2016 WL 675868 (U.S.) (Appellate Brief)
Supreme Court of the United States.

David A. ZUBIK, et al., Petitioners,

v.

Sylvia BURWELL, Secretary of Health and Human Services, et al., Respondents.

Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191.
February 17, 2016.

On Writs of Certiorari to the United States Courts of Appeals
for the Third, Fifth, Tenth, and District of Columbia Circuits

Brief of Amicus Curiae Black Women's Health Imperative in Support of Respondents

Mark A. Packman, Kami E. Quinn, Jenna A. Hudson, Tamra B. Ferguson, Kristiné M. Hansen, Mamie L. Glaeberman, Gilbert LLP, 1100 New York Ave., N.W., Ste. 700, Washington, D.C. 20005, (202) 772-2320, packmanm @gotofirm.com, for amicus curiae Black Women's Health Imperative.

*i TABLE OF CONTENTS

*iii TABLE OF AUTHORITIES

Cases

*1 INTEREST OF *AMICUS CURIAE* [1]

Amicus curiae Black Women's Health Imperative (the "Imperative") is the only organization in the United States devoted solely to advancing the health of this country's 21 million Black women through advocacy, health education, research, and leadership development. In addition to documenting the enormous health disparities that exist for Black women, the Imperative places Black women and their experiences at the forefront and exposes the conditions and systems that impose undue health burdens on Black women.

Black women face particular burdens in exercising their reproductive rights. Black women historically have had less access to and control over their reproductive and preventive healthcare and are at a disproportionately greater risk than other women for many serious, life-altering, and long-term health concerns. Today, lingering stereotypes and social, political, and economic conditions adversely impact Black women's reproductive decisions.

***2** As part of its advocacy for the health of Black women, the Imperative seeks to prevent Black women from being forced to choose between their family's financial well-being and their own reproductive and preventive healthcare. The Imperative has an interest in this case because many Black women work for nonprofit religious organizations and will suffer substantial harm if they are denied equal access to contraceptive care. The Imperative thus supports respondents' position that petitioners should not be granted the exemption they seek.

All parties have consented to the filing of this brief.

SUMMARY OF THE ARGUMENT

Amicus curiae agrees with respondents that the contraceptive-coverage mandate, with its accommodation for petitioners, does not violate the Religious Freedom Restoration Act of 1993 ("RFRA")[2]. As set forth fully in respondents' brief, with the accommodation, the mandate does not impose a substantial burden on petitioners, furthers a compelling governmental interest, and is the least restrictive means of furthering that interest. In this brief, *amicus curiae* focuses on the compelling interest advanced by the mandate.

Black women will be uniquely impacted by the outcome of this case because they are disproportionately impacted by certain health issues, ***3** tend to be less economically advantaged, and have high levels of religious commitment. These realities build on the historic lack of control that Black women have had over their reproductive health. If petitioners are exempted from the mandate, the Court will have given nonprofit religious organizations its seal of approval to infringe on individual women's religious liberty by denying those women equal access to the same contraceptive coverage granted to other women.

As Justice Ginsburg stated, "one person's right to free exercise must be kept in harmony with the rights of her fellow citizens, and 'some religious practices [must] yield to the common good.' "[3] Petitioners here do not ask that they be permitted to do something, that others are prohibited from doing in order to exercise their religious beliefs; rather, petitioners want this Court to permit them to deny their employees' congressionally-granted rights, based on the *employers'* religious beliefs. This Court historically has not allowed one private party's religious liberties to infringe on the religious liberties of others. RFRA was enacted specifically to return to jurisprudence under which the Court permitted exceptions to a generally applicable law only when other individuals' religious rights would not be affected by those exceptions.[4]

***4** "Charitable organizations [including nonprofit religious ones] are estimated to employ more than 10% of the U.S. workforce."[5] At least 75% of those employees are women, many of whom are Black women.[6] Religious nonprofit organizations to whom the current accommodation applies include private grammar schools, universities, hospitals, healthcare networks, the YMCA, and charitable organizations such as the Salvation Army. These organizations employ many people who do not follow all of the tenets of their employers' religion, or do not adhere as strictly to those tenets as do the governing bodies of those organizations. For example, many Catholics do not eschew birth control, but nevertheless may work in a Catholic hospital, school, or other nonprofit religious organization. Employer organizations cannot be permitted to exercise their religion in a way that infringes on the constitutional rights of their individual employees.

