Nos. 13-354 & 13-356

IN THE

Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

HOBBY LOBBY STORES, INC., ET AL.

CONESTOGA WOOD SPECIALTIES CORPORATION, ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

On Writ of Certiorari to the United States Courts of Appeals for the Tenth and Third Circuits

BRIEF OF THE GUTTMACHER INSTITUTE AND PROFESSOR SARA ROSENBAUM AS AMICI CURIAE IN SUPPORT OF THE GOVERNMENT

DAWN JOHNSEN
INDIANA UNIVERSITY
MAURER SCHOOL OF LAW
211 South Indiana Ave.
Bloomington, IN 47405
(812) 855-3942

WALTER DELLINGER
(*Counsel of Record*)
wdellinger@omm.com
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, DC 20006
(202) 383-5300

Attorneys for Amici Curiae
[Additional Counsel Listed on Inside Cover]

ANTON METLITSKY
LEAH GODESKY
LUCY E. HILL*
O'MELVENY & MYERS LLP
7 Times Square
New York, NY 10036
(212) 326-2000

ANNA-ROSE MATHIESON
O'MELVENY & MYERS LLP
Two Embarcadero Center
28th Floor
San Francisco, CA 94111
(415) 984-8700

*Not yet admitted; supervised by principals of the firm.

TABLE OF CONTENTS

Page

INTEREST OF AMICI CURIAE 1

INTRODUCTION AND SUMMARY OF ARGUMENT 3

ARGUMENT 7

I. ELIMINATING COST BARRIERS TO EFFECTIVE CONTRACEPTIVE USE REDUCES THE INCIDENCE OF UNINTENDED PREGNANCY TO THE BENEFIT OF WOMEN AND FAMILIES. 7

A. Contrary to Conestoga Wood's Claim, Reducing the Cost of Contraception Reduces Rates of Unintended Pregnancy..... 9

B. Reducing Unintended Pregnancy Reduces the Need for Abortion and Promotes the Educational, Economic, and Social Advancement of Women..... 21

II. THE RELIGIOUS EXEMPTION SOUGHT BY PLAINTIFFS WOULD SUBSTANTIALLY BURDEN WOMEN'S ABILITY TO MAKE CHILDBEARING DECISIONS IN ACCORD WITH THEIR OWN RELIGIOUS AND MORAL BELIEFS, HEALTH NEEDS, AND FAMILY RESPONSIBILITIES..... 29

CONCLUSION 36

TABLE OF AUTHORITIES

Page

CASES

Autocam Corp. v. Sebelius,
730 F.3d 618 (6th Cir. 2013).....34, 35

Braunfeld v. Brown,
366 U.S. 599 (1961)..... 32

Cutter v. Wilkinson,
544 U.S. 709 (2005).....5, 29, 31

Estate of Thornton v. Caldor, Inc.,
472 U.S. 703 (1985).....5, 29

Griswold v. Connecticut,
381 U.S. 479 (1965)..... 8

Hobby Lobby Stores, Inc. v. Sebelius,
723 F.3d 1114 (10th Cir. 2013)..... 30

Hotze v. Sebelius,
2014 WL 109407 (S.D. Tex. Jan. 10,
2014)..... 32

Korte v. Sebelius,
735 F.3d 654 (7th Cir. 2013).....34, 35

Planned Parenthood of Se. Pa. v. Casey,
505 U.S. 833 (1992)..... 8

United States v. Lee,
455 U.S. 252 (1982)..... 31

STATUTES

29 U.S.C. § 206(a)(1)(C) 16

42 U.S.C. § 300gg-13..... 3

REGULATIONS

78 Fed. Reg. 39,870 (July 2, 2013)..... 33

TABLE OF AUTHORITIES (continued)

Page

OTHER AUTHORITIES

Catalina Amuedo-Dorantes & Jean Kimmel, *The Motherhood Wage Gap for Women in the United States: The Importance of College and Fertility Delay*, 3 Rev. Econ. Household 17 (2005) 28

Elizabeth Oltmans Ananat & Daniel M. Hungerman, *The Power of the Pill for the Next Generation: Oral Contraception's Effects*, 94 Rev. Econ. & Stat. 37 (2012) 26

Martha J. Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply,* Q. J. Econ. 289 (Feb. 2006) 12

Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages* (Nat'l Bureau of Econ. Research, Working Paper No. 17922, Mar. 2012) 26, 27

McKinley L. Blackburn et al., *Fertility Timing, Wages, and Human Capital*, 6 J. Population Econ. 1 (1993) 28

Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Family Planning*, 48 Morbidity & Mortality Wkly. Rep. 1073 (1999) 22

TABLE OF AUTHORITIES
(continued)

Page

Ctrs. for Disease Control & Prevention, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010,* 59 Morbidity & Mortality Wkly. Rep. 1 (2010), *available at*, http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf. 34, 35

Michael E. Chernew et al., *Value-Based Insurance Design*, 26 Health Aff. w195 (2007) 31

Agustin Conde-Agudelo et al., *Birthspacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 JAMA 1809 (2006) 22

Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 Persp. on Sexual & Reprod. Health 226 (2007) 18

Kelly R. Culwell & Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995–2002: The Effect of Insurance Status*, 110 Obstetrics & Gynecology 1371 (2007) 18

Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, National Health Statistics Report No. 62 (Feb. 14, 2013) 7, 10, 11

David L. Eisenberg et al., *Correlates of Dual-Method Contraceptive Use: An Analysis of the National Survey of Family Growth (2006–2008)*, Infectious Diseases in Obstetrics & Gynecology, 1 (2012) 11

TABLE OF AUTHORITIES
(continued)

Page

David Eisenberg et al., *Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 J. Adolescent Health S59 (2013) 16

Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008*, 104 Am. J. Pub. Health S43 (2014) 8, 9, 25

Lawrence B. Finer et al., *Changes in Out-of-Pocket Payments for Contraception by Privately Insured Women During Implementation of the Federal Contraceptive Coverage Requirement*, 89 Contraception 97 (2014)..... 18

Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 Persp. on Sexual & Reprod. Health 94 (2008) 17, 18

Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics*, 87 Contraception 465 (2013) 27

Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2010* (July 2013) 21

TABLE OF AUTHORITIES
(continued)

Page

Jennifer J. Frost et al., Guttmacher Inst., *Improving Contraceptive Use in the United States,* In Brief, 2008 Series, No. 1 (2008) 14

Aileen M. Gariepy et al., *The Impact of Out-of-Pocket Expense on IUD Utilization Among Women with Private Insurance*, 84 Contraception e39 (2011) 16, 17, 18

Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18 (2008) 23

Rachel Benson Gold et al., Guttmacher Inst., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System* (2009) 7, 10, 23

Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730 (2002) 26

Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* (2009) 19

Guttmacher Inst., *State Policies in Brief: Insurance Coverage of Contraceptives* (Jan. 1, 2014), *available at* http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf. 19

TABLE OF AUTHORITIES
(continued)

Page

Guttmacher Inst., *Unintended Pregnancy in the United States* (Dec. 2013), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html 9, 25

R.A. Hatcher et al., *Contraceptive Technology* (20th ed. 2011).....13, 15, 17

Stanley K. Henshaw, *Unintended Pregnancy in the United States,* 30 Fam. Plan. Persp. 24 (1998)..... 9

Heinrich Hock, *The Pill and the College Attainment of American Women and Men* (Oct. 9, 2007) (unpublished study, Florida State University) 26, 27

Jo Jones et al., *Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995*, National Health Statistics Reports No. 60 (2012).....10, 11

Rachel K. Jones, Guttmacher Inst., *Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills* (2011)..... 34

Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358 (2011)..... 9

Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41 (2011) 25

TABLE OF AUTHORITIES
(continued)

Page

Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 Persp. on Sexual & Reprod. Health 294 (2002) 12

Kathryn Kost & Stanley Henshaw, Guttmacher Inst., *U.S. Teenage Pregnancies, Births and Abortions, 2008: National Trends by Age, Race and Ethnicity* 2 (2012), *available at* http://www.guttmacher.org/pubs/USTPtrends08.pdf 25

Hal C. Lawrence, Testimony Before the Institute of Medicine Committee on Preventative Services for Women (Jan. 12, 2011), *available at* http://www.iom.edu/~/media/Files/Activity%2520Files/Women/PreventiveServicesWomen/Lawrence_ACOG.pdf 22

