Nos. 19-431, 19-454

In the Supreme Court of the United States

LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME, *Petitioner*
v.
PENNSYLVANIA, ET AL., *Respondents.*

DONALD J. TRUMP, PRESIDENT OF THE
UNITED STATES, ET AL., *Petitioners*
v.

PENNSYLVANIA, ET AL., *Respondents*.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR *AMICI CURIAE* THE NATIONAL WOMEN'S LAW CENTER, THE NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, THE NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE JUSTICE, SISTERLOVE, INC., AND 50 ADDITIONAL ORGANIZATIONS IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*[1]

The National Women's Law Center ("NWLC") is a nonprofit legal advocacy organization founded in 1972 dedicated to the advancement and protection of legal rights and opportunities of women and all who suffer from sex discrimination.

The National Asian Pacific American Women's Forum ("NAPAWF") is the only national, multi-issue Asian American and Pacific Islander women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for AAPI women, girls, and transgender and gender non-conforming people, using a reproductive justice framework.

The National Latina Institute for Reproductive Justice ("NLIRJ") is the only national reproductive justice organization dedicated to advancing health, dignity, and justice for 29 million Latinas, their families, and communities in the United States.

Founded in July 1989, SisterLove, Inc. is an HIV/AIDS and reproductive justice nonprofit service organization focusing on women, particularly women of African descent. SisterLove's mission is to eradicate the adverse impact of HIV/AIDS and other sexual and reproductive oppressions upon all women, their

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[1] Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for any party authored this brief in whole or in part, and no entity or person, aside from *amici* and their counsel, made any monetary contribution toward the brief's preparation or submission. Pursuant to Supreme Court Rule 37.3, counsel of record for all parties have consented to this filing.

families, and their communities through education, prevention, support, and human rights advocacy.

NWLC, NAPAWF, NLIRJ, SisterLove, and the 50 additional *amici* listed in the Appendix are committed to ensuring that individuals who may become pregnant have access to full and equal health coverage, including contraceptive coverage without cost-sharing, as guaranteed by the Affordable Care Act ("ACA").

SUMMARY OF THE ARGUMENT

The ACA contraceptive coverage requirement directs health plans to cover, without cost sharing, all Food and Drug Administration ("FDA")-approved methods of contraception for women,[2] as well as related education, counseling, and services. 42 U.S.C. § 300gg-13(a)(4); U.S. Health Res. & Servs. Admin., *Women's Preventive Services Guidelines*, https://bit.ly/2UCnw9P (last visited Mar. 31, 2020). In 2018, the Departments of Health and Human Services, Treasury, and Labor (the "Departments") promulgated two Final Rules that would substantially undermine this statutory requirement by allowing any nongovernmental employer or university unilaterally to exempt itself from the law and deny insurance coverage of contraception and related services to employees, students, and their dependents. Religious Exemptions

[2] This brief uses the term "women" given that one important purpose of the ACA was to ensure that women's health care needs are met. As *amici* discuss, the denial of reproductive health care and related insurance coverage also affects some gender non-conforming people and transgender men, and the ACA's preventive services benefit, like all ACA provisions designed to protect against sex discrimination, applies regardless of gender identity.

and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018) (hereinafter "Religious Exemption"); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018) (hereinafter "Moral Exemption," and together with the Religious Exemption the "Rules" or "Final Rules").

The Departments claim authority to issue these sweeping exemptions under the ACA and the Religious Freedom Restoration Act ("RFRA"), 42 U.S.C. § 2000bb *et seq.*, but neither law supplies such authority. The Rules' expansive exemptions would undermine the purpose of the ACA's contraceptive coverage requirement and significantly harm individuals across the country, defying this Court's long-standing requirement that claims for religious accommodation under RFRA must "take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." *Cutter v. Wilkinson*, 544 U.S. 709, 720 (2005); *see also Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 729 n.37 (2014).[3] As detailed herein through both personal stories and statistics, this harm

[3] Moreover, as Respondents and other *amici* explain, RFRA does not delegate authority to agencies to issue rules creating exemptions from generally applicable laws based on the agency's own determination that RFRA has been violated. *See* Br. for Resp'ts 46–47; Br. for Legal Scholars, Seth Davis et al. as *Amici Curiae*, *Little Sisters of the Poor v. Pennsylvania et al.*, No. 19-431 (Apr. 8, 2020).

is significant and will particularly affect Black, Latinx,[4] Asian American and Pacific Islander ("AAPI") women and other people of color, young people, people with limited resources, transgender men and gender non-conforming people, immigrants, people with limited English proficiency, survivors of sexual and interpersonal violence, and others who face multiple and intersecting forms of discrimination.

Part I of the brief explains that the serious harm the Rules will cause to individuals nationwide contravenes both the ACA and RFRA, and so neither statute can authorize, let alone require, the Rules. Part II explains how the Departments grossly underestimate this harm due to faulty assumptions about who will lose coverage and their ability to overcome the resulting increased cost and non-financial barriers to contraceptive care. Part III explains how these increased barriers will: (a) jeopardize health by increasing unintended pregnancies and aggravating medical conditions, (b) undermine individuals' autonomy and control over their lives, and (c) threaten the economic security and equality of women and all who can become pregnant. Given the immense harms these Rules will cause nationwide, this Court must affirm the decision below.

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[4] "Latinx" is a term that represents a gender-neutral alternative to Latino and Latina and encompasses the identities of transgender and gender non-conforming individuals of Latin American descent.

ARGUMENT

I. The Serious Harm the Rules Will Cause Contravenes Both the ACA and RFRA, and Thus Neither Statute Can Authorize These Rules.

