to access a pharmacy.[33] Further, fifty-one percent of rural counties in Minnesota do not have a sexual health clinic, affecting the 53,430 women who live there.[34] In total, 283,400 women in Minnesota live in contraceptive deserts, meaning no provider in their county provides reasonable access to the full range of

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[30] *See* Yang, *supra* note 21, at 1415.
[31] NWLC calculations based on 2021 American Community Survey, accessed through Steven Ruggles et al., *Integrated Public Use Microdata Series USA* (IPUMS USA): Version 11.0 (Minneapolis: University of Minnesota, 2023).
[32] Lucas A. Berenbrok et al., *Access to Community Pharmacies: A Nationwide Geographic Information Systems Cross-Sectional Analysis*, 62 J. AM. PHARMACISTS ASS'N. 1816, 1818(2022), https://bit.ly/3CCZhO8.
[33] *Id.* at 1819–20.
[34] Directory of Family Planning Services, Minnesota Department of Health (Apr. 7, 2023), https://bit.ly/42SP6j0; Power to Decide, *Contraceptive Access in Minnesota* (Nov. 16, 2022), https://bit.ly/3Xc7277 [hereinafter Contraceptive Access in Minnesota].

contraceptive methods.[35] Thus, Minnesotans in many medically underserved counties who have been denied EC by their local pharmacy have fewer alternative places to find the medication they need.

If a pharmacy refuses to fill an EC prescription, finding an alternative pharmacy will also be more costly. More time searching for EC means more time away from other obligations. For example, to travel to a different pharmacy, an individual might need to take additional time off work and will also need to incur greater out of pocket expenses on childcare coverage, gas or transportation fare, and food out of the home. For the many Minnesotans living in rural areas, these costs are even higher. If the second pharmacy then refuses to dispense EC and refers the individual to yet another pharmacy, the financial demand increases again. Studies confirm that cost is a major determinant of whether people obtain contraceptive care, particularly for those with limited resources.[36] And these barriers disproportionately impact certain groups, including women, who are more likely than men to forgo care because

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[35] Contraceptive Access in Minnesota, *supra* note 34.
[36] *See* Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 GUTTMACHER POL'Y REV. 7, 10 (2011).

of cost;[37] immigrants, who often lack access to transportation and may have to travel great distances;[38] and people of color, who are more likely to live in poverty in Minnesota.[39]

Further, as Ms. Anderson's experience demonstrates, Minnesota's weather can make it even more difficult for people to get to another pharmacy once denied care. Minnesota experiences up to 32 days per year of extreme weather, including thunderstorms and tornados, winter storms, extreme cold, and extreme heat.[40] Traveling to a second pharmacy that is farther from home can be unsafe—if not impossible—on some days of the year in Minnesota.

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[37] *See* Adele Shartzer et al., *Health Care Costs Are a Barrier to Care for Many Women*, URBAN INST. HEALTH POL'Y CTR. (Jan. 2015), https://bit.ly/44r1U16.

[38] *See* Athena Tapales et al., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, 98 CONTRACEPTION 47 (2018), https://bit.ly/3NhidGZ.

[39] *See* NWLC calculations based on 2017–2021 American Community Survey, public use microdata, U.S Census Bureau (showing that_between 2017-21, 23% of Black women, 17.3% of Latinas, 11.2% of Asian women and 36.4% of Native women aged 18-54 lived in poverty, compared to 6.1% of white, non-Hispanic men and 8.4% of white, non-Hispanic women).

[40] *See* NWLC calculations on the number of days of thunderstorms/tornados and winter storms are based on *Event Summaries*, U.S. Department of Commerce National Oceanic & Atmospheric Administration, National Weather Service, https://bit.ly/44dYBdU; NWLC calculations on the number of days of extreme cold and heat are based on Jennifer Runkle et al., *Minnesota State Climate Summary 2022*, NOAA Technical Report NEDIS 150-MN, https://bit.ly/3JlWM6j.

3. People denied emergency contraception are harmed because they are put at risk of unwanted pregnancy.

People denied emergency contraception may ultimately become pregnant against their will, which is a serious harm. People seeking emergency contraception are expressing a clear intent to prevent a pregnancy. Some may simply desire not to become pregnant or a parent at that point in time. For others, preventing pregnancy may be necessary to treat or manage other health conditions or to take back control of their bodies and lives after sexual assault or intimate partner violence. For all those who are forced to carry an unwanted pregnancy to term, harms include long-term health, safety, autonomy, educational, and economic consequences.

a. Individuals denied emergency contraception face substantial health and safety risks.