Marty Lederman, Hobby Lobby *Part III—There Is No "Employer Mandate,"* Balkinization (Dec. 16, 2013), http://balkin.blogspot.com/2013/12/hobby-lobby-part-iiitheres-no-employer.html 32

Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills Between 1996 and 2006*, 83 Contraception 528 (2011). 17

David S. Loughran & Julie M. Zissimopoulos, *Why Wait?: The Effect of Marriage and Childbearing on the Wages of Men and Women*, 44 J. Hum. Res. 326 (2009) 28

TABLE OF AUTHORITIES
(continued)

Page

Brianna M. Magnusson et al., *Contraceptive Insurance Mandates and Consistent Contraceptive Use Among Privately Insured Women*, 50 Med. Care 562 (2012)..... 20

Amalia R. Miller, *The Effects of Motherhood Timing on Career Path*, 24 J. Population Econ. 1071 (2011)..... 28

Nat'l Business Group on Health, *Investing in Maternal and Child Health: An Employer's Toolkit* (Kathryn Phillips Campbell ed. 2007), *available at* http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/mch_toolkit.pdf 33

Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291 (2012).....20, 24, 25

Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 Contraception 360 (2007)..... 20

Susheela Singh & Jacqueline E. Darroch, *Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries*, 32 Fam. Plan. Persp. 14 (2000) 25

Susheela Singh et al., *Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes*, 41 Stud. Fam. Plan. 241 (2010)..... 25

TABLE OF AUTHORITIES
(continued)

Page

Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 Lancet 625 (2012) 25

Hiromi Taniguchi, *The Timing of Childbearing and Women's Wages*, 61 J. Marriage & Fam. 1008 (1999) 28

James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397 (2011) 15

James Trussell, *Update on and Correction to the Cost-Effectiveness of Contraceptives in the United States*, 85 Contraception 611 (2012) 17

James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5 (2009) 15

Amanda Wendt et al., *Impact of Increasing Inter-Pregnancy Interval on Maternal and Infant Health*, 26 (Supp. 1) Paediatric & Perinatal Epidemiology 239 (2012) 23

Charles F. Westoff, *Recent Trends in Abortion and Contraception in 12 Countries*, DHS Analytical Studies No. 8 (Feb. 2005) 24

Elizabeth Ty Wilde et al., *The Mommy Track Divides: The Impact of Childbearing on Wages of Women of Differing Skill Levels* (Nat'l Bureau of Econ. Research, Working Paper No. 16582, Dec. 2010) 28

TABLE OF AUTHORITIES
(continued)

Page

Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 New Eng. J. Med. 1998 (2012).....12, 13

BRIEF OF THE GUTTMACHER INSTITUTE AND PROFESSOR SARA ROSENBAUM AS AMICI CURIAE IN SUPPORT OF THE GOVERNMENT

This brief is submitted on behalf of the Guttmacher Institute and Professor Sara Rosenbaum as amici curiae in support of the government.[1]

INTEREST OF AMICI CURIAE

Amici are the Guttmacher Institute and Professor Sara Rosenbaum.

Now in its fifth decade, the Guttmacher Institute is a private, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education designed to generate new ideas, encourage enlightened public debate, and promote sound policy and program development. The Institute's overarching goal is to ensure the highest standard of sexual and reproductive health for all people worldwide by promoting evidence-based policies and conducting research according to the highest standards of methodological rigor. Attention to accuracy is fundamental to the Institute's work. It produces a wide range of resources on topics pertaining to sexual and reproductive health and

---

[1] No counsel for any party has authored this brief in whole or in part, and no person other than amici, their members, or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Letters from Conestoga Wood Specialties Corporation and the government consenting to all amici briefs are on file with the Clerk's office, and a letter from Hobby Lobby Stores, Inc., consenting to the filing of this brief is submitted herewith.

publishes two peer-reviewed journals. The information and analysis it generates on reproductive rights issues are widely cited by policymakers, the media and advocates across the ideological spectrum.

Professor Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University School of Public Health and Health Services, where she also holds appointments in the University's Schools of Law and Medicine. Professor Rosenbaum has focused her career on issues of health and health equity for all Americans. Her expertise lies in public and private health insurance and its role in ensuring access to affordable, high-quality preventive, primary, and specialized health care, especially in the case of women and children. A member of the Institute of Medicine and the Guttmacher Institute's board of directors, Professor Rosenbaum enjoys wide recognition in her field. She has authored nearly 100 peer-reviewed journal articles and is the leading author of *Law and the American Health Care System* (2d edition), which offers a panoramic legal overview of health care access, financing, and quality, as well as a comprehensive discussion of law and women's health. Professor Rosenbaum's work helped inform the design and implementation of the Affordable Care Act.

