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

IN THE

Supreme Court of the United States

DAVID A. ZUBIK, ET AL.,

Petitioners,

v.

SYLVIA BURWELL, ET AL.,

Respondents.

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

BRIEF OF HEALTH POLICY EXPERTS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

Amici curiae are health policy experts who have been working for decades to strengthen the U.S. health care system's ability to deliver high quality care in a more efficient manner. *Amici* believe that the U.S. health care system must improve quality of care, health outcomes, patient experience, and patient access at the same time that it reduces costs. *Amici* have contributed to the development of wide-ranging initiatives that are underway across the nation

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici curiae* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have given their consent to this filing in letters that have been lodged with the Clerk.

in an effort to achieve these critical goals. As experts in health policy, *amici* have a strong interest in how government regulation shapes the health care system. Information about each *amicus* is set forth in the Appendix.

Petitioners' claim that there are feasible alternatives to the accommodation that would as effectively further the compelling government interests in public health and gender equality is, at heart, a claim about health policy. This makes it critical that the Court consider what health policy experts like *amici* have to say about the plausibility of that claim. *Amici* respectfully submit that it is imperative for the Court, in evaluating whether Petitioners' alternatives to the accommodation would work as advertised, to understand that those alternatives would be fundamentally out of step with the national drive toward making high quality care more accessible.

SUMMARY OF ARGUMENT

The Religious Freedom Restoration Act of 1993 (RFRA) provides that the government may not "substantially burden a person's free exercise of religion" unless the policy "is in furtherance of a compelling governmental interest" and is the "least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1(a)-(b). This brief focuses on the "least restrictive means" portion of that test.

1. To qualify as a less restrictive means, an alternative to a challenged policy must be both feasible and as effective as the challenged policy at furthering the compelling government interests at stake. To meet the least restrictive means standard, the government need not consider every conceivable alternative to the challenged policy, much less build a record that it did so. The least restrictive means standard is satisfied if each proposed alternative to the challenged policy would be less effective or infeasible.

2. The challenged policy in these cases is the accommodation. The accommodation relieves non-profit religious employers with religious objections to contraceptive coverage of any responsibility to fund or administer such coverage while ensuring that such coverage remains seamless for the female plan participants of those employers. It does this by providing for a health insurance issuer or third-party administrator to seamlessly fill the gap in coverage that would otherwise exist. Seamless contraceptive coverage is critical to furthering the compelling government interests in public health and gender equality. Social science shows that obstacles to obtaining contraceptive services—be they cost barriers, burdensome additional steps, or having to navigate multiple health plans and provider networks—reduce the rate at which women utilize such services, thereby harming public health and diminishing gender equality. This is why the accommodation is carefully crafted to eliminate such obstacles.

3. Petitioners' alternatives are not so carefully crafted. All would erect obstacles of one kind or another to women obtaining contractive services, rendering them much less effective at furthering the compelling government interests in public health and gender equality. These alternatives would also be infeasible. Each would require fundamental legislative and regulatory change that would effectively remake existing programs. Petitioners plainly have not proposed any alternative that would be both feasible and remotely as effective.

ARGUMENT

RFRA provides that the government may not "substantially burden a person's free exercise of religion" unless the policy "is in furtherance of a compelling governmental interest" and is the "least restrictive means of furthering that compelling governmental interest." *Id.* We strongly disagree with Petitioners' contention that the government's accommodation of their religious objection to contraceptive coverage imposes

a "substantial burden" on their free exercise of religion. In fact, the accommodation relieves non-profit religious employers with religious objections to contraceptive coverage of any responsibility to fund or administer such coverage, by providing for a health insurance issuer or third-party administrator to seamlessly fill the gap in coverage that would otherwise exist. But we assume for the sake of argument that the accommodation does impose a substantial burden on free exercise of religion, and we also assume that the accommodation furthers at least two compelling government interests: (1) public health and (2) gender equality. We make these assumptions so that we may focus on the least restrictive means stage of the RFRA test.

I. THE LEAST RESTRICTIVE MEANS STANDARD IS EXCEPTIONALLY—BUT NOT UNREASONABLY—DEMANDING.

The least restrictive means standard is "exceptionally demanding," *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2780 (2014), but not unreasonably so.[2] This Part identifies the criteria that an alternative must meet to count as a less restrictive means. It then clarifies a misconception about the least restrictive means standard.

A. A Less Restrictive Means Must Be Both as Effective and Feasible.

Once a court reaches the least restrictive means stage of the RFRA analysis, it has already determined, or at least assumed for the sake of argument, that the challenged policy furthers a compelling interest. A less restrictive means must be "at least as effective" as the challenged policy in furthering that interest. *Reno* v. *Am. Civil Liberties Union*, 521 U.S. 844, 874 (1997); *see also Turner Broad. Sys., Inc.*

[2] There is a strong argument that RFRA does not incorporate the least restrictive means standard employed in political speech and other strict scrutiny cases. *See* Br. of Scholars of Religious Liberty Part II. But this brief shows that the accommodation meets even that standard.

v. *F.C.C.*, 520 U.S. 180, 221 (1997) (rejecting an alternative because it "would not be as effective in achieving" one of the government interests at stake).

But it is not enough that an alternative be as effective as the challenged policy; it must also be "feasible." *United States* v. *Playboy Entm't Grp., Inc.*, 529 U.S. 803, 815 (2000); *see also Ashcroft* v. *Am. Civil Liberties Union*, 542 U.S. 656, 666 (2004) (alternatives must be "available"). When the government makes policy, it does so within certain constraints. Petitioners' alternatives must be considered within the same constraints. In other words, "existing, recognized, workable" alternatives can qualify as less restrictive means, but alternatives that would impose "a whole new program or burden" on the government cannot. *Hobby Lobby*, 134 S. Ct. at 2786 (Kennedy, J., concurring).[3]

B. To Satisfy the Least Restrictive Means Standard, Respondents Need Show Only That the Alternatives Would Not Be Either as Effective or Feasible.

The government need not "refute every conceivable option" other than the one it chose in order to satisfy the least restrictive means standard. *Holt* v. *Hobbs*, 135 S. Ct. 853, 868 (2015) (Sotomayor, J., concurring).[4] And it certainly need not do so "at a particular point in time." *Id.*; *see also Sable Commc'ns of Cal., Inc.* v. *F.C.C.*, 492 U.S. 115, 133 (1989) (Scalia, J., concurring) (a law satisfies the least restrictive means standard if the alternatives suffer from "infeasibility," regardless of whether "data" or a "considered

[3] In this brief, the phrase "as effective and feasible" is shorthand for the following: To qualify as a less restrictive means, an alternative must be (1) as effective as the challenged policy and (2) available and workable.