The Departments assert that the ACA and RFRA authorize, and indeed require, the sweeping exemptions proposed in the Final Rules. Br. for Fed. Pet'rs. at 20–30. They are mistaken.[5]

First, it would be nonsensical for Congress to have given the Departments authority to create these exemptions because they reintroduce the very health inequities and barriers to care that Congress intended to eliminate when it enacted the women's preventive services provision of the ACA. *See* Br. for Members of Congress as *Amici Curiae* in Support of Resp'ts, *Little Sisters of the Poor v. Pennsylvania et al.*, No. 19-431 (Apr. 8, 2020) (collecting legislative history showing provision intended to remedy sex discrimination in health care and improve access to preventive services for women, including contraceptive care). Indeed, despite the Departments' claims to the contrary and their tortured reading of the statute, there is no authority in the preventive services provision to exempt employers from its requirements. Accordingly, each of the courts below that has considered whether the ACA authorizes the Rules has held the ACA "does not authorize the Agencies to exempt plans from providing the required coverage." *Pennsylvania v.*

[5] The Departments do not (and cannot) argue that RFRA authorizes the Moral Exemption. *See* Br. for Fed. Pet'rs., 20-31.

President, 930 F.3d 543, 570–72 (3d Cir. 2019); *accord California v. U.S. Dep't of Health & Human Servs.*, 941 F.3d 410, 424–25 (9th Cir. 2019) ("examin[ing] the plain terms and core purposes" of the ACA and concluding that "nothing in the statute permits the agencies to determine exemptions from the requirement" (citation and internal quotation marks omitted)). The agencies cannot rewrite the ACA to cause the very harm the statute sought to remedy.

Second, RFRA neither authorizes nor requires the Religious Exemption. According to the government's interpretation, if any federal agency determines that any law would substantially burden a person's religious exercise, then that agency may issue a rule allowing any person to exempt themselves unilaterally from the law. But such reasoning flies in the face of the Court's longstanding precedent. *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709–10 (1985) (statute that elevates "absolute and unqualified right" to practice religion "over all other interests contravenes a fundamental principle of the Religion Clauses"); *see also Cutter*, 544 U.S. at 722 (a religious exemption must "not override other significant interests"); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring) (prisoner entitled to religious accommodation because it "would not detrimentally affect others who do not share petitioner's belief").

Indeed, when considering claims for religious accommodation under RFRA and its sister statute, the Religious Land Use and Institutionalized Persons Act (42 U.S.C. §§ 2000cc *et seq.*), the Court has always required consideration of harm to third parties. *See*

Hobby Lobby, 573 U.S. at 729 n.37 (citing *Cutter*, 544 U.S. at 720). In *Hobby Lobby*, in which the Plaintiff corporations brought a RFRA challenge to the ACA contraceptive coverage requirement, the Court concluded that the existing "accommodation" process was an available less restrictive means of accommodating the Plaintiffs' objections only upon concluding that "women would still be entitled to all FDA-approved contraceptives without cost sharing," and the effect on women "would be precisely zero." *Id.* at 693. The Court also rejected the suggestion "that 'RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on . . . thousands of women.'" *Id.* (quoting Ginsburg, J., dissenting) (alteration in original). And in *Zubik v. Burwell*, the Court directed the government to "ensur[e] that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage.'" 136 S. Ct. 1557, 1560 (2016) (citation omitted).

The court below thus properly weighed the harm to women in rejecting the claim that RFRA authorizes the Rules, *see Pennsylvania*, 930 F.3d at 574, and this Court should affirm.

II. The Departments Underestimate and Minimize the Harm the Rules Will Cause.

A. The Departments Significantly Understate the Loss of Coverage.

The undeniable effect of the Rules will be a nationwide loss of coverage, with significant attendant financial, personal, and societal costs. The

Departments themselves estimate that the exemptions will affect anywhere from 70,500 to 126,400 women, with a price tag of $41.2 to $67.3 million. 83 Fed. Reg. 57,578–81. While these estimates alone show the impact will be substantial, the Departments' many faulty assumptions result in a grievous failure to capture the full scale and scope of harm.

First, in one estimate, the Departments assume that only those entities that filed litigation or used the "accommodation" process, and a trivial number of similar entities, will use the exemption. *Id.* at. 57,576–78, 57,581, 57,625–27. The Departments assume that of the 209 entities using the "accommodation," only 109 would use the new exemption, and 100 would continue their accommodated status. *Id.* at 57,576–78, 57,581. But they provide no basis for the assumption that any entities will voluntarily continue to comply with the "accommodation" if given the opportunity to exempt themselves. Second, while the Departments maintain that publicly traded corporations can have religious beliefs and may take advantage of the exemption, the Departments nevertheless cavalierly assume that none will use it. *Id.* at 57,562–63, 57,579. Yet even the Departments point out that "this assumption is significant because 31.3 percent of employees in the private sector work for publicly traded companies." *Id.* at 57,580. Ultimately, by exempting all non-governmental employers and universities, the Rules invite thousands of new entities to refuse to comply with the law.

Second, the Departments seriously underestimate the likely impact of the Moral Exemption, which does nothing to circumscribe what types of convictions may be used to invoke the exemption, nor does it have any mechanism to permit oversight. *See id.* at 57,625–28. As the District Court below aptly explained when enjoining the interim Rules, which are identical to the Final Rules in this respect, the moral Rule would allow "an employer with a sincerely held moral conviction that women do not have a place in the workplace to simply stop providing contraceptive coverage. . . . It is difficult to comprehend a rule that does more to undermine the Contraceptive Mandate or that intrudes more into the lives of women." *Pennsylvania v. Trump*, 281 F. Supp. 3d 553, 577 (E.D. Pa. 2017).