Amici have a strong interest in the resolution of this case. In particular, amici believe that, as shown below, effective family planning yields enormous societal benefits for American women, children, and families, and that the contraceptive-coverage provision at issue in this case is crucial to achieving those benefits.

INTRODUCTION AND SUMMARY OF ARGUMENT

The federal Centers for Disease Control and Prevention named improved family planning one of the ten great public health achievements of the 20th century. Removing barriers to the full range of contraceptive options improves the health of women and families, reduces the need for abortion, and promotes the advancement of women and society.

Under the federal laws challenged in this case, if an employer not eligible for exemption or accommodation chooses to offer its employees a health insurance plan as a benefit of employment, the plan must include all contraceptive methods for women, without cost sharing or other fees.[2] This provision allows an individual woman to choose the method of contraception most appropriate for her circumstances and health needs and most consistent with her own personal religious and moral values.

A number of owners of for-profit companies have challenged the contraceptive coverage provision, arguing that the Religious Freedom Restoration Act (RFRA) should allow them to exclude from coverage in their company insurance plans any contraceptive

---

[2] 42 U.S.C. § 300gg-13; U.S. Dep't Health & Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines (visited Jan. 25, 2014). Coverage includes "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." It does not include male sterilization or condoms.

options that are inconsistent with the religious views of the corporate employer.

Legal requirements that contraception be covered in health insurance plans are neither novel nor unprecedented: 28 states require certain health insurance plans to cover all or almost all prescription methods of contraception. What is critically important about the federal requirement is that it provides women access to the full range of contraceptive methods without imposing fees or cost sharing on the patient.

Amici the Guttmacher Institute and Professor Sara Rosenbaum, drawing on extensive data, argue that the guarantee of coverage serves compelling societal and individual interests. Those who challenge these requirements suggest that because most women are already using contraception, the guarantee cannot be all that important. That assertion is fundamentally wrong. It fails to recognize the vastly different effectiveness and cost of different forms of contraception, the substantial degree to which cost determines which contraceptive methods are actually used, the health and social factors that affect a woman's method choice, and the resulting consequences for women's health, family well-being, and risk of unintended pregnancy and abortion.

First, some methods of contraception are far more effective in practice than others. For example, the hormonal intrauterine device ("IUD") is *45 times* more effective than oral contraceptives and *90 times* more effective than male condoms in preventing pregnancy based on typical use.

Second, cost is a major factor in determining which contraceptives women choose. Almost *one-third* of American women report that they would change their contraceptive method if cost were not an issue. Initiating use of an implant or IUD can cost a month's salary for a woman working full time at minimum wage.

Third, access to the range of contraceptive methods without cost sharing can dramatically reduce the rate of unintended pregnancy, with profound consequences for women and society. Effective family planning facilitates women's educational and career goals and contributes to the economic stability of women and their families. Women with health conditions that increase the risk of pregnancy and childbirth particularly benefit from reliable methods of contraception, allowing them to plan pregnancy consistent with their medical needs. Enabling women to space their pregnancies better also enables them to have healthier babies. Finally, reducing the rate of unintended pregnancy is by far the most widely accepted and effective means of reducing the need for and incidence of abortion.

Accommodation of individual religious beliefs is a principle of great importance, but this Court has noted that the scope of any such accommodation "must be measured so that it does not override other significant interests," including those of third parties.[3] The burden imposed on third parties in this case is far more severe than the "convenience or interests . . . of other employees" cited by the Court in rejecting an accommodation in *Estate of Thornton v.*

[3] *Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005).

Caldor, Inc.[4] Giving legal force to a corporate employer's beliefs against contraception would deny to female employees and their insured family members vital access to the full range of contraceptive methods, inflicting financial harm and erecting obstacles to needed medical care.