[4] *Holt* concerns the Religious Land Use and Institutionalized Persons Act (RLUIPA), but RLUIPA plaintiffs "seek religious accommodations pursuant to the same standard as set forth in RFRA." *Holt*, 135 S. Ct. at 860 (citation and internal quotation marks omitted).

judgment on infeasibility" was studied or presented by the Congress that enacted the law) (internal quotation marks omitted).

Respondents need show only that each proposed "plausible, less restrictive alternative" to the accommodation would not be either as effective or feasible, and thus that the accommodation is the "least restrictive available means." *Playboy*, 529 U.S. at 823–824. This brief supports Respondents by doing just that.

C. Petitioners Distort the Least Restrictive Means Standard by Rehashing Their Compelling Interest Arguments at This Distinct Stage of the RFRA Analysis.

The *East Texas Baptist University* (*ETBU*) Petitioners argue that "the pervasive exemptions from the contraceptive mandate" demonstrate not only that the challenged policy does not further compelling interests but also that it is not the least restrictive means of furthering any such interests. ETBU Pet. Br. 77. This argument is indicative of an analytical confusion that is pervasive among Petitioners and their *amici*. What differentiates Petitioners from houses of worship, employers that sponsor grandfathered plans, and small businesses is potentially relevant to an equal protection analysis,[5] but it is definitely irrelevant to the least restrictive means standard.

In enacting and implementing the Affordable Care Act (ACA), like any other legislation of significance, the legislative and executive branches considered numerous tradeoffs affecting many priorities. Public health and gender equality were certainly two of the important values that figured into these considerations. "But no legislation pursues its purposes at all costs. Deciding what competing values will

[5] No equal protection claim is before the Court in these cases, *see* Resp. Br. 69; regardless, the government has more than sufficiently justified its line-drawing, *see* Resp. Br. 61–72.

or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice." *Rodriguez* v. *United States*, 480 U.S. 522, 525–526 (1987) (per curiam).

Petitioners can prevail at the least restrictive means stage of the RFRA analysis—and justify striking down the accommodation, an embodiment of the "essence of legislative choice"—only if they can identify an as effective and feasible alternative. Rhetorical flourishes about what is "good enough" for the employees of other employers have no bearing on that determination. ETBU Pet. Br. 77. This is why the comparisons that Petitioners draw between themselves and other employers—employers that are distinguishable from Petitioners, and thus present policymakers with different tradeoffs, *see* Resp. Br. 61–72—do them no good at this stage of the RFRA analysis. Tellingly, the *ETBU* Petitioners cite no cases to support the relevance of these comparisons to the least restrictive means standard.

II. THE ACCOMODATION PROVIDES SEAMLESS CONTRACEPTIVE COVERAGE THAT FURTHERS COMPELLING INTERESTS IN PUBLIC HEALTH AND GENDER EQUALITY.

To further the compelling interests of public health and gender equality, the accommodation provides seamless access to contraceptive services by ensuring that women: (1) do not confront cost barriers to contraceptive coverage and services; (2) need not take additional steps to obtain contraceptive coverage; and (3) can obtain contraceptive services in concert with other care from trusted providers. The accommodation achieves such seamlessness without requiring objecting non-profit religious employers to fund or administer contraceptive coverage by ensuring that a health insurance issuer or third-party administrator fills the gap in coverage that would otherwise exist. *See, e.g.*, 29 C.F.R. § 2590.715–2713A(b)(2), (c)(2). This seamlessness is the linchpin of the accommodation; it is fundamental to

furthering the compelling interests in public health and gender equality.

1. Critically, the accommodation ensures that women can obtain contraceptive coverage at no additional cost. The elimination of cost barriers is foundational to achieving the government's compelling interests. Social science is clear that, when women must cover even some of the cost of their preventive services, their use of those services—including contraceptives (particularly those that may be most effective or appropriate)—drops dramatically. *See* Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 108–9 (2011);[6] Guttmacher Inst. Br. 7–18; *see also* Amal Trivedi, et al., *Effect of Cost Sharing on Screening Mammography in Medicare Health Plan*, New Eng. J. Med. 358, 375-83 (2008).

2. Similarly, under the accommodation, female plan participants obtain contraceptive coverage without taking any additional steps. This aspect of seamlessness is also critical, because common sense tells us—and social science confirms—that the more barriers there are to doing something the less likely people are to do it. "Inertia" is the name psychologists have given to this phenomenon. *See* Benjamin G. Voyer, '*Nudging' Behaviours in Healthcare: Insights From Behavioural Economics*, 21.3 British J. Healthcare Mgmt. 130, 130–135 (2015) (inertia "refers to the fact that individuals prefer sticking to existing or standard behaviours, rather than doing something different or involving an effortful choice"); *see also* Richard H. Thaler & Cass R. Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness* (2009).

Two of the most influential studies in this area involve organ donations and 401(k) plans. Many people say they want to be organ donors and to save for retirement. But,

[6] *Available at* http://www.iom.edu/reports/2011/clinical-preventive-services-for-women-closing-the-gaps.aspx.

when people must take even the modest step of checking a box or enrolling in a plan—when, in other words, being an organ donor or saving for retirement does not happen by default—inertia impedes the ability of many to fulfill their true preferences, even where the stakes are high. *See* Eric J. Johnson & Daniel G. Goldstein, *Do defaults save lives?*, 302 Science 1338, 1338–39 (2003);[7] Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116.4 Q. J. of Econ. 1149, 1149–87 (2001).[8]

Women who seek access to contraceptive services are no different from the general population in this regard, and one insightful study documents how making contraception even slightly more accessible by removing barriers "is associated with a 30% reduction in the odds of conceiving an unplanned pregnancy *** * *** and a 46% reduction in the odds of an abortion." Diana Greene Foster, et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 Obstetrics & Gynecology of N. Am. 566, 566 (2011).[9] The accommodation, taking into account this social science, ensures that women need not take any additional step in order to obtain contraceptive coverage.

3. Once the coverage is obtained, it is also critical that access to the services likewise be seamless—i.e., that women are able to continue receiving the services in concert with other care from trusted providers. As detailed below, most of the alternatives would require women to switch providers only with respect to contraceptive services. In contrast, the accommodation enables women to continue to receive contraceptive services as an integrated part of the care

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[7] *Available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1324774.

[8] *Available at* http://www.retirementmadesimpler.org/Library/The%20Power%20of%20Suggestion-%20Inertia%20in%20401(k).pdf.