***5** In its opinion in *Burwell v. Hobby Lobby*, in the context of for-profit employers, the Court upheld the very accommodation challenged here: the ability to avoid providing employer-sponsored health plan coverage of contraception by notifying the Department of Health and Human Services ("HHS") (or a third-party administrator ("TPA")) that the employer objects on religious grounds.[7] Through that accommodation, the employer's rights are protected, and the employees who so desire are able to obtain the same contraceptive coverage as other women. However, petitioners here want a full exemption even from that accommodation, leaving their employees without access to the contraceptive care Congress has granted other women. A complete exemption for all nonprofit religious organizations will have catastrophic effects on women's ability to access the preventive care without cost sharing. Accordingly, *amicus curiae* joins respondents in opposing petitioners' requested relief.

ARGUMENT

I. ACCESS TO CONTRACEPTION IS A COMPELLING GOVERNMENT INTEREST [8]

This Court has long held that "women (and men) have a constitutional right to obtain ***6** contraceptives …." [9] Congress agrees: "[T]here is nothing 'optional' about contraception. It is a medical necessity for women during 30 years of their lifespan. To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable." [10] Indeed, since 1972, Medicaid has required coverage for family planning in all state programs with no cost-sharing requirements. [11]

As the District of Columbia Circuit Court held in one of the cases on appeal here:

> The government has overlapping and mutually reinforcing compelling interests in promoting public health and gender equality. The contraceptive coverage requirement specifically advances those interests. It was adopted to promote women's equal access to health care appropriate to their needs, which in turn serves women's health, the health of children, and women's equal enjoyment of their ***7** right to personal autonomy without unwanted pregnancy. [12]

A. Reducing Unintended Pregnancies Is A Public Health Goal

The United States Government has a longstanding public health interest in reducing the number of unintended pregnancies. As the Office of Disease Prevention and Health Promotion has ***8** stated, "[f]amily planning is one of the ten great public health achievements of the 20th Century." [13]

In the 1960s and 1970s, Presidents Johnson and Nixon began to call the public's attention to the problem of unplanned and unwanted childbearing and its consequences for individual women and men, their children, communities, and the nation. [14] Within three years of FDA approval of the first birth control pill in 1960, 2.3 million American women were taking the pill, despite its significant side effects at the time. [15] By enabling women to control when and whether to become pregnant, the pill heralded opportunities for education, careers, and economic advancement that previously had been out of reach. In the mid-1990s, long-acting, reversible contraceptive methods ("LARC") such as the intrauterine device ("IUD") were introduced or significantly improved, and the proportion of women choosing LARC rose accordingly. [16] While greater upfront costs hinder access to LARC for women of ***9** limited means, these methods are associated with the lowest rates of unintended pregnancies. [17]

Yet even with these advances, 3.4 million of the 6.6 million pregnancies in the United States each year are unintended. [18] Cost barriers to consistent use of the most effective forms of contraceptives contribute to an unplanned pregnancy rate for poor women that is five times that of higher income women, [19] and Black women have the highest unintended pregnancy rate of any racial or ethnic group. [20]

Yet even the cost of reliable and effective contraception is minimal compared to the costs arising from unintended pregnancies. In fact, "[for e]very $1.00 invested in helping women avoid pregnancies they did not want to have, "the United States would" save $7.09 in Medicaid expenditures that would otherwise be needed." [21]

***10** Unintended pregnancies adversely affect women, their families, and the nation. Unintended pregnancies elevate health risks for women and children, and impose other costs on society. For example, women whose pregnancies are unintended are more likely to experience depression, anxiety, or domestic violence during those pregnancies.[22] Children who are born as the result of unintended pregnancy suffer increased health risks on average, including preterm birth, low birth weight, and associated complications.[23] A short interval between pregnancies, often a result of unintended pregnancies, also can result in serious health consequences for infants, such as low birth weight and prematurity.[24]

Furthermore, an unintended pregnancy can create economic hardship for an entire family, and both parents will be hampered in their educational or career endeavors. Fewer resources, both financial and emotional, may be available for other children in the family when parents are faced with an unintended pregnancy. The increased risk of mothers suffering from depression negatively impacts other family members, and the mothers' ***11** partner relationships are at greater risk of dissolution.[25]