Third, the Departments improperly assume that employees of objecting entities share their employers' objections. *See* 83 Fed. Reg. 57,563–64, 57,581, 57,626. To the contrary, women of faith and their dependents who rely on objecting entities for health insurance use contraception and will be affected by a loss of coverage. According to a 2011 study, virtually all (99%) sexually experienced women have used a method of contraception other than natural family planning, and this number is virtually identical (98%) for Catholic women. Rachel K. Jones & Joerg Dreweke, Guttmacher Inst., *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use* 4 (2011), https://bit.ly/2R0buFg. A 2016 survey found that the majority of people across religious affiliations (with the lone exception of white evangelical Protestants) believe that employers should be required to cover contraception even if they claim to have a

religious objection. Pew Research Ctr., *Where the Public Stands on Religious Liberty vs. Nondiscrimination* 8 (2016), https://pewrsr.ch/2JqSmvR. Women of faith will lose a vital health benefit under the Rules.

Fourth, the Departments wrongly assume that the harm will be mitigated because some employers may still choose to cover some, but not all, methods of contraception. *See, e.g.*, 83 Fed. Reg. 57,575. But allowing employers to pick and choose covered methods undermines people's ability to use the method that is most appropriate for them, increasing the risk of unintended pregnancy. Inconsistent and incorrect contraceptive use accounts for 41% of unintended pregnancies in the U.S.; non-use accounts for 54%. Adam Sonfield et al., Guttmacher Inst., *Moving Forward: Family Planning in the Era of Health Reform* 8 (2014), https://bit.ly/2QWhbUs. Women are more likely to use contraception consistently and correctly when they can use the method that suits their needs. Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 Perspectives on Sexual & Reproductive Health 94, 99, 101–03 (2008).

B. The Departments Erroneously Assume that Those Who Lose Contraceptive Coverage Can Overcome the Increased Cost and Other Barriers.

1. The Departments Erroneously Suggest that the Rules Will Not Significantly Affect Women with Low Incomes, Women of Color, and Young Women.

Downplaying the harm the Rules will cause, the Departments suggest that the Rules will not significantly affect women most at risk of unintended pregnancy—including, among others, women with low incomes, women of color, and young women—because these individuals are less likely to depend upon health plans subject to the Rules. 83 Fed. Reg. 57,547, 57,551, 57,574, 57,576, 57,608. But that is incorrect.

Many low-wage workers and their dependents rely on employer-sponsored health insurance. Alanna Williamson et al., Kaiser Family Found., *ACA Coverage Expansions and Low-Income Workers* 4 (2016), https://bit.ly/3azjMLZ. Nationwide, over 640,000 private sector employers offering health insurance have workforces that are mostly low-wage.[6] So too in Pennsylvania and New Jersey, which have respectively about 23,000 and 17,000 such employers. *See supra* note 6.

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[6] Nat'l Women's Law Ctr. ("NWLC") calculations from Medical Expenditure Panel Survey ("MEPS") United States Tables V.A.1., V.A.2, VII.A.1, VII.A.2 (2018), https://bit.ly/2UOFFAh (last visited Mar. 31, 2020).

Likewise, nationwide 37% of private sector employers offering health insurance (or over 1.3 million employers) are in the retail and non-professional services industries. *Id.* These workers tend to earn lower wages, earning a median annual income of $35,000 per year, compared to $48,000 for workers across all industries.[7] Female retail salespeople in Pennsylvania have a median hourly wage of $13.79. *See supra* note 7. Black female retail salespeople make significantly less, $12.98. *Id.* These earnings equate to a median monthly income of $2,391 for all female and $2,250 for Black female retail salespersons. This is less than the approximately $2,700–$3,700 needed for a single person with no children to cover basic monthly expenses such as housing, food, transportation, health care, taxes, and other necessities in Pennsylvania. Economic Policy Institute, *Family Budget Calculator: Monthly Costs*, https://bit.ly/2JsJIgh (last visited Mar. 31, 2020) (range based on Pittsburgh and Chester County, respectively).

Indeed, contrary to the Departments' suggestion, women of color will be particularly harmed by the Rules. Women of color overwhelmingly use contraception: nearly all Hispanic (97.2%), Black (99%), and Asian (98.6%) sexually-experienced women have used at least one method of contraception. William D. Mosher & Jo Jones, Ctrs. for Disease Control & Prevention, *Use of Contraception in the United States:*

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[7] NWLC calculations for full-time, year-round workers from 2018 American Community Survey (hereinafter ACS) Single-Year Estimates, using Steven Ruggles et al., *Integrated Public Use Microdata Series*, IPUMS USA, Univ. of Minn., http://www.ipums.org (hereinafter IPUMS).

1982–2008 19 (2010), https://bit.ly/3bGCKjI. Moreover, women of color are overrepresented in the low-wage workforce. In 2018, Latinas made up 16% of women in the overall workforce, but 25% of women in the forty lowest-paying jobs. Black women likewise made up 13% of women in the overall workforce but 15% of women in the forty lowest-paying jobs. For some AAPI subgroups, women are substantially overrepresented in the low-paid workforce: Vietnamese, Thai, Nepalese, and Burmese women comprise, respectively, 0.67%, 0.1%, 0.05%, and 0.04% of the overall workforce but respectively 1.29%, 0.16%, 0.9%, and 0.8% of women in the low-paid workforce. Bureau of Labor Statistics, *May 2018 National Occupational Employment & Wage Estimates*, https://bit.ly/3dTgfu2.

Finally, because the ACA allows young adults to remain on their parent's or guardian's health plan until age 26, 45 C.F.R. § 147.120, many are dependents on employer-sponsored plans and therefore also at risk of losing coverage under the Rules. In 2018, 8.4 million young adults (ages 19–25) were dependents on employer-based health insurance plans.[8] Also, many young people rely on student health plans governed by the ACA. Each of these young adults risks losing contraceptive coverage if their university, employer, or parents' employer objects to providing it.