[9] *Available at* http://bit.ly/1ebyZRQ.

furnished by their current providers. Social science also confirms the significance of this aspect of seamlessness. Studies have clearly established that strong relationships between women and their providers result in more effective contraceptive care. Lawrence Leeman, *Medical Barriers to Effective Contraception*, 34 Obstetrics & Gynecology of N. Am. 19, 22 (2007) (detailing the benefits derived from "a good relationship with a health care provider," including higher continuation rates and better education); Judith Bruce, *Fundamental elements of the quality of care: A simple framework*, 21.2 Studies in Family Planning 61, 74 (1990) (describing the importance of "interpersonal relations" in the provision of contraceptive services).

4. As detailed above, seamlessness is a critical component of furthering the government's compelling interest in public health. Likewise, it promotes gender equality by assuring "women equal access to * * * goods, privileges, and advantages." *Roberts* v. *United States Jaycees*, 468 U.S. 610, 626 (1984). In the absence of seamlessness, women are less likely to obtain needed care. This hinders gender equality by not only hurting women and their health but also exacerbating discrimination against women in the health care system, the workplace, and society at large. *See* Inst. of Med. at 108–109.

III. NONE OF PETITONERS' ALTERNATIVES WOULD BE FEASIBLE OR REMOTELY AS EFFECTIVE IN FURTHERING THE COMPELLING INTERESTS IN PUBLIC HEALTH AND GENDER EQUALITY.

While the government has carefully crafted its accommodation to further its compelling interests in public health and gender equality, the same cannot be said of Petitioners and their alternatives. Petitioners state that the "government may not 'assume a plausible, less restrictive alternative would be ineffective' just because it 'requires a consumer to take action.'" ETBU Pet. Br. 72 (quoting

Playboy, 529 U.S. at 824). But Respondents and their *amici* make no such assumption. This brief *shows*, one alternative at a time, that the alternatives are neither as effective nor feasible.

A. Health Insurance Exchanges

Petitioners' insistence that obtaining contraceptive coverage on the Exchanges is a less restrictive alternative is wrong. Petitioners leave ambiguous whether female plan participants who need contraceptive coverage would seek only contraceptive coverage on the Exchanges or would be left to find comprehensive health coverage on the Exchanges. Regardless, neither alternative would be an as effective or feasible means of furthering the government's compelling interests in public health and gender equality. Either option would create burdensome obstacles for female plan participants that would impede their ability to obtain recommended care. Both would require fundamental changes to existing statutory and regulatory schemes before they could be implemented. And both would single out women in contravention of both the government's compelling interest in gender equality and federal civil rights law (which could not, as a constitutional matter, be amended to accommodate such discriminatory treatment). In short, neither alternative would come close to providing the seamless contraceptive coverage available under the accommodation.

1. Requiring Female Plan Participants to Obtain Stand-Alone Contraceptive Coverage on the Exchanges Would Not Be as Effective or Feasible.

a. Obtaining Contraceptive Services Through the Exchanges Would Not Be Remotely as Effective in Furthering Public Health and Gender Equality.

Finding and obtaining stand-alone contraceptive coverage on the Exchanges would not be easy. Although Petitioners attempt to minimize the burden women would face as well as the damage that burden would do to public health and gender equality, *see, e.g.*, Zubik Pet. Br. 75, it is clear that finding and obtaining stand-alone contraceptive coverage on the Exchanges would be a substantial barrier for many women.

First, women would be required to learn of and find their way to the Exchanges in search of supplemental contraceptive coverage (presumably with no help from the employers that sponsor their primary health plans). This alone would be a significant barrier, given that the government, despite considerable effort, continues to face challenges in reaching individuals to inform them of the Exchanges in general. *See* Kaiser Family Found., *Few Uninsured Know Date of Pending Deadline for Obtaining Marketplace Coverage; Many Say They Will Get Coverage Soon, Though Cost is a Concern* (Dec. 2015).[10] And, here, given the presumed non-cooperation of objecting employers, the government could not know the identities of the women at issue to target them for outreach and education. Moreover, there is no guarantee that an insurer in a given state would offer contraceptive-only policies on that state's Exchange. Even assuming a contraceptive-only policy were available, women would need to shop for coverage and then navigate the enrollment process.

Each incremental additional step would serve as a barrier to women obtaining coverage. *See supra* Part II. And the well-documented pervasiveness of low health insurance literacy, which is not surprising given how inherently complex a consumer product health insurance is, would compound the cumulative effect of these barriers. Linda J. Blumberg, et al.,

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[10] *Available at* http://kff.org/health-costs/press-release/few-uninsured-know-date-of-pending-deadline-for-obtaining-marketplace-coverage-many-say-they-will-get-coverage-soon-though-cost-is-a-concern/.

Public Understanding of Basic Health Insurance Concepts on the Eve of Health Reform, Urban Inst. Health Policy Ctr. (Dec. 2013) ("Almost two out of three adults specifically targeted for enrollment in the new health insurance Marketplaces (60.1 percent) report gaps in their understanding of basic insurance concepts, including co-payments, premiums, deductibles, coinsurance, and provider networks.").[11] Obtaining coverage on an Exchange can be challenging, and, here, it certainly would not be seamless. Under the accommodation, women face *none* of these obstacles.

Even if a woman could obtain a contraceptive-only plan on an Exchange, she would be limited by that stand-alone plan's provider network. If a woman's current obstetrician, gynecologist, or primary care provider were not a member of that provider network, she would have to switch providers with respect only to contraceptive services and lose the benefit of both her potentially longstanding relationships with providers in her primary health plan and the integration of her contraceptive care with her other preventive care. A system that requires a woman to visit two doctors for her preventive care would materially reduce the number of women who *actually* receive such care. *See supra* Part II. It could also undermine that care by separating one component for isolated consideration for no clinical reason.

The absurdity of Petitioners' alternative is further laid bare when one considers what contraceptive coverage entails. Petitioners focus on contraceptive *pharmaceuticals*, but a key component of the contraceptive methods subject to the coverage requirement is "patient education and counseling for all women with reproductive capacity." Health Res. & Servs. Admin., *Women's Preventive Services Guidelines*.[12]

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[11] *Available at* hrms.urban.org/briefs/hrms_literacy.html.

[12] *Available at* http://www.hrsa.gov/womensguidelines/ (last visited Jan. 25, 2016).

Patient education and counseling often occur as a part of the well-woman preventive care visits that plans are also required to cover. *See id.* Petitioners' alternative could require a woman to see one doctor for education and counseling about contraceptive methods and another for education and counseling about the rest of her preventive care.[13] This disjointed and inefficient scheme would clearly not be as effective in furthering the government's compelling interests in either public health or gender equality.