Unintended pregnancies burden broader society as well, with costs such as lost productivity for employees and lost tax revenue for the government.[26] Studies show a direct causal relationship between reducing unintended pregnancies and increasing educational attainment among women, as well as lower crime rates and better academic, economic, and health outcomes among children.[27]

Expenditures are one of the more direct measures of the costs borne by communities, states, and the nation as a result of unintended pregnancies. Taxpayers spend more than $12 billion each year on unintended pregnancies.[28] The direct medical costs alone - including care and treatment for births, abortions, ectopic pregnancies, and miscarriages - total over $4.6 billion annually.[29] Overall, government expenditures on unintended ***12** pregnancies nationwide totaled $21.0 billion in 2010, including $14.6 billion in federal expenditures and $6.4 billion in state expenditures.[30]

That many of these costs are avoidable is well documented. As mentioned above, spending for coverage of contraceptives yields significant savings.[31] Private health plans also save money by providing access to contraceptives: a National Business Group on Health report, drawing on actuarial estimates by PricewaterhouseCoopers, confirmed that when insurance policies cover contraception, insurers save more than it costs them to provide contraception.[32]

An unintended pregnancy is virtually certain to impose substantial, unplanned-for expenses and time demands on any family, and those demands fall disproportionately on women. As the Supreme Court has recognized "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[33]

***13 B. Reducing The Frequency Of Unintended Pregnancies Would, In Turn, Reduce The Frequency Of Abortions**

In addition to the foregoing benefits, reducing the frequency of unintended pregnancies in the United States would reduce the frequency of abortion.[34] Currently, four in ten unintended pregnancies in the United States end in abortion.[35] By the age of 45, at least half of American women will experience an unintended pregnancy, and 30% of American women will have had an abortion.[36] Although the overall abortion rate has declined since 1990, the rate has increased for women who live at or below the poverty level.[37] Black women are among the populations that are overrepresented among abortion patients.[38]

Research confirms that education about, and use of, current LARC methods such as implants and IUDs results in fewer abortions.[39] LARC methods ***14** are the most effective in preventing pregnancy.[40] LARCs require fewer repeat physician's appointments than the oral birth control pill or other prescriptions that must be renewed. However, LARCs also have

significantly higher upfront costs than other methods, due in large part to their need to be administered by a medical professional. [41]

Those high costs cause many women to choose less effective methods or even to forego contraception completely. [42] As Justice Ginsburg noted, "The cost of an IUD, one of the most convenient and effective forms of reversible contraception, is nearly a month's full-time pay for workers earning the minimum wage, and its cost makes it less likely that women will use it." [43] Even less effective means of contraception come at a high cost: birth control pills can cost up to $50 a month ($600 a year), and vaginal hormonal rings can cost up to $90 a month ($1080 a year). These costs are only the costs of the contraception, and do not include any out-of-pocket costs for the necessary physician's office visits.

Lower or no-cost contraception makes it more likely women will use contraception to prevent unintended pregnancies and promote general health. The Institute of Medicine has noted and Congress ***15** has recognized that "The elimination of cost sharing for contraception […] could greatly increase its use, including the use of the more effective [LARC] methods, especially among poor and low-income women most at risk for unintended pregnancy." [44] Furthermore, current evidence confirms that improved access to LARC methods can result in fewer unintended pregnancies and abortions, and considerable cost savings to the health care system. [45]

II. BLACK WOMEN WILL BE PARTICULARLY IMPACTED BY PETITIONERS' REQUEST FOR RELIEF

Race, like sex, is an immutable characteristic, and one that a Black woman cannot leave at the door. Laws, government policies, and societal conditions have systematically disadvantaged the entire female population, including their rights to reproductive self-determination, but the impact on Black women has been particularly pronounced and systematic. Black women have faced, and continue to face, a myriad of structural impediments to self-determination, including in their reproductive health and choices. The government therefore has a compelling interest in ensuring that Black women have full access to contraception.