It is thus error to assume that the Rules will have little effect on individuals with low incomes, women of color, or young people, as many such individuals have insurance through a private employer or university and

[8] NWLC calculations based on 2019 Current Population Survey Annual Social and Economic Supplement, using IPUMS.

will lose coverage if their plan sponsor claims the new exemption.

2. The Departments Fail to Account for the Effect of Increased Cost and Other Barriers on Individuals' Ability to Access Contraceptive Care.

Without coverage, individuals will again face financial, logistical, informational, and administrative barriers to accessing the contraceptive method they need. These changes will particularly affect women of color, women with low incomes, young people, transgender and gender non-conforming people, and others facing health disparities due to systemic barriers.

Without insurance coverage, contraception is expensive. As of 2017, women without insurance could expect to pay about $850 annually—or $4,250 over five years assuming static costs—on oral contraception and attendant care. Jamila Taylor & Nikita Mhatre, *Contraceptive Coverage Under the Affordable Care Act*, Ctr. for Am. Progress (Oct. 6, 2017), https://ampr.gs/2xyLVnH. Long-acting contraceptives, among the most effective contraceptives, carry the highest upfront costs: IUDs can cost up to $1,300 up front, in addition to costs of ongoing care and removal. Erin Armstrong et al., *Intrauterine Devices and Implants: A Guide to Reimbursement*, Nat'l Family Planning & Reprod. Health Ass'n 5 (July 2015), https://bit.ly/2UREVdr; Planned Parenthood, *IUD*, https://bit.ly/2Uw5YvT (last visited Mar. 31, 2020).

Before the ACA, women spent between 30% and 44% of their out-of-pocket health costs just on contraception. Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Affairs 1204, 1208 (2015), https://bit.ly/3atIMnI. Over half of young women reported experiencing a time when they could not afford contraception consistently before the ACA. Zenen Jaimes et al., Generation Progress & Advocates for Youth, *Protecting Birth Control Coverage for Young People* 1 (2015), https://bit.ly/2UJJqXq. By way of example, one young woman named Rebecca made $115 per week in 2004 and could not afford to purchase contraception. She relied on free sample packets of contraception at her doctor's office. When these samples were no longer available, Rebecca became pregnant and ultimately miscarried, experiences which emotionally devastated her.[9]

Thanks, however, to the ACA's contraceptive coverage requirement, an estimated 61.4 million women are eligible for coverage of their contraception, irrespective of cost. NWLC, *New Data Estimates 61.4 Million Women Have Coverage of Birth Control Without Out-of-Pocket Costs* 1 (Dec. 2019), https://bit.ly/2UuDjaF. Within ten months of implementation of the contraceptive coverage requirement, median spending for almost all contraceptive methods fell to zero. Becker & Polsky, *supra*, at 1208; Bearek et al., *Changes in Out-Of-Pocket*

[9] Submitted May 1, 2018. The stories in this brief come from online submissions to the NWLC website. The individuals have consented to sharing their stories.

Costs for Hormonal IUDs After Implementation of the Affordable Care Act: An Analysis of Insurance Benefit Inquiries, 93 Contraception 139, 141 (2016). Unsurprisingly, lower costs have corresponded with an increase in use, particularly of the most effective forms of contraception: one study found that "the removal of the cost barrier to IUDs and implants has increased their rate of adoption after the ACA." Ashley H. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs Among Privately Insured Women*, 28-3 Women's Health Issues 219, 222 (2018); *see also* Megan L. Kavanaugh et al., *Health Insurance Coverage and Contraceptive Use at the State Level: Findings from the 2017 Behavioral Risk Factor Surveillance System*, 2 Contraception: X 1, 3-5 (forthcoming 2020) (finding insurance coverage significantly associated with use of most FDA-approved contraceptives, including IUDs, injectables, and pills).

The Rules threaten to reverse these gains. Studies confirm that cost is a major determinant of whether people obtain contraceptive care, particularly for those with lower incomes and people of color. Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 Guttmacher Pol'y Rev. 7, 10 (2011). One in three Latina and four in ten Black women of reproductive age report that they could not afford to pay more than $10 for contraception. Nat'l Latina Inst. Reproductive Health, *Latina/o Voters' Views and Experiences Around Reproductive Health* 8 (Oct. 4, 2018), https://bit.ly/2R0YPBN; PerryUndem, *Results from a National Survey of Black Adults: The Lives and Voices of Black America on the Intersections of Politics, Race,*

and Public Policy 34 (Sept. 25, 2017), https://bit.ly/2w7cvUE.

Prior to the ACA, studies found that "[e]ven small increments in cost sharing have been shown to reduce the use of preventive services." *See* Inst. of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* 109 (2011), https://bit.ly/3447N6v (hereinafter "IOM Rep."). People will also use contraceptive methods that are medically inappropriate or less effective due to cost constraints. Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 Contraception 360, 360, 363 (2007); Guttmacher Inst., *Insurance Coverage of Contraception* (Aug. 2018), https://bit.ly/2UTuOVF. Research conducted by the Urban Institute in 2018 confirms that even with the tremendous gains from the ACA, "real or perceived cost prevented some [women] from using the birth control method of their choice." Rebecca Peters et al., Urban Inst., *"Birth Control Is Transformative": Women Share Their Experiences with Contraceptive Access* 5 (Mar. 2019), https://urbn.is/2JwxoLU. The impending coronavirus-driven recession will make contraceptive coverage all the more critical as people become even more sensitive to cost constraints. Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* 5 (2009), https://bit.ly/3dJAVEz. Research demonstrates that during the last recession, some women ceased using contraception, skipped pills, delayed filling prescriptions, or purchased fewer packets at once. *Id.*

The Rules will also create new logistical, informational, and administrative barriers to accessing contraception. The health care system is complicated for those without insurance, requiring resources such as free time or the ability to take time off from work without losing pay, regular and unlimited phone and internet access, privacy, transportation, English language comprehension, and ability to read and respond to complex paperwork. It is, therefore, particularly difficult for individuals with limited English proficiency and for people in low-wage jobs—disproportionately women of color—who often work long, unpredictable hours with little or no scheduling flexibility or reliable access to transportation. NWLC, *Collateral Damage: Scheduling Challenges for Workers in Low-Wage Jobs and Their Consequences* 1–3 (2017), https://bit.ly/3dLFxtJ.