Women would be materially less likely to obtain contraceptive coverage and services, especially in light of the social science findings set out in Part II, if they were required to overcome such barriers. Unlike the accommodation, Petitioners' alternatives would increase the likelihood of both unintended pregnancy and abortion, and would undermine the compelling interests in public health and gender equality. The accommodation's elimination of all such barriers increases the chances that women will receive the services they need, thus more effectively advancing the government's compelling interests.

b. Sending Only Female Plan Participants to the Exchanges Would Hinder, Not Further, Gender Equality.

Forcing female plan participants who want contraceptive coverage to obtain it on the Exchanges not only would fail to promote the government's compelling interest in gender equality, but would in fact undermine it. Women, and women only, would be required to go outside their employer-

[13] Even if a woman's provider were in network for both of her plans, stand-alone contraceptive coverage would still create billing complexities—namely, a provider would have to bill at least two different plans for services rendered during the same office visit. This would no doubt lead to increased red tape, potentially discouraging a woman from further accessing contraceptive services. In contrast, the seamlessness of the accommodation minimizes such red tape.

sponsored plan to receive coverage for the full care clinical experts say they need. Petitioners' alternative would stigmatize women who need access to contraceptive care, doing further damage to gender equality in the process.

c. Obtaining Stand-Alone Contraceptive Coverage on the Exchanges Would Not Be Feasible Due to Statutory, Regulatory, and Practical Barriers.

Effectiveness is only the first criterion an alternative must meet to be deemed a less restrictive means. The Court must also decide whether obtaining contraceptive-only coverage on the Exchanges is a feasible alternative. It is not.

Petitioners omit a crucial fact when urging the Court to send women to the Exchanges to obtain contraceptive-only coverage: No such policies exist or could exist in compliance with the law. Specifically, non-grandfathered individual market policies must comply with the essential health benefits requirement—that is, they must cover a comprehensive set of services known as essential health benefits. *See* 42 U.S.C. § 300gg-6(a); *see also* 42 U.S.C. § 18021(b) (defining "essential health benefits"). Only "excepted benefits" are exempt from this requirement. *See, e.g.*, 42 U.S.C. § 300gg-21(b). Contraceptive-only policies are not an excepted benefit. *See, e.g.*, 45 C.F.R. § 148.220(b). Even if contraceptive-only coverage could exist, Congress would also need to amend the ACA to permit stand-alone contraceptive policies to be legally offered on the Exchanges. Currently, contraceptive-only policies are not permitted to be offered on the Exchanges, because the Exchanges may offer only "qualified health plans," as defined by the ACA. 42 U.S.C. § 18031(d)(2)(B)(i) ("An Exchange may not make available any health plan that is not a qualified health plan."). Stand-alone contraceptive coverage is not a "qualified health plan" because it does not cover all essential health benefits. *See* 42 U.S.C. § 18021(a)(1)(B); *cf.* 42 U.S.C. §

18031(d)(2)(B)(ii) (allowing only for the sale of stand-alone dental benefits on the Exchanges; unlike contraceptive benefits, dental benefits cover services that are typically covered and provided separately from other services). To allow contraceptive-only coverage to be offered on the Exchanges, Congress would have to amend the ACA.

Even if the law were changed to permit the Exchanges to lawfully offer contraceptive-only policies, there would be insufficient funding to provide for the full subsidization of all such plans. Put simply, in addition to amending the statute, Congress would have to appropriate substantially more funds to make this coverage available to women at no additional cost, to the detriment of other governmental priorities. *See* 78 Fed. Reg. 39,877 (noting that "with respect to the accommodation for insured coverage established under these final regulations, providing payments for contraceptive services is cost neutral for issuers" because "the costs of providing contraceptive coverage are balanced by cost savings from lower pregnancy-related costs and from improvements in women's health"—savings that would be unavailable to finance stand-alone contraceptive coverage offered on Exchanges). This would be necessary to put women in remotely the same position, and therefore to make the alternative remotely as effective as the accommodation. There could be no premiums or cost-sharing for this coverage, given that cost has been shown to be a significant barrier to accessing preventive services. *See supra* Part II.

Finally, because this alternative would be unlawful under Title VII of The Civil Rights Act of 1964, it is not a feasible alternative. Indeed, it presents a paradigmatic case of gender discrimination under Title VII, which makes it an "unlawful employment practice for an employer * * * to discriminate against any individual with respect to * * * compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U.S.C. § 2000e-2(a)(1). And this Court has

seemingly recognized that the Pregnancy Discrimination Act of 1978 broadened Title VII to prohibit any employment discrimination related to pregnancy. *See Int'l Union, et al.* v. *Johnson Controls, Inc.*, 499 U.S. 187, 199 (1991) (holding that classifying employees on the basis of their childbearing capacity, whether or not they were already pregnant, "must be regarded, for Title VII purposes, in the same light as explicit sex discrimination"); *see also* H.R. REP. NO. 95-948, at 2 (1978), *as reprinted in* 1978 U.S.C.C.A.N. 4749, 4750 (noting that the dissenting Justices' view in *Gen. Elec. Co.* v. *Gilbert*, 429 U.S. 125 (1976), was the correct interpretation of Title VII—namely, that a plan that "included comprehensive coverage for males, and failed to provide comprehensive coverage for females" is discriminatory under Title VII). Moreover, even if Congress wanted to enshrine this discrimination against women in the statutory code, it could not amend Title VII to do so on account of the constitutional guarantee of equal protection of the laws. *See United States* v. *Virginia*, 518 U.S. 515, 531 (1996) ("Parties who seek to defend gender-based government action must demonstrate an 'exceedingly persuasive justification.'") (citation and internal quotation marks omitted). RFRA's least restrictive means requirement does not and could not demand that the government adopt an alternative that is prohibited by law.

2. Compelling Female Plan Participants to Leave Their Employer-Sponsored Plan and Obtain Health Coverage, Including Contraceptive Coverage, on the Exchanges Likewise Would Not Be as Effective or Feasible.

Petitioners suggest in the alternative that female plan participants should forgo their employer-sponsored plans and instead obtain comprehensive health coverage that includes contraceptive coverage on the Exchanges (while male plan participants would continue to receive full health benefits

through the employer-sponsored system). This alternative would not qualify as a less restrictive means for reasons similar to those discussed above. If anything, this alternative would compound those concerns. For example, this alternative is even more likely to disrupt the important relationships many women have with their current providers, given the almost certain difference in provider networks.