*16 A. Black Women Have Long Been Dispossessed Of Reproductive Self-Determination

Beginning with slavery, Black women endured a long history of laws, policies, and practices dispossessing them of their reproductive self-determination. Only one hundred and fifty years ago, Black women, as the legal property of white men, had no control over their own reproduction. "[T]he manipulation of procreative sexual relations became an integral part of the sexual exploitation" for female slaves. [46] As slaves, Black women were "concerned with bearing, nourishing, and rearing children whom slaveholders needed for the continual replenishment of their labor force." [47] After Congress outlawed the overseas slave trade, Black women's reproductive commoditization became vital to slave-owners, as slave women were the only means by which slave-owners could replenish their slaves. [48]

The practices and policies in the century that followed encouraged or forced Black women to limit or refrain from reproduction due to racist mindsets that deemed Black people undesirable and too populous compared to their white counterparts. In the early 1900s, Black women were told they "needed to control family size in order to integrate, through education and jobs, into the American mainstream" while white European immigrants ***17** were told to increase reproduction to fulfill "Manifest Destiny." [49] During the same time period, negative eugenics theory sought to reduce the population and procreation of socially undesired populations (based on race or intelligence) and targeted Black women "for planned population reduction through both government and privately financed means." [50]

Beginning in the 1950s, policies that encouraged Black women to limit or refrain from reproduction gave way to practices by which they were forcibly, and often unknowingly, sterilized. [51] By the 1980s, "43 percent of the women sterilized in federally

funded family planning programs were African Americans." [52] Black women were often coerced into, or worse, forced to, undergo sterilization procedures by health care workers, physicians, and clinics. [53] Black women have virtually no history of reproductive selfdetermination; stripping away equal access to contraception will only continue that history for the ***18** many Black women who work for religious nonprofit organizations, and for their families and dependents.

B. Black Women Are Disproportionately Affected By Certain Health Issues For Which Doctors Recommend Contraceptive Use

Black women's interest in contraception is rooted in both a right to reproductive self-determination and the health issues which Black women experience at higher rates than other American women. As a group, Black women are disproportionately affected by a variety of health issues which contraception either alleviates or for which pregnancy is contraindicated. Some of the most relevant of these are diabetes, heart disease, lupus, and HIV/AIDS.

Diabetes is more prevalent among Black women than almost any other ethnic group. "Compared to non-Hispanic white adults, the risk of [being] diagnosed [with] diabetes was … 77% higher among non-Hispanic blacks." [54] Diabetes can result in pregnancy complications including miscarriage or birth defects. In fact, the American Diabetes Association standards of care for reproductive-age women with diabetes include: (1) "use of effective contraception at all times, unless the patient is in good metabolic control and actively trying to ***19** conceive" and (2) counseling about the risk of fetal impairment associated with unplanned pregnancies and poor metabolic control. [55]

In addition to diabetes, Black women disproportionately suffer from heart disease, which is the number one cause of death for all women in the United States. Black women have twice the age standardized rate of fatal incidence of cardiovascular disease as white women. As a group, Black women are also more likely to have multiple risk factors for heart disease, including high blood pressure, diabetes, and obesity. Many cardiac conditions are exacerbated during pregnancy: the American College of Cardiology and the American Heart Association Task Force on Practice Guidelines recommend that that clinicians counsel women with certain heart conditions against pregnancy. [56]

Lupus, an auto-immune disorder affecting the skin, joints, blood, kidneys, and other systems, affects women almost exclusively. Ninety percent of people with lupus are women, and Black women are diagnosed with lupus two to three times as often as white women. Women with lupus who become pregnant are three to seven times more likely to suffer from, for example, thrombosis, infection, renal failure, hypertension, and preeclampsia. The risk of ***20** maternal death for women with lupus is twenty times the risk for pregnant women without lupus. [57]

The standards of care for lupus require that women with lupus have access to contraception. The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) standard instructs women with lupus to use contraception. The Centers for Disease Control and Prevention ("CDC") clinical guidance similarly concludes that unintended pregnancy presents an unacceptable health risk for women with lupus. [58]

Black women and their communities are disproportionately affected by additional health and environmental issues that may warrant short or long term pregnancy avoidance assisted by contraception.