Without contraceptive coverage, cost constraints will also force many who lose coverage away from trusted providers who know their medical histories. This poses particular challenges for people of color, people with limited English proficiency, and the LGBTQ community. These communities already face multiple barriers to obtaining reproductive health services, including language barriers, providers' limited geographic availability, implicit bias, and outright discrimination. *See* Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 649: Racial & Ethnic Disparities in Obstetrics & Gynecology 3 (2015), https://bit.ly/39ya9f8; Sandy E. James et al., Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 96–99 (2016), https://bit.ly/3dGOzIx. Switching from a trusted provider is particularly

harmful for transgender and gender non-conforming people, who report pervasive provider discrimination and ignorance of transition-related care. James, et al., *supra*, at 96–99. So too for Black women, for whom access to culturally effective care by trusted providers is critical given this country's legacy of racist and coercive policies denying Black women's reproductive autonomy, as well as of persistent provider bias contributing to significant racial health disparities. In Our Own Voice: National Black Women's Reproductive Justice Agenda, *Our Bodies, Our Lives, Our Voices: The State of Black Women and Reproductive Justice* 15, 47 (June 27, 2017), https://bit.ly/2WWJYw0.

Stories of individuals who lack insurance coverage today illustrate the difficult choices those who lose contraceptive coverage will be forced to make if the Rules are permitted to take effect. Take Ariel, who was 19-years-old and in need of contraception to manage heavy periods and debilitating cramps. Ariel lost insurance coverage and discovered her pill would cost $66 a month, or $792 a year. Ariel was homeless and forced to choose between basic necessities, like food, and her health. As she describes it, "$66 a month when I could barely [afford to] eat, wasn't going to happen." Because she could not afford contraception, her conditions were unmanaged.[10]

Sofi's experience highlights how individuals will forgo use of contraception when costs increase. When Sofi was 22, she was able to get an IUD covered without out-of-pockets costs as a dependent on her mother's insurance. But when her IUD became

[10] Submitted April 24, 2018.

displaced, Sofi no longer had insurance because her mother had been laid off from her job. Without coverage, Sofi faced a $2000 bill to have the IUD replaced—the same as her monthly income. Forced to choose between paying rent and paying for a new IUD, Sofi reports that she went "without affordable birth control or insurance for almost seven months."[11]

Similarly, Emily's story demonstrates how some individuals will be forced to use contraceptive methods that are less effective for their particular needs when faced with increased costs. Emily needed an IUD to prevent pregnancy and manage the heavy bleeding and painful periods of her Dysfunctional Uterine Bleeding. Without coverage, the IUD would cost nearly $700, and there was no option to pay in installments. This was cost prohibitive for Emily and her partner—it was the same amount as their monthly rent. Because Emily could not afford an IUD, she used condoms. Not only are condoms less effective in preventing pregnancy than IUDs, James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397, 398 (2011), but they did nothing to alleviate the symptoms of Emily's medical condition.[12]

Finally, Rylie's story highlights the burden the Rules will cause for young people, who often have little income, large educational debt, and limited ability to absorb extra costs. As a freshman in college, Rylie relied upon contraception to regulate her menstrual cycle. However, Rylie's coverage through her mother's

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[11] Submitted April 26, 2018.

[12] Submitted April 27, 2018.

employer-sponsored plan at a Catholic elementary school did not cover contraception. Rylie had to pay $30 out of pocket each month. As she explains, "it may not seem like much, but I don't have much income, being a full-time student, and I'm trying to save money to cover the costs of my education as well."[13]

In sum, the Rules will make contraception cost-prohibitive and inaccessible for many—particularly those who lack resources necessary to overcome the barriers the Rules create. The Departments are incorrect to assume otherwise.

3. The Departments are Wrong to Assume that This Harm Will Be Offset by Public Programs.

The Departments also incorrectly assume that those who lose contraceptive coverage can alternatively access contraception through existing government-sponsored programs, such as Title X, Medicaid, and state-run programs. 83 Fed. Reg. at 57,548, 57,551, 57,605. While the Rules will force thousands to seek contraceptive care from these already-strained programs, causing the States fiscal harm, many who lose coverage will not be able to access care through these programs due to eligibility restrictions and capacity constraints. In addition to income- and category-based eligibility criteria for Medicaid, *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (limiting Medicaid eligibility for childless, non-pregnant adults to 133% of the federal poverty line), anti-immigrant provisions restrict Medicaid eligibility for most lawful permanent

[13] Submitted April 26, 2018.

residents—many of whom are Latinx and AAPI—for five years. 8 U.S.C. § 1613(a). People like Trinity, whose family has a low income but still did not qualify for Medicaid, would be particularly harmed under the Rules. Without insurance, Trinity could not afford the type of contraception that met their needs, and Trinity ultimately had two unplanned pregnancies.[14]