Additionally, the need for more funding would significantly increase under this alternative. The government would need to fully subsidize not just the cost of contraceptive coverage, but the full cost of comprehensive coverage (both premiums and cost-sharing), to put female plan participants in the same place financially as they are under the accommodation. Under the current statute, no subsidies are available for individuals who are offered affordable and adequate coverage by their employers. 26 U.S.C. § 36B(c)(2)(B)(i). And, even if Petitioners were to decline to offer such coverage to their female plan participants, subsidies are currently available only to individuals with certain levels of household income on a sliding scale. 26 U.S.C § 36B(b).[14] Many women would not meet these statutorily defined thresholds. Congress would need to rewrite the statute to make female plan participants eligible for additional subsidies, regardless of income, which would significantly increase the costs to the government. More to the point, such a rewrite would upend a fundamental precept of the statutory scheme by subsidizing the cost of coverage of individuals who have access to employer-sponsored coverage. Congress designed the ACA to build upon, not supplant, the pre-existing employer-based system. *See Univ. of Notre Dame* v. *Burwell*, 786 F.3d 606, 625 (7th Cir. 2015) (Hamilton, J., concurring) ("The heart of the

[14] In addition, the current statute imposes a tax penalty on large employers that fail to offer coverage to full-time employees and their dependents if such an employee receives a subsidy. 26 U.S.C. § 4980H.

Affordable Care Act was a decision to approach universal health insurance by expanding the employer-based system of private health insurance that had evolved in our country, rather than to substitute a new 'single payer' government program to pay for health care, like the systems in place in the United Kingdom and Canada.").

Assuming Congress were to amend the statutory scheme and to provide this additional funding, Petitioners also offer no suggestion as to how the government could police access to subsidies without an administrative mechanism to confirm with an objecting employer that the applicant is indeed one of its plan participants. Petitioners presumably would object to any such administrative mechanism, as evidenced by the arguments they make in these cases.

B. Medicaid and Medicare

Alternatively, Petitioners propose that the government use "some other 'public option,'" like Medicaid or Medicare, to provide contraceptive coverage to female plan participants. Zubik Pet. Br. 81 (citation omitted); *see also* Br. for State of Tex. 19-20 (proposing programs similar to the Texas Women's Health Program, presumably implemented at the federal level). But an examination of the scope of these public programs reveals that they are implausible alternatives to the seamless contraceptive coverage under the accommodation.

First, a woman may not be eligible to enroll in Medicaid in her home state. An applicant's Medicaid eligibility is determined by each state based on criteria specified by federal law, including income-level. *See, e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(IV), (VI), (VIII). Federal law mandates that states cover certain groups of individuals. 42 U.S.C. § 1396a(a)(10)(A)(i) (listing, for the most part, mandatory eligibility groups). But other eligibility groups are optional. *Id.* § 1396a(a)(10)(A)(ii) (listing optional eligibility groups). A notable optional eligibility group is the ACA's so-called

Medicaid expansion population—adults with household incomes up to 133 percent of the federal poverty level who are not otherwise eligible for Medicaid. *See Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2604–2607 (2012) (effectively rendering this population an optional one). Thirty-two states have undertaken the ACA's Medicaid expansion. Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision* (Jan. 2016).[15] Women who live in states that have not undertaken the ACA's Medicaid expansion may not qualify for Medicaid under any of the state's eligibility categories, and even women who live in states that have undertaken the ACA's Medicaid expansion may not qualify for Medicaid because they have family incomes that exceed 133 percent of the federal poverty line.[16]

Second, a given state's Medicaid program may not cover the full range of Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling for women of reproductive age, as recommended by the Health Resources and Services Administration (HRSA) and required to be covered under the preventive services coverage requirement. *See* HRSA, *Women's Preventive Services Guidelines*; *see also* Emp. Benefits Sec. Admin., *FAQs About Affordable*

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[15] *Available at* http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last visited Jan. 24, 2016).

[16] In some states where the ACA's Medicaid expansion has not been undertaken, state-run programs attempt to provide similar contraceptive coverage. Petitioner's *amici* propose programs like these as alternatives. In addition to eligibility obstacles, these programs present concerns over limited provider networks and funding shortfalls, making them implausible alternatives. *See* Kinsey Hasstedt, *How Texas Lawmakers Continue to Undermine Women's Health*, Health Affairs Blog (May 20, 2015), *available at* http://healthaffairs.org/blog/2015/05/20/how-texas-lawmakers-continue-to-undermine-womens-health/. More fundamentally, Petitioners' *amici* fail to acknowledge that Respondents have no control over such programs.

Care Act Implementation (Part XXVI) (May 2015) (hereinafter EBSA, *FAQs About Affordable Care Act*) ("Plans and issuers must cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women in its current Birth Control Guide.").[17] Although the Department of Health and Human Services (HHS) has classified coverage of "family planning services and supplies furnished * * * to individuals of child-bearing age," 42 U.S.C. § 1396d(a)(4)(C), as a mandatory benefit under Medicaid, 42 C.F.R. § 440.210, meaning that all state Medicaid programs must cover that type of services, the scope of services covered within that type varies by state. Depending on a given beneficiary's eligibility group, a state may cover a narrower scope of family planning services. *See* Kaiser Family Found., *Medicaid and Family Planning: Background and Implications of the ACA* (Feb. 2016) (hereinafter Kaiser, *Medicaid and Family Planning)*;[18] *see also* National Health Law Program, *Intrauterine Devices and Implants: A Guide to Reimbursement* (July 2015) (hereinafter NHeLP, *Intrauterine Devices and Implants*).[19]

For example, women who are eligible for Medicaid under the ACA's Medicaid expansion are entitled to coverage of the full range of FDA-approved contraceptive methods as recommended by HRSA. *See* 42 C.F.R. § 442.347; 78 Fed. Reg. 42,160-01, 42,224–26. But more than half of states provide a narrower range of family planning services to people who would not otherwise be eligible for Medicaid, and limit the availability of those services to individuals at or near 200 percent of the federal poverty level. Guttmacher

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[17] *Available at* http://www.dol.gov/ebsa/faqs/faq-aca26.html.

[18] *Available at* http://kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/.

[19] *Available at* https://www.acog.org/-/media/Departments/LARC/LARCReport2014.pdf?dmc=1&ts=20160107T1125352013.