For example, Black women are disproportionately affected by HIV and account for the majority of women living with HIV in the U.S. In 2010, Black women comprised approximately 64% of new HIV infections among women, despite making up only 13% of the female population. The rate of new HIV infections for Black women is 20 times higher than the rate for white women (38.1 per ***21** 100,000, compared to 1.9). [59] Antiretroviral medication can reduce the risk of perinatal (mother to child) HIV transmission to less than 1%, however, perinatal HIV infections still occur, and the CDC views a lack of family planning services for women with HIV as a "missed opportunity in preventing perinatal HIV transmission." [60]

Women exposed to high levels of environmental toxins, such as high levels of lead in water, may pass those toxins through the placenta when pregnant. For pregnant women, exposure to high levels of lead may result in spontaneous abortion, low birth weight, and impaired neuro-development. [61]

HIV and lead poisoning are two examples of the cycle of public health threats once unrecognized, but now known to disproportionately affect poor communities and communities of color. Recent federal guidance on the impending spread of Zika virus, with its potential for grave implications during pregnancy, again demonstrates the need for ***22** unimpeded contraceptive access for women of reproductive age. On February 12, 2016, the CDC recommended that women of reproductive age residing in areas of ongoing Zika virus transmission, "should be counseled on strategies to prevent unintended pregnancy [… and that] long acting reversible contraception … might be the best choice." [62]

Additionally, women taking certain medications that pose serious risks to maternal and fetal health must avoid pregnancy, making access to contraception critical. Many commonly prescribed medications are known to directly cause or increase the risk of birth defects or to cause health problems in pregnant women, while the effects of other medications are currently unknown. [63]

Approximately 5.8% of pregnant women in the United States, including Black women, take ***23** medications during their pregnancies that the FDA categorizes as either showing evidence of risk to a fetus even though the potential benefits to the mother may outweigh those risks, or as being highly likely to cause birth defects if taken by women during pregnancy or even shortly before conception. [64] Numerous studies recommend that women of reproductive age who are taking these drugs also use contraception to prevent pregnancy. [65]

Denying Black women equal access to contraception therefore impacts all aspects of their health - not just their reproductive health.

C. Black Women Tend to be Less Economically Advantaged, Which Increases Their Need for Affordable Contraceptives

Black women typically continue to face more economic challenges than do white women, further increasing barriers to access to contraceptive care.

Black women often fare worse economically than their white counterparts, leaving them less able to pay for preventive care, including contraception. ***24** According to the National Women's Law Center, nearly one in four Black women lives in poverty, and Black women earn only 64 of the 78 cents on the dollar white women earn, when compared to white men. [66] Furthermore, Black women are more likely to work in low-paying jobs and more likely to work in administrative positions. According to the U.S. Bureau of Labor Statistics, the median weekly fulltime wage for Black women is $611, less than the weekly full-time wage for employees of nonprofit religious organizations of $641. Even the full-time median wage for Black women does not demonstrate the harsh economic reality that is underemployment as 29% of Black women work part-time, unable to find full-time employment. [67] Women earning less than $650 per week simply cannot afford the costs of effective contraception, but also cannot afford the economic and social costs of an unintended pregnancy.

Whether employed full-time or part-time, a Black woman's economic situation affects not only her own well-being, but also that of her family. Black women are more likely to be the single head of their household than are white women, and nearly half of families headed by Black women are ***25** considered poor. [68] A Black woman's financial contributions as a single parent are just as vital when married, as 50% of married Black women earn at least half of the family's income. [69]

Black women's economic realities often leave them unable to afford the out-of-pocket costs for preventive care. As a result, Black women will often forego contraception at risk of an unintended pregnancy, which may cause a further financial strain on their and their family's economic wellbeing. This reality emphasizes the government's compelling interest in providing access to contraception.

D. Black Women Have Higher Levels of Religious Commitment, Making Them More Likely To Be Impacted By the Requested Exemption

The majority of Black people in the U.S. report that they are religious, with most self-identifying as members of a historically Black Protestant (often Baptist) congregation, or as Evangelical Protestants. [70] Additionally, Black ***26** women report higher levels of religious commitment than do even Black men:

More than eight-in-ten black women (84%) say religion is very important to them, and roughly six-in-ten (59%) say they attend religious services at least once a week. No group of men or women from any other racial or ethnic background exhibits comparably high levels of religious observance. [71]

Despite their deeply held religious beliefs, 9 in 10 Black women who attend religious services at least weekly support publicly-funded contraception, even though their religions often proscribe the use of birth control. [72]

Black women who are members of more conservative congregations are not alone in rebuking the teachings of their religion with regard to contraception. For example, the Catholic Church prohibits the use of birth control altogether, other than "natural family planning," yet 68% of woman who identify as Catholic will use methods such as sterilization (32%), a hormonal method (including the birth control pill, 31%), or the IUD (5%) during ***27** their lifetime but only 2% will rely on natural family planning alone. [73]

The high percentage of Black women who are religious and also use contraception strongly suggests that many of those women also are employees of hospitals, schools, or other nonprofit organizations that operate under a faith that prohibits the use of contraception. These women should be permitted their freedom to accept some, but not all, of the tenants of the faith of the organization that employs them. Granting the petitioners' requested relief would deny them that right. *Amicus curiae* therefore respectfully supports respondents and urges this Court to require petitioners to comply with the exemption to the mandate.