The Departments point to recent changes made to the Title X program as the silver bullet to offset harm resulting from the Rules. 83 Fed. Reg. at 57,551. Specifically, HHS's Title X rule redefines an eligible "low-income family" to include women who lose contraceptive coverage because of an employer's objection. 84 Fed. Reg. 7714, 7734 (Mar. 4, 2019). But Congress was well aware of the decades-old Title X program when it enacted the ACA and determined that reform was necessary to ensure access to affordable contraception. *See, e.g.*, 155 Cong. Rec. S12025 (Dec. 1, 2009) (statement of Sen. Boxer) (women's preventive services provision addresses "critical issue by requiring that all health plans cover comprehensive women's preventive care and screenings" including "family planning services"); *id.* at S12027 (statement of Sen. Gillibrand) (similar). Clearly, then, Congress did not regard Title X as an adequate substitute. Indeed, this redefinition also contravenes the plain meaning and purpose of Title X by failing to prioritize access for low-income women. *See* 42 U.S.C. § 300a-4(c)(2). It also does nothing to ensure Title X providers actually have capacity to meet the expanded client population. Currently, 19 million women in need lack reasonable

[14] Submitted May 20, 2018.

access in their county to a publicly funded health center offering the full range of contraceptives. Power to Decide, *Birth Control Access: Lack of Access = Lack of Power*, https://bit.ly/3bHz95a (last visited Mar. 31, 2020). And these shortages are compounded by HHS's own restructuring of the Title X program, which has already resulted in the closure of over 1,000 sites. Henry J. Kaiser Family Found., *The Status of Participation in the Title X Federal Family Planning Program* (Dec. 20, 2019), https://bit.ly/3dJIxa7. Thus, the Departments cannot assume that individuals who lose contraceptive coverage as a result of the Rules will be able to access care through Title X.

Accordingly, due in part to existing restrictions and demands, and in part due to HHS's own actions, the Departments cannot rely on government-sponsored programs to disclaim the real harm that these Rules will cause, particularly for those who can least afford it.

III. Neither the ACA Nor RFRA Authorizes the Rules Because They Will Detrimentally Affect the Health, Autonomy, and Economic Security of Those Who Lose Contraceptive Coverage.

A. The Rules Will Harm the Health of Individuals and Families.

Contraception is a vital component of preventive health care: it allows people to avoid unintended pregnancy and related health consequences; is critical for individuals with underlying medical conditions that would be further complicated by pregnancy; and has other health benefits unrelated to preventing

pregnancy. While most women aged 18–44 who use contraception do so to prevent pregnancy (59%), many also use it both for pregnancy prevention and to manage medical conditions (22%). Caroline Rosenzweig et al., Kaiser Family Found., *Women's Sexual and Reproductive Health Services: Key Findings from the 2017 Kaiser Women's Health Survey* 3 (Mar. 13, 2018), https://bit.ly/341zw7Z. By reinstating barriers to contraception, the Rules will harm the health of individuals and families.

1. The Rules Will Place More People at Risk for Unintended Pregnancy and Associated Health Risks.

By limiting access to contraception, the Rules threaten to increase the risk of unintended pregnancy, which, due to systemic barriers, is already higher for women of color and young people, including LGBTQ youth. IOM Rep., at 103–04; Intersections of Our Lives, *Reproductive Justice for Women of Color* (Oct. 2017), https://bit.ly/2JuToH2; Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 Am. J. Pub. Health 1379, 1383 (2015). Increased access to contraception without cost-sharing has been found to result in fewer unintended pregnancies, Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1291 (2012), and one study estimated that denying contraceptive coverage would result in 33 more pregnancies per 1000 women. William Canestaro et al., *Implications of Employer Coverage of*

Contraception: Cost-Effectiveness Analysis of Contraception Coverage Under an Employer Mandate, 95 Contraception 77, 83, 85 (2017). Based on that study, and using the Administration's own likely low estimates of the Rules' impact, 83 Fed. Reg. 57,578–81, the Rules would result in at least 2,326 to 4,171 more unintended pregnancies.

Women with unplanned pregnancies are more likely to delay prenatal care, leaving potential health complications unaddressed and increasing risks of infants with low birth weight and preterm birth. IOM Rep. at 103. Women with unintended pregnancies are also at higher risk for maternal morbidity and mortality, maternal depression, and physical violence during pregnancy. *Id.*; Amy O. Tsui et al., *Family Planning and the Burden of Unintended Pregnancies*, 32 Epidemiologic Rev. 152, 165 (2010); Office of Disease Prevention & Health Promotion, *Family Planning*, https://bit.ly/2US8vQg (last visited Mar. 31, 2020). Rates of pregnancy-related mortality are at crisis levels in the United States—more than doubling from 1987 to 2016. Ctrs. for Disease Control & Prevention, *Pregnancy Mortality Surveillance System*, https://bit.ly/39wQagZ (last updated Feb. 4, 2020). Black women in the United States are between three and four times more likely to die from pregnancy-related causes than white women, and the maternal mortality ratio for Black women is now higher than in many developing countries. Black Mamas Matter Alliance, *Black Mamas Matter Toolkit Advancing the Right to Safe and Respectful Maternal Health Care* 21 (2018), https://bit.ly/2R2AWd3. By creating additional

barriers to contraception, the Rules will increase rates of unintended pregnancy and significant health risks.

2. The Rules Will Undermine Health Benefits from Contraception.

Contraception offers many health benefits. It is necessary to prevent pregnancy for people with medical conditions complicated by pregnancy, including diabetes, obesity, pulmonary hypertension, and cyanotic heart disease. IOM Rep. at 103–04. Contraception also offers several health benefits unrelated to pregnancy. It treats menstrual disorders, reduces menstrual pain and risk of certain cancers (such as endometrial and ovarian cancer), and helps protect against pelvic inflammatory disease, among other conditions. *Id.* at 107.

Indeed, contraception helps manage a variety of medical conditions. For example, Megan has polycystic ovary syndrome and takes birth control to regulate her menstrual cycle and reduce her chances of developing ovarian cancer, of which she has a family history.[15] Kathleen uses birth control to treat a condition called Postural Orthostatic Tachycardia Syndrome, which causes irregular blood pressure, extreme dizziness, and chronic fatigue.[16] Julie needs a specific kind of low-hormone birth control to treat her anxiety and panic attacks.[17] And Amy takes birth control to reduce symptoms of dysmenorrhea, regulate her periods, and

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[15] Submitted April 30, 2018.