Inst., *Medicaid Family Planning Eligibility Expansions* (Feb. 1, 2016) (hereinafter Guttmacher, *Medicaid Family Planning*).[20] Moreover, the ACA allows states to amend their state Medicaid plans to establish family planning programs using income-based eligibility standards. 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XXI), 1396d(a)(4)(C). Twenty-five states have done so. Guttmacher, *Medicaid Family Planning*, at 1. Some states may cover a narrower scope of services under these plans, and thus may not cover all eighteen FDA-approved contraceptive methods now required by recent HHS guidance. *See* Kaiser, *Medicaid and Family Planning*; *see also* EBSA, *FAQs About Affordable Care Act*. Furthermore, the state's selected care delivery system also may affect the scope of covered family planning services. The majority of women ages 15 to 49 who receive comprehensive benefits through Medicaid are enrolled in some form of managed care, and states' managed care contractors may cover a narrower set of services and impose prior authorization requirements and other utilization restrictions on brand contraceptive drugs or other, more expensive contraceptive methods like implants and intrauterine devices. *See* Kaiser, *Medicaid and Family Planning*; NHeLP, *Intrauterine Devices and Implants*.

Even if these concerns could be overcome, Petitioners' alternative would still impose significant burdens on women seeking access to contraceptive services. Women would be required to sign up for Medicaid, find a Medicaid-participating provider from whom they could receive contraceptive services, and make separate trips to see their Medicaid provider and, if needed, to fill a prescription at a Medicaid network pharmacy in order to obtain their contraceptive services. Not only would these burdensome steps discourage women from receiving contraceptive

[20] *Available at* http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

services or using the contraceptive method that is most effective for them, thereby undermining the government's compelling interests in public health and gender equality, but also these burdens would disparately affect female employees' use of their employee benefits compared to their male colleagues, further undermining the government's compelling interest in gender equality. For all of these reasons, this alternative would not be nearly as effective as the accommodation in furthering the government's compelling interests in public health and gender equality.

In addition, this alternative clearly would be not feasible, as it effectively would require Congress to create an entirely new Medicaid program. Congress would have to fundamentally transform the Medicaid program by, among other things, creating a new mandatory eligibility group to include the female plan participants of objecting non-profit religious employers,[21] eliminating the income-level eligibility criteria for those individuals, and establishing new federal standards for the scope of services that must be covered by each state Medicaid program. That would take Congress, HHS, and each of the states, working together, time and effort to implement, and would require HHS and each of the states to incur additional costs to provide coverage of those services to the new population. And it would impose a significant ongoing administrative burden on HHS and state Medicaid agencies to verify the eligibility of the women at issue, coordinate the provision of services within the state's existing fee-for-service or managed care delivery system, and assure that the women at issue have adequate access to the full range of recommended contraceptive services.

[21] Though not at issue in these cases, presumably, this new group would also include female plan participants of closely held for-profit secular employers with religious objections to contraceptive coverage. Similar concerns exist with respect to Petitioners' other alternatives.

Relying on Medicare as the "public option" to provide contraceptive coverage would be no more effective or feasible. Most female plan participants do not meet the statutory Medicare eligibility criteria, *see* 42 U.S.C. §§ 426, 426-1, 1395c, 1395o (generally providing for Medicare eligibility for individuals over the age of 65, disabled individuals, and individuals with end-stage renal disease), and Medicare may not cover the full-range of FDA-approved contraceptive methods. *See* Ctrs. for Medicare & Medicaid Servs. (CMS), *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems*, 2016 OPPS Final Rule Addenda, Addenda B & D1 (Jan. 2016) (listing intrauterine device insertion and removal procedure codes as non-covered);[22] CMS, *Physician Fee Schedule Final Rule with Comment Period*, CY 2016 PFS Relative Value Files (RVU16A) (Jan. 2016) (same).[23] Congress would be required to, among other things, create a new category of individuals who are eligible for Medicare that includes the women at issue and provide for coverage of the full range of FDA-approved contraceptive methods for those individuals. That also would impose significant additional costs and administrative burdens on the Medicare program. RFRA does not require Congress to take on a whole new burden in order to accommodate Petitioners' exercise of their religion. *See Hobby Lobby*, 134 S. Ct. at 2786 (Kennedy, J., concurring).

C. Title X

[22] *Available at* https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1633-FC-2016-OPPS-FR-Addenda.zip (last visited Feb. 4, 2016).

[23] *Available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending (last visited Feb. 4, 2016).

Petitioners propose an alternative under which HHS would provide contraceptives to female plan participants through the Title X Family Planning Program. Zubik Pet. Br. 80; ETBU Pet. Br. 76. Petitioners' *amici* propose a similar alternative. Br. for State of Tex. 19–20. This alternative would not be nearly as effective a means of achieving the government's compelling interests in public health and gender equality because it would pose multiple, significant obstacles to access to contraceptives—a far cry from the seamless contraceptive coverage under the accommodation. Moreover, requiring women to take significant additional steps to obtain access to contraceptive services would impose an added burden on female employees with respect to their employee benefits that would not exist for their male colleagues. That would directly undermine the government's compelling interest in gender equality.

Understanding the scope of the Title X Family Planning Program makes clear that it would be an unworkable alternative for providing contraceptives to the women at issue. The program is funded through a limited appropriation from Congress to award grants to state and local health departments and non-profit family planning and community health agencies that provide family planning services at a limited number of service sites in the states, the District of Columbia, and the eight U.S. territories and Freely Associated States. *See* 42 U.S.C. § 300(a); 42 C.F.R. §49(A); C.I. Fowler, et al., *Family Planning Annual Report: 2014 National Summary*, RTI International, 7 (Aug. 2015).[24] Congress directs the HHS Secretary, in making grants under Title X, to take into account "the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance."

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[24] *Available at* http://www.hhs.gov/opa/pdfs/title-x-fpar-2014-national.pdf.

42 U.S.C. § 300(b). Another congressional directive is to obtain assurances "satisfactory to the Secretary that—(1) priority will be given in such [Title X] project or program to the furnishing of such services to persons from low-income families." 42 U.S.C. § 300a-4(c)(1). To implement this statutory directive, HHS requires grant recipients to give priority in the provision of services to individuals from families with incomes at or below 100 percent of the federal poverty guidelines issued pursuant to 42 U.S.C. § 9909(2); not to charge those individuals for the services provided (except to the extent that payment will be made by a third party); and to provide that charges for services to individuals with incomes from 100 percent to 250 percent of the federal poverty guidelines will be made on a sliding scale based on ability to pay. 42 C.F.R. §§ 59.2, 59.5(a)(6)-(8).

Under the current program, a woman may not have access to a Title X clinic. HHS reports that there is at least one Title X-funded family planning clinic in approximately 75% of U.S. counties. HHS Office of Population Affairs, *About Title X Grants*.[25] That means that there are no Title X clinics in approximately 25% of U.S. counties; even in counties with one or more Title X clinics, there are many cities and towns that do not have Title X sites. Thus, a woman might be required to travel many miles in order to find a Title X clinic at which she could obtain free contraceptives.