*28 CONCLUSION

Currently, respondents offer religious nonprofit organizations an accommodation under which their employees can obtain contraceptive coverage without their employers having to provide it directly. One question before this Court is whether this accommodation comports with the RFRA. Simply put, the answer is Yes. As addressed in respondents' brief, an employer's right to exercise the religion of its head officer or administrator is not substantially burdened by a requirement to notify the Department of Health and Human Services (or a third-party administrator) that the employer objects to including contraceptive coverage in its employer-sponsored health plan. Additionally, the government has a compelling interest in promoting women's health and ensuring equal access to contraception coverage. Meeting women's essential contraception and preventive health needs has positive impacts on their societal, economic, and health status. This impact is particularly pronounced for Black women, who also are most likely to be impacted by the requested exemption because they have higher levels of religious commitment. If religious nonprofit organizations such as hospitals, universities, and community-wide charitable organizations are granted a complete exemption, the women who work for those organizations - many of whom do not have a religious objection to contraception - will be stripped of the right to birth control without cost-sharing that all other women have been granted by the Affordable Care Act and this Court's jurisprudence. In short, the sought exemption would place the employer's

***29** religious beliefs above those of the individual employees, and that cannot stand. Accordingly, this Court should deny petitioners' requested relief and affirm.

Footnotes

1 In accordance with Supreme Court Rule 37.6, *amicus curiae* Black Women's Health Imperative affirms that the position it takes in this brief has not been approved or financed by petitioners, respondents, or their counsel. Neither petitioners, respondents, nor their counsel had any role in authoring, nor made any monetary contribution to fund the preparation or submission of this brief. Pursuant to Supreme Court Rule 37.3, *amicus curiae* Black Women's Health Imperative states that all parties have consented to the filing of this brief; evidence of written consent of all parties has been filed with the clerk.

2 42 U.S.C. § 2000bb (2016).

3 *Burwell v. Hobby Lobby Stores*, 134 S. Ct. 2751, 2802, 189 L. Ed. 2d 675 n. 25 (2014) (Ginsburg, J., dissenting) (quoting *United States v. Lee*, 455 U.S. 252, 259 (1982)).

4 *See Wisconsin v. Yoder*, 406 U.S. 205, 92 S. Ct. 1526, 32 L. Ed. 2d 15 (1972) (Amish parents withdrawing children from school after 8th grade did not affect other students' access to education); *Sherbert v. Verner*, 374 U.S. 398, 83 S. Ct. 1790, 10 L. Ed. 965 (1963) (Seventh-Day Adventist woman receiving unemployment benefits after refusing employment that required her to work on her faith's Sabbath did not affect others' eligibility for benefits, nor did it require others to refrain from work on Saturday); *see also Holt v. Hobbs*, 135 S. Ct. 853, 190 L. Ed. 2d 747 (2015) (permitting a Muslim prisoner to grow a beard did not prohibit other prisoners from shaving).

5 U.S. Bureau of Labor Statistics, *TED: The Economics Daily* (Oct. 10, 2014), http://www.bls.gov/opub/ted/2014/ted_20141021.htm.

6 Univ. of Denver Col. Women's Coll., *Benchmarking Women's Leadership in the United States* 121 (2013), http://www.womenscollege.du.edu/media/documents/BenchmarkingWomensLeadershipintheUS.pdf.

7 *Burwell*, 134 S. Ct. at 2759.

8 With respect to petitioners' arguments that the mandate imposes a substantial burden and is not the least restrictive means of furthering a compelling governmental interest, *amicus curiae* incorporates the arguments asserted by respondents.

9 *Burwell*, 134 S. Ct. at 2780 (2014) (quoting *Griswold v. Connecticut*, 381 U.S. 479, 485-486 (1965)).

10 144 Cong. Rec. S9, 194 (daily ed. July 29, 1998) (statement of Senator Snowe) (quoting statement by American College of Obstetricians and Gynecologists).