[16] Submitted June 29, 2018.

[17] Submitted May 29, 2018.

reduce acne.[18] By reinstating barriers to contraception, the Rules will aggravate these and other medical conditions and undermine necessary health benefits.

B. The Rules Will Undermine Individuals' Autonomy and Control Over Their Lives.

Access to contraception is critical to people's autonomy, particularly for survivors of rape and intimate partner violence, communities whose sexual and reproductive lives have historically been subjected to the control of others, and transgender men and gender non-conforming people who can become pregnant.

Access to the full range of FDA-approved contraception is vital for survivors of sexual violence. Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 554, Reproductive and Sexual Coercion 2–3 (2013), https://bit.ly/2UuJZpk. Approximately 1 in 5 women in the U.S. (or 25.5 million women) will be raped or subjected to attempted rape. Sharon G. Smith et al., Ctrs. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2015 Data Brief—Updated Release* 2 (Nov. 2018), https://bit.ly/2wKgqam. Access to emergency contraception without cost-sharing empowers sexual assault survivors to prevent pregnancy, and it is especially critical for students given the high rate of sexual assault among college and high school students. NWLC, *Sexual Harassment & Assault in Schools*, https://bit.ly/39roZEc (last visited Mar. 31, 2020).

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[18] Submitted June 27, 2018.

Contraception without cost-sharing is also vital for survivors of intimate-partner violence. Over 1 in 3 women in the U.S. (4.6 million women) experience intimate partner violence, and abusive partners frequently restrict women's access to money to gain control. Leigh Goodmark, *A Troubled Marriage: Domestic Violence and The Legal System* 42 (2011). Samantha is one such survivor. Samantha did not have access to money and could not pay for contraception out of pocket, and when she became pregnant, her abusive partner threatened her until she was able to escape.[19]

Abusive partners also often engage in "reproductive coercion" to promote unwanted pregnancies, including interfering with contraception or abortion. Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 Contraception 457, 457–58 (2010). Particular forms of contraception, including the shot and long-acting reversible contraceptives, enable women to prevent pregnancy with reduced risk of detection by or interference from potentially abusive partners. Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 554, *supra*, at 2–3. For instance, for individuals with abusive partners who monitor menstrual bleeding, the copper IUD is a safe option because typically it does not cause missed periods and also is undetectable and not removable by an abusive partner. *Id.* Without these options, pregnancy can entrench a woman in an abusive relationship, endangering the woman, her pregnancy, and her

[19] Submitted June 7, 2018.

children. By impeding access to contraceptive methods less susceptible to interference, the Rules will take away a woman's ability to exercise control at a time when it is vital for the safety of herself and her family. *See id.*

Freedom from reproductive coercion is also critically important for communities with histories of subjection to the control of others in their sexual and reproductive lives. During slavery, Black women were treated as property, with no ability to resist unwanted sex or childbearing. Deborah Gray White, *Ar'n't I a Woman?: Female Slaves in the Plantation South* 68 (1999). And reproductive coercion has been visited upon others in this country, including Native American women, individuals with disabilities, and LGBTQ individuals. Carole Joffe & Willie J. Parker, *Race, Reproductive Politics and Reproductive Health Care in the Contemporary United States*, 86 Contraception 1, 1 (2012); *see also Proud Heritage: People, Issues, and Documents of the LGBT Experience*, Vol. 2 205 (Chuck Stewart ed., 2015); Elena R. Gutiérrez, *Fertile Matters: the Politics of Mexican-Origin Women's Reproduction* 35–54 (2008); *Buck v. Bell*, 274 U.S. 200, 205 (1927). For these groups in particular, some of whom are still subject to reproductive coercion, autonomy over their reproductive health decisions is critically important. *See, e.g.*, Women Enabled, Int'l & Lurie Inst. For Disability Policy, Joint Submission to the United Nations Universal Periodic Review: United States of America 4 (2019), https://bit.ly/2Jus9MN. In taking away contraceptive coverage, the Rules hamper individuals' ability to make decisions about whether to

use contraception and which method to use, undermining their autonomy.

Contraception is also critical to the autonomy of transgender men and gender non-conforming people. Discrimination in society at large and in health care already contributes to a higher incidence of depression, anxiety, and suicide among transgender men. SL Budge et al., *Anxiety and Depression in Transgender Individuals: The Roles of Transition Status, Loss, Social Support, and Coping*, 81 J. Consult Clin. Psych. 545 (2013); Fatima Saleem & Syed W. Rizvi, *Transgender Associations and Possible Etiology: A Literature Review*, 9 Cureus 1, 2 (2017). For some, like Zachary, a transgender man, pregnancy and menstruation can create greater gender dysphoria—the distress resulting from misalignment between one's physical body and sense of self. Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 Obstetric Med. 4, 6 (2015). Zachary was pregnant once, and the stress caused him to miscarry. He suffered greater gender dysphoria and depression from the incident and fears the "major dysphoria" that would occur were he to become pregnant again.[20]

C. The Rules Will Undermine Individuals' Economic Security and Equality.

This Court has recognized that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992). By

[20] Submitted November 13, 2018.

imposing barriers to contraception, the Rules will thwart people's ability to plan, delay, space, and prevent pregnancies. This, in turn, will undermine their financial stability, educational advancement, and career goals. These consequences do not occur in a vacuum but must be considered in light of existing economic and social disparities.