Many individuals who have their EC prescriptions or requests for OTC EC obstructed by pharmacies will face negative consequences to their health and safety if they are forced to carry an unwanted pregnancy.

While most women aged 18–44 use contraception to prevent pregnancy (59%), many also use it to manage medical conditions (22%).[41] Pregnancy can dangerously exacerbate pre-existing health conditions, like diabetes[42] and gender dysphoria. Indeed, contraception is critical to the health and autonomy of transgender men and gender non-conforming people because it permits individuals to align their gender identity further with their physiology.[43] Additionally, those with certain serious health conditions, like pulmonary hypertension (which is more common among Black women[44]) and cyanotic heart disease are counseled to avoid pregnancy due to the very high risk of maternal and fetal mortality.[45] Further, pregnancy also may not be compatible

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[41] *See* Caroline Rosenzweig et al., *Women's Sexual and Reproductive Health Services: Key Findings from the 2017 Kaiser Women's Health Survey 1,* 3 (Mar. 13, 2018), https://bit.ly/341zw7Z.
[42] *See Diabetes and Pregnancy*, CENTERS FOR DISEASE CONTROL & PREVENTION, https://bit.ly/3ph43O8.
[43] *See* Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 OBSTETRIC MED. 4, 6 (2015).
[44] Nadine Al-Naamani et al., *Racial and Ethnic Differences in Pulmonary Arterial Hypertension*, 7 PULMONARY CIRCULATION 793, 793 (2017), https://bit.ly/3NkRN7p.
[45] *See* Evin Yucel & Doreen DeFaria Yeh, *Pregnancy in Women with Congenital Heart Disease*, 19 CURRENT TREATMENT OPTIONS IN CARDIOVASCULAR MED. 73, 80–82 (2017).

with certain important medications, like some anti-psychotic drugs or chemotherapies.[46]

Preventing pregnancy can also be essential to ensuring the safety of those experiencing intimate partner violence. Abusive partners often engage in "reproductive coercion" to promote unwanted pregnancies, including interfering with the victimized partner's ability to use contraception.[47] EC is a discreet and confidential method of pregnancy prevention that can support reproductive autonomy.[48] Without prevention methods, pregnancy can entrench a woman in an abusive relationship, endangering herself, her pregnancy, and any children she already has.[49] For some, pregnancy represents a dangerous "period of risk" for physical abuse.[50]

Further, EC plays a unique and important role in empowering survivors of sexual assault to prevent pregnancy. Sexual assault survivors' use of

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[46] *See* Hannah Betcher et al., *Use of Antipsychotic Drugs During Pregnancy,* 6 CURRENT TREATMENT OPTIONS IN PSYCHIATRY 17, 27 (2019); Molly Brewer et al., *Chemotherapy in Pregnancy*, 54 CLIN. OBSTETRICS & GYNECOLOGY 602, 603 (2011).

[47] Am. Coll. of Obstetricians & Gynecologists, Committee Opinion No. 554, Reproductive and Sexual Coercion 1, 1–2 (2013), https://bit.ly/3qSVPwh.

[48] *See id.* at 2–3.

[49] Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 CONTRACEPTION 457, 457–58 (2010).

[50] Linda E. Saltzman et al., *Physical Abuse Around the Time of Pregnancy: An Examination of Prevalence and Risk Factors in 16 States*, 7 MATERNAL & CHILD HEALTH J. 31, 31 (2003).

emergency contraception is associated with fewer PTSD symptoms.[51] There are intersectional implications as well; individuals with disabilities have a particularly strong need for access to EC because they face an increased risk of sexual abuse and assault compared to the general population.[52] But they may be particularly burdened if they need to find an alternative pharmacy after a denial of care because of a lack of accessible options and common misconceptions about their reproductive health needs.[53]

b. Individuals denied emergency contraception face substantial economic and social costs.

Individuals unable to obtain EC after a pharmacy refusal are likely to face negative consequences with respect to their economic security, workforce participation, and educational opportunities if they are forced to carry a pregnancy.