Even after making her way to a Title X clinic, a woman may not be able to obtain contraceptive services because she may not meet the clinic's income-level requirements to qualify for free services. *See* 42 C.F.R. §§ 59.2, 59.5(a)(6)-(8). In addition, Title X clinics must prioritize serving low-income individuals, and asking those clinics to use their scarce resources to serve female plan participants of objecting non-profit religious employers would likely have

[25] *Available at* http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/about-title-x-grants/ (last visited Feb. 15, 2016).

the effect crowding out lower-income women. Title X clinics serve a vital role as safety net providers of contraceptive services, and they do not have the resources to serve an additional population: In 2013, Title X clinics met only one fifth of U.S. women's need for publicly funded family planning services. Kinsey Hasstedt, *Title X: The Lynchpin of Publicly Funded Family Planning in the United States*, Health Affairs Blog (Aug. 10, 2015).[26] Prioritizing women in plans of objecting employers, without regard to income, would fundamentally alter the purpose of the current Title X program.

Even if all of these concerns could be overcome, this alternative would not provide seamless access to contraceptive services. To the contrary, women would be required to take significant additional steps to obtain access to those services. Women would have to make a special trip to the Title X clinic to obtain their contraceptive services, rather than receiving such services during a physical/wellness visit or at the pharmacy where they fill their other prescriptions. These additional steps would result in access that is not seamless and thus would not further the government's compelling interests in public health and gender equality nearly as effectively as the accommodation. Moreover, imposing these additional burdens on women—but not men—to obtain preventive services would discriminate against women, thereby undermining the compelling interest in gender equality.

Nor would using Title X clinics to provide access to contraceptives be a feasible alternative. Petitioners cavalierly suggest that it would be "as simple as ensuring that Title X clinics have sufficient funding to cover the cost of providing free contraceptives to the employees of employers with religious objections who want them, and informing those

[26] *Available at* http://healthaffairs.org/blog/2015/08/10/title-x-the-lynchpin-of-publicly-funded-family-planning-in-the-united-states/.

employees of this existing, recognized, workable, and already-implemented framework for obtaining free contraceptives." ETBU Pet. Br. 76 (citation and internal quotation marks omitted). Of course, expanding the number and location of Title X clinics to serve these additional women would require a substantial increase in funding from Congress. Congress has authorized only a limited appropriation for Title X clinics, and the amount of that appropriation has decreased significantly in recent years. *See* Consolidated Appropriations Act, 2016, Div. H, Tit. II, Pub. L. No. 114-113, 129 Stat. 2242 (2015) (providing for approximately $286.5 million in funding for Title X family planning projects); HHS Office of Population Affairs, *Title X Funding History (*showing substantial decrease in appropriated funds since 2010*).*[27] HHS is not permitted to expend funds in a manner not authorized by Congress. *See* 31 U.S.C. § 1301(a).

But additional funding is only the starting point. Even if Congress were to significantly increase appropriations to fund additional Title X clinics, there would be no guarantee that a grantee would open a Title X clinic within a reasonable distance of a given female plan participant's home or workplace. HHS would depend on new or existing grantees to apply for additional grants through a competitive application process that, among other things, requires potential grantees to identify subcontractors and facilities to open additional sites. Those clinics also would be required to identify sources of funding to support their projects in addition to Title X funds, as HHS regulations prohibit the agency from making grants for 100 percent of a project's estimated costs. 42 C.F.R. § 59.7.

HHS would also have to fundamentally alter the current policy priorities and program requirements for existing Title

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[27] *Available at* http://www.hhs.gov/opa/about-opa-and-initiatives/funding-history/ (last visited Feb. 4, 2016).

X clinics. Most notably, HHS requires grant recipients to give priority in the provision of services to individuals from families with incomes at or below 100 percent of the federal poverty guidelines. 42 C.F.R. §§ 59.2, 59.5(a)(6)-(8); *see also* Fowler, *Family Planning Annual Report: 2014 National Summary*, 22, ex. 15.[28]

For all of these reasons, Petitioners' claim that HHS would need to make only "minor adjustments" to the Title X program is a gross understatement. Zubik Pet. Br. 80. Rather, to accept this alternative would require HHS to make such substantial changes to the Title X program that it would be tantamount to an entirely new program. RFRA does not require the government to adopt such an infeasible alternative. *See Hobby Lobby*, 134 St. Ct. at 2786 (Kennedy, J., concurring).

D. Federal Tax Incentives

Petitioners further suggest that the government could create tax incentives for "contraceptive suppliers to provide these medications and services at no cost to consumers" or "give tax incentives to consumers so that they would not have to bear the cost of contraceptives." Zubik Pet. Br. 81 (citation

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[28] Petitioners' *amici* also propose a variation on the Title X alternative in the form of state-funded programs that use the existing framework of the Title X program, such as Colorado's Family Planning Initiative. Br. for State of Tex. 20. Most fundamentally, these programs are not federally controlled, and thus Respondents could not guarantee that a state would do what Petitioners' *amici* propose—making them an infeasible alternative. And, even where these programs exist, they face a host of obstacles, including funding problems and reductions in the provision of training and services. *See, e.g.*, Mark Salley, *News: State Health Department Seeks Funding for Successful Family Planning Initiative*, Colo. Dep't of Pub. Health & Env't (July 1, 2015), *available at* https://www.colorado.gov/pacific/cdphe/news/CDPHE-family-planning-funding.

and internal quotation marks omitted). Such an approach would not be anywhere near as effective a means for furthering the government's compelling interests in public health and gender equality as the seamless contraceptive coverage available under the accommodation. For starters, providing tax incentives to "contraceptive suppliers" of "medications" would not facilitate female plan participants' access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women of reproductive age, as recommended by HRSA. HRSA, *Women's Preventive Services Guidelines*. For example, such tax incentives would not help women obtain other FDA-approved contraceptives, such as intrauterine devices or implants, or provide coverage for the physician visit and procedure needed to insert them. Nor would tax incentives to unspecified "suppliers" of contraceptive "services"—by which Petitioners presumably mean physicians, nurse practitioners, and similar professionals—help women find a health care practitioner from whom they could seek education or counseling regarding the most appropriate method of contraception for them, and, if needed, obtain a prescription for the contraceptive method of their choice. After all, not all physician practices may choose to participate in a tax credit program, so women could be required to undertake significant efforts to identify a doctor who would provide free contraceptive services. That doctor may not be the same doctor the woman uses for her other preventive services. There similarly would be no guarantee that any particular manufacturer of a contraceptive drug or device would participate in such a program and therefore that women would have access to the full range of FDA-approved contraceptive methods.