Access to contraception has life-long economic benefits: enabling women to complete high school and higher levels of education, improving their earnings and labor force participation, and securing their economic independence. Adam Sonfield et al., Guttmacher Inst., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children* 7–8 (Mar. 2013), https://bit.ly/39yA8ms. The availability of the oral contraceptive pill alone is associated with roughly one-third of the total wage gains for women born from the mid-1940s to the early 1950s. Martha J. Bailey et al., *The Opt-in Revolution? Contraception and the Gender Gap in Wages*, 4 Am. Econ. J. Appl. Econ. 225, 241 (2012). While significant wage disparities persist, especially for women of color,[21] contraception has helped advance gender equality by

[21] Currently, women in the U.S. who work full time are paid only 82¢ for every dollar paid to their male counterparts. The disparities are even greater for women of color. Latina women make only 54¢ for every dollar paid to white men, and that number is 57¢ for Native American women, 62¢ for Black women and as low as 50¢ and 52¢ for AAPI women in some ethnic subgroups. NWLC, *The Wage Gap: The Who, How, Why, and What To Do* (Sept. 2019), https://bit.ly/2WZOb26; Jasmine Tucker, NWLC, *Equal Pay for Asian American and Pacific Islander Women* (Jan. 2020), https://bit.ly/3axtWfT.

reducing these pay gaps. Sonfield et al., *Social and Economic Benefits*, *supra*, at 14.

Access to oral contraceptives has improved women's educational attainment, which in turn has increased women's participation in many professions including law and medicine. *Id.* at 7–16. In the 2018 Urban Institute study, nearly all women reported that birth control was "extremely important" in their lives, saying it allowed them to pursue academic and professional goals and achieve financial stability. Peters et al., *Birth Control Is Transformative* at 9; Nat'l Latina Inst. Reprod. Health, *Latina/o Voters' Views* at 6 (77% of Latina women say having access to affordable birth control has been important in their lives). Many women have personal stories about the importance of birth control to their lives. For example, Laurel was able to pursue her dream of becoming an architect because she was able to plan her family and create a solid financial foundation before having children.[22] JMT credits her academic success and career as an engineer to reproductive planning assistance for low-income individuals.[23] And because of birth control, Loren is able to focus on her studies and clinic practice as she pursues her Doctorate in Psychology.[24]

The Departments are well-aware of these significant benefits. They previously explained that before the ACA, disparities in health coverage "place[d] women in the workforce at a disadvantage compared to

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[22] Submitted November 13, 2018.

[23] Submitted June 4, 2018.

[24] Submitted November 13, 2018.

their male co-workers[,]" that "[r]esearchers have shown that access to contraception improves the social and economic status of women[,]" and that the contraceptive coverage requirement "furthers the goal of eliminating this disparity by allowing women to achieve equal status as healthy and productive members of the job force." 77 Fed. Reg. 8,725, 8,728.

Unplanned pregnancies can entrench economic hardship. Studies show having a child creates both an immediate decrease in women's earnings and a long-term drop in their lifetime earning trajectory. *See, e.g.*, Sonfield et al., *Social and Economic Benefits*, *supra*, at 14–15 (reviewing studies). Mothers who work full time typically make only 69¢ for every dollar paid to fathers. *See* NWLC, *The Wage Gap*, *supra* note 21. Women without children also have greater employment rates than both mothers and pregnant women. Jennifer Bennett Shinall, *The Pregnancy Penalty*, 103 Minn. L. Rev. 749, 795–96 (2018). Indeed, unplanned births reduce labor force participation by as much as 25%. Ana Nuevo Chiquero, *The Labor Force Effects of Unplanned Childbearing*, Boston Univ., Job Market Paper 3 (Nov. 2010), https://bit.ly/2wVrmBZ.

Avoiding unplanned pregnancy is especially important for individuals in low-wage jobs, who are disproportionately women of color. *See supra* note 8 and accompanying text. People in low-wage jobs are less likely to have parental leave or predictable and flexible work schedules. NWLC, *Collateral Damage*, at 1, 4. Moreover, many who become pregnant while working in low-wage jobs are denied pregnancy accommodations and face workplace discrimination;

some are forced to quit, fired, or pushed into unpaid leave. NWLC, *It Shouldn't Be a Heavy Lift: Fair Treatment for Pregnant Workers* 1 (2016), https://bit.ly/2UymZG4. And the total costs of raising a child are staggering, accounting for 27% of low-income families' gross income. Mark Lino et al., U.S. Dep't of Agric., *Expenditures on Children by Families, 2015* 10 (2017), https://bit.ly/3dP9HfE. For Claire, finding a way to afford birth control when she graduated college was a top priority given her family's limited income. Claire knew that becoming pregnant and giving birth while uninsured would have resulted in their being evicted from their homes or forced into bankruptcy.[25]

Finally, because of systemic barriers, young people who are pregnant may not be able to pursue their educational goals. Young adults who give birth as teens are much less likely to obtain a high school diploma than their counterparts. Jennifer Manlove & Hannah Lantos, *Data Point: Half of 20- to 29-Year-Old Women Who Gave Birth in Their Teens Have a High School Diploma*, Child Trends (Jan. 11, 2018), https://bit.ly/2WZA64M. Overall, only 53% of young women who gave birth as teens received a high school diploma by age twenty-nine, compared to 90% of women who did not have a child. *Id.*

In sum, by imposing barriers to contraception, the Rules jeopardize the financial well-being, job security, workforce participation, and educational attainment of those who can become pregnant, as well as their health, safety, and autonomy. The Rules thus threaten

[25] Submitted June 16, 2018.

to deprive women of the ability to "participate equally in the social and economic life of the [n]ation," *Casey*, 505 U.S. at 856, and to deprive the nation of the benefits of their contributions.

CONCLUSION

Neither the ACA nor RFRA authorizes these Rules. The Rules will cause serious harm to individuals who can become pregnant, in particular those with low incomes, people of color, and others who already face systemic barriers to care. For the reasons contained herein and in Respondents' brief, *amici* respectfully request that this Court affirm the decision below.

Respectfully submitted,

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April 8, 2020

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