Pregnancy and childbirth impose significant, direct costs. Many women in low-wage jobs who become pregnant are denied pregnancy accommodations and face workplace discrimination, forcing some to quit or

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[51] *See* Nikole Ferree et al., *The Influence of Emergency Contraception on Post Traumatic Stress Symptoms Following Sexual Assault,* 8 J. FORENSIC NURSING 122, 127 (2012).
[52] *See Sexual Abuse*, DISABILITY JUSTICE, https://bit.ly/3riM5eP.
[53] *See* Alex Zielinski, *Why Reproductive Health Can Be a Special Struggle for Women with Disabilities*, THINK PROGRESS (Oct. 1, 2015), https://bit.ly/46bCJBu.

be fired or pushed into unpaid leave.[54] Despite recent critical workers' rights advances, some employers will continue to deny pregnant workers' reasonable accommodations.[55]

Then, there are the costs of the health care needed by the pregnant person, including prenatal care, psychological care, physical therapy, or treatment of other conditions that arise because of pregnancy.[56] Even for those with health insurance, the average out-of-pocket cost of a vaginal birth increased from $2,910 in 2008 to $4,314 in 2015[57]; costs have undoubtedly only increased since. For those without insurance, the most recent study available showed that having an uncomplicated vaginal birth could cost up to $30,000, and a cesarean delivery could cost $50,000.[58] These costs are compounded by pregnancy or birth complications, or if the child requires intensive neonatal care.

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[54] *See It Shouldn't Be a Heavy Lift: Fair Treatment for Pregnant Workers*, NAT'L WOMEN'S L. CTR. 1 (2013), https://bit.ly/3NxnqdW.

[55] *See, e.g.*, *What You Should Know About the Pregnant Workers Fairness Act*, EEOC, https://bit.ly/3rdHGcU.

[56] *See* Matthew Rae et al., *Health costs associated with pregnancy, childbirth, and postpartum care*, PETERSON-KFF HEALTH SYSTEM TRACKER (Jul. 13, 2022), https://bit.ly/3O1mZtH.

[57] *See* Michelle H. Moniz et al., *Out-of-Pocket Spending for Maternity Care among Women with Employer-Based Insurance, 2008–15*, 39 HEALTH AFFAIRS 18, 20 (2020).

[58] TRUVEN HEALTH ANALYTICS, THE COST OF HAVING A BABY IN THE UNITED STATES 3 (Jan. 2013), https://bit.ly/3NGNcxu.

Beyond these immediate costs, those forced to carry a pregnancy to term will also suffer long term impacts that affect their ability to participate equally in society. For example, experts conducting "[e]conomic analyses have found clear associations between the availability and diffusion of oral contraceptives, particularly among young women, and increases in US women's education, labor force participation, and average earnings, coupled with a narrowing in the wage gap between women and men."[59] In addition to the immediate economic costs of having a child—including child care, food, housing, and other necessities—those who bear children also face diminished earnings, interference with career advancement, disruption of education, and fewer resources for children they already have.[60] This is especially true with respect to childbirth from unintended pregnancies.[61]

People capable of pregnancy are aware of these impacts. When asked why they use contraceptives, nearly all women in a 2018 survey reported that it was "extremely important" in their lives, saying it allowed them to pursue

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[59] Jennifer J. Frost & Laura Dubertstein Lindberg, *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics*, 87 CONTRACEPTION 465, 465 (2013).
[60] ADAM SONFIELD ET AL., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 14–15 (2013), https://t.ly/BUHH_.
[61] *Id.*

academic and professional goals and achieve financial stability.[62] The importance of contraception to women's lives makes the emotional injury of a pharmacy refusal only that much more devastating.

CONCLUSION

When a pharmacy implements a policy that results in blocked access to emergency contraception, it discriminates on the basis of sex, including pregnancy. Turning customers away based on sex, or based on pregnancy, is squarely the kind of harm that the Minnesota Human Rights Act was intended to prevent. Pharmacies, like most businesses, are places of public accommodation and may not turn people away based on protected characteristics if they are going to do business in the state of Minnesota.

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[62] Rebecca Peters et al., *"Birth Control Is Transformative": Women Share Their Experience with Contraceptive Access*, at 9, URBAN INSTITUTE (Mar. 2019), https://t.ly/dG-3.

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