11 Inst. of Med., *Clinical Preventive Services For Women: Closing The Gaps* 16 (2011), http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.

12 *Priests For Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 263-64 (D.C. Cir. 2014)*cert. granted sub nom. Roman Catholic Archbishop of Washington v. Burwell*, 136 S. Ct. 444 (2015) and *cert. granted sub nom. Priests for Life v. Dep't of Health & Human Servs.*, 136 S. Ct. 446 (2015) (holding that the accommodation for religious employers "is supported by the government's compelling interest in providing women full and equal benefits of preventive health coverage, including contraception and other health services of particular relevance to women"). Moreover, the petitioners' allegation that "tens of millions" of people receive exemptions to the mandate is misleading: the majority of the "grandfathered plans" offer some level of reduced-cost, if not no-cost, contraceptive coverage. Moreover, the number of workers covered by these grandfathered policies is declining and will continue to do so until no such plans are offered. The percentage of employers offering at least one grandfathered plan dropped to 35% in 2015, down from 72% in 2011, and only 25% "of covered workers [were] enrolled in a grandfathered health plan in 2015," down from 56% in 2011. [12] The natural phasing out of these plans as they change in response to market conditions, and thus lose their grandfathered status, furthers the compelling government interest to ensure equal access to preventive and contraceptive coverage without cost sharing.

13 Off. of Disease Prevention and Health Promotion, *Family Planning*, http://www.healthypeople.gov/2020/topics-objectives/topic/family-planning (last visited Feb. 16, 2016).

14 *See* Martha J. Bailey, *Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception*, Brookings Papers on Econ. Activity (2013).

15 Jerrold S. Greenberg et al., *Exploring the Dimensions of Human Sexuality* 200 (5th ed. 2014).

16 Jo Jones et al., *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use since 1995*, Nat'l Ctr. for Health Statistics Reports (2012).

17 *Provision of No-Cost, Long Acting Contraception and Teenage Pregnancy*, 371 New Engl. J. Med. 1316, 1316-23 (2014).

18 Lawrence B. Finer & Mia R. Zolna, *Shifts In Intended and Unintended Pregnancies in the United States, 2001-2008*, 104 Am. Journal of Public Health (2014); *see also* Jones et al., *supra* note 16, at 4.

19 *See* Adam Sonfield, *What Women Already Know: Documenting the Social and Economic Benefits of Family Planning*, 16 Guttmacher Policy Rev. 1, 10 (2013); Gillian B. White, *Unplanned Births: Another Outcome of Economic Inequality?*, The Atlantic, Mar. 4, 2015, http://www.theatlantic.com/business/archive/2015/03/unplanned-births-another-outcome-of-economic-inequality/386743/.

20 Jones et al., *supra* note 16; Finer & Zolna, *supra* note 18.

21 The Guttmacher Institute, Fact Sheet: *Contraceptive Use in the United States*, 2 (Oct. 2015).

22 Inst. of Med., *supra* note 11, at 16-18, 103; *see also Korte v. Sebelius*, 735 F.3d 654, 725 (7th Cir. 2013) (Rovner, J., dissenting).

23 Inst. of Med., *supra* note 11, at 16-18, 103.

24 Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. at 39,872; Inst. of Med., *supra* note 11, at 16-18, 103.

25 Sarah S. Brown & Leon Eisenberg, Nat'l Acad. Press, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 81 (1995), http://www.nap.edU/read/4903/chapter/1.

26 J.J. Frost et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 Milbank Q. 696-749 (2014), http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12080/full.

27 Adam Thomas & Emily Monea, Brookings, *The High Cost of Unintended Pregnancy*, 2 (2011).

28 *Id.* at 3.

29 James Trussell et al., *Burden of Unintended Pregnancy in the United States: Potential Savings With Increased Use of Long-Acting Reversible Contraception* 154-161 (2013).

30 Thomas Sawhill & E. Monea, *An Ounce of Prevention: Policy prescriptions to reduce the prevalence of Fragile Families*, 20 Future of Children 133, 147 (2010), http://www.futureofchildren.org/futureofchildren/publications/docs/20_02_07.pdf.

31 The Guttmacher Institute, *supra* note 21, at 2.

32 *Id.*

33 *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 856, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992); Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. at 39,873 ("access to contraception improves the social and economic status of women").

34 Brown & Eisenberg, supra note 25, at 80.

35 Frost, *supra* note 26.

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