In addition to failing to guarantee access to the full range of HRSA-recommended contraceptive services, this alternative would present women seeking access to contraceptives with

administrative and practical barriers. For example, a woman who wants an oral contraceptive would need to find a program to obtain free contraceptive drugs from the manufacturer, to avail herself of the program (including satisfying its eligibility verification requirements, absent confirmation from the objecting employer that she is a plan participant), to find a physician or other prescribing practitioner who is participating in the program (who may be different from her regular provider) to prescribe the drug, and to locate a pharmacy at which she can obtain the drug for free (which may be different from her regular pharmacy). Such significant burdens would make it less likely that women would obtain the contraceptive services that are most effective for them. They also would fall solely on women. In short, this alternative would undermine, rather than advance, the government's compelling interests in public health and gender equality.

This alternative also would not be feasible. Congress has not authorized the provision of such tax incentives, and federal appropriations law prohibits the Department of the Treasury from providing the incentives without congressional authorization. *See* 31 U.S.C. § 1301(a). Presumably, the costs of financing such tax incentives would be considerable, so as to encourage participation by pharmaceutical manufacturers, medical device manufacturers, physicians, advance practice nurses, and the like. Even assuming that Congress were to create an entirely new tax incentive program for these "suppliers" of contraceptives, pharmaceutical manufacturers, pharmacies, and others could have any number of business reasons not to participate in the program.

The *Zubik* Petitioners' proposal that the "simplest version of this approach would be to grant refundable tax credits for the cost of contraceptive services purchased by people enrolled in religious objectors' health plans" would be even less effective and feasible. Zubik Pet. Br. 82. Providing refundable tax credits to women would do nothing to

mitigate the substantial up-front cost of purchasing contraceptive services, particularly of more expensive methods like intrauterine devices. This is of great concern given that cost has been shown to be a significant barrier to accessing recommended preventive health care services. Inst. of Med. at 19. Women would not receive the tax credit until after their tax returns for the year were processed in the subsequent calendar year. Women also would face numerous additional administrative and practical barriers in seeking access to contraceptive services, such as finding a physician or other prescribing practitioner who is participating in the program (who may be different from their regular provider) to discuss the range of available contraceptive methods and, if needed, prescribe a contraceptive drug, and locate a pharmacy at which she can obtain the drug (which may be different from their regular pharmacy)—not to mention the maintenance of receipts in order to claim the tax credit. These burdens not only make it less likely that women would obtain the contraceptive services that are most effective for them, but also are burdens that men would not have to bear in order to access preventive services. For these reasons, this alternative would undermine the government's compelling interests in public health and gender equality.

CONCLUSION

For the foregoing reasons, and for those set forth in the Respondents' brief, the judgments below should be affirmed.

Respectfully submitted,

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APPENDIX

AMICI CURIAE INFORMATION

Robert Berenson, M.D., is an Institute Fellow with the Urban Institute and a board-certified internist. He has served as the Vice-Chair of the Medicare Payment Advisory Commission, Director of the Center for Health Plans and Providers in the Centers for Medicare & Medicaid Services, and as Assistant Director of the White House Domestic Policy Staff.

Linda J. Blumberg, Ph.D., is a health economist and senior fellow in the Urban Institute's Health Policy Center. Her research includes a broad array of analyses on health care financing, health system reform, private insurance markets, health care costs, and access to care.

Claire Brindis, Dr.P.H., is Professor of Pediatrics and Health Policy at the University of California, San Francisco, where she is also the Director of the Philip R. Lee Institute for Health Policy Studies and holds the Caldwell B. Esselstyn Chair in Health Policy. She is also a Director of the Bixby Center for Global Reproductive Health and served on the Institute of Medicine Committee on Preventive Services for Women (2010-2011).

Judith Feder, Ph.D., is a professor and founding dean of Georgetown University's McCourt School of Public Policy and an Urban Institute Fellow. She has published widely on how best to promote affordable health insurance coverage that assures meaningful access to necessary care. Feder, a political scientist, is a former Department of Health and Human Services principal deputy assistant secretary and a member of the National Academy of Medicine.

Sherry Glied, Ph.D., is Professor of Public Service and Dean of New York University's Robert F. Wagner Graduate School of Public Service. She was confirmed by the U.S. Senate as Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services. She had previously served as Senior Economist for health care and

labor market policy on the President's Council of Economic Advisers in 1992-1993, under Presidents George H.W. Bush and Bill Clinton.

Joseph P. Newhouse, Ph.D., is the John D. MacArthur Professor of Health Policy and Management at Harvard University, Director of the Division of Health Policy Research and Education, chair of the Committee on Higher Degrees in Health Policy, and Director of the Interfaculty Initiative in Health Policy. He is a member of the faculties of the Harvard Kennedy School, the Harvard Medical School, the Harvard T.H. Chan School of Public Health, and the Faculty of Arts and Sciences, as well as a Faculty Research Associate of the National Bureau of Economic Research.

Cathy Schoen, M.S., is a health care and policy economist with over 30 years of experience working on federal, state, and local health care and policy issues. Until her retirement, she was Senior Vice President of Policy, Research and Evaluation at the Commonwealth Fund, a non-partisan non-profit foundation based in New York. She was a Brookings Fellow and a health economist overseeing benefit designs, Medicaid expansion options, and ambulatory care reimbursement alternatives for the federal government (Department of Health, Education and Welfare, Office of the Assistant Secretary for Planning and Evaluation) during the 1970s.

Neel Shah, M.D., M.P.P., is an Assistant Professor of Obstetrics, Gynecology and Reproductive Biology at Harvard Medical School. Prior to joining the faculty, he founded Costs of Care, a global non-governmental organization that curates insights from clinicians to help delivery systems provide better care at lower cost.

Katherine Swartz, Ph.D., is a Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard T.S. Chan School of Public Health. She has written extensively about health insurance, people who lack health insurance, and policies to improve access to health care.

Judith G. Waxman, J.D., is one of the nation's leading healthcare law and policy analysts, having more than 35 years of experience working to improve the health of women and other vulnerable groups. She has worked as a senior staff leader in health and reproductive rights policy at the National Women's Law Center, Families USA, and the National Health Law Program, as well as serving as a senior policy analyst at the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) and an attorney-advisor for the Public Health Service.

Carol S. Weisman, Ph.D., is Distinguished Professor of Public Health Sciences, Obstetrics and Gynecology, as well as Health Policy and Administration at the Pennsylvania State University College of Medicine. She is a sociologist and health services researcher with a principal interest in women's access to primary and preventive care and in quality of care for women. She has led numerous research projects on these topics and is the author of over 150 publications. She served on the Institute of Medicine Committee on Preventive Services for Women (2010-2011).