In these cases, the shifting of a burden to third parties would involve even more than economics and personal health, as significant as they are. Denying coverage of the most effective methods (or, in some cases, all methods) of contraception leads predictably and directly to unintended pregnancies. Removing the contraceptive coverage guarantee would place some women with religious objections to abortion in what is for them a morally difficult position: they might desire but be unable to afford the most reliable methods of contraception and therefore be at increased risk for confronting an unintended pregnancy and the difficult decisions that ensue. For all women, denying practical access to the method of contraception that is right for their health and life circumstances and the well-being of their families can represent a most serious incursion into their individual moral autonomy and the course of their lives.

Affording women effective access to the full range of methods of contraception will advance their health and that of their newborns, enhance their ability to make decisions in accord with their own religious and moral beliefs, reduce the incidence of unintended pregnancy and abortion, and support the aspirations of women and society. For these reasons, the

---

[4] 472 U.S. 703, 709 (1985).

Court should hold that the Religious Freedom Restoration Act does not require the exemptions sought by the plaintiffs.

ARGUMENT

I. ELIMINATING COST BARRIERS TO EFFECTIVE CONTRACEPTIVE USE REDUCES THE INCIDENCE OF UNINTENDED PREGNANCY TO THE BENEFIT OF WOMEN AND FAMILIES.

The ability to control whether and when to have children is fundamental to a woman's ability to control almost all other aspects of her life, thus affecting nearly all members of society. A typical American woman wishing to have only two children must, on average, spend three decades—more than three quarters of her reproductive life—avoiding unintended pregnancy.[5] Women commonly seek to control the timing of each child's birth to protect their families' well-being and economic stability while protecting their own health and increasing the chances for a healthy start for their children. For these reasons, virtually all women across a variety of religious affiliations have used at least one method of contraception.[6]

---

[5] Rachel Benson Gold et al., Guttmacher Inst., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System* 6 (2009).

[6] Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, National Health Statistics Report No. 62, 8 (Feb. 14, 2013) (among women age 15-44 who have ever had sex with a man, 98.6% of Catholic women, 99.4% of women who are Baptist or affiliated with oth-

Half a century ago, this Court recognized the importance of the right to use contraception in *Griswold v. Connecticut*.[7] In reaffirming that right in 1992, the Court noted the by-then familiar benefits that had accrued to women and society: "The 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."[8]

In practice, however, a woman is not always able to avoid unintended pregnancy throughout her long reproductive life. Approximately half of all pregnancies in the United States are unintended[9]—that is, over three million pregnancies each year.[10] More

---

er fundamentalist Protestant sects, 99.5% of women affiliated with other Protestant denominations, and 99.4% of women with no religious affiliation have used contraception).

[7] 381 U.S. 479 (1965).

[8] *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992).

[9] Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States*, *2001–2008*, 104 Am. J. Pub. Health S43, S44 (2014). For study purposes, "[w]hen calculating unintended pregnancy rates, we counted pregnancies about which women felt indifferent along with intended pregnancies; therefore, the unintended pregnancy rate only included pregnancies that were unambiguously unintended." *Id.* at S43.

[10] This problem is particularly acute among poor women, who experience an unplanned pregnancy rate five times that of higher-income women. Finer & Zolna, *supra* note 9, at S45-46 (defining (i) "poor women" as women with incomes at or below the federal poverty level, and (ii) "higher income women" as those at or above 200% of the federal poverty level). Indeed, over the last two decades, unintended pregnancy has become increasingly concentrated among poor women: while the unin-

than half of all American women will experience an unintended pregnancy.[11] Forty percent of unintended pregnancies end in abortion,[12] and three in ten American women will have an abortion at some point in their lives.[13]

Vital to effectively timing childbirth and making abortion less necessary is enabling more women to prevent unintended pregnancy in the first place. That depends almost entirely on correct and consistent use of effective contraception. And that, in turn, depends on a woman's ability to choose the method of contraception most appropriate to her needs, in consultation with her health care provider, unhampered by cost concerns that often drive women toward less effective methods.

A. Contrary to Conestoga Wood's Claim, Reducing the Cost of Contraception Reduces Rates of Unintended Pregnancy.

1. Petitioner Conestoga Wood seeks to deny the connection between economic barriers to effective

---

tended pregnancy rate among women with incomes below the federal poverty line increased 56% between 1994 and 2008, the rate among higher-income women decreased 24% during the same period. Guttmacher Inst., *Unintended Pregnancy in the United States* (Dec. 2013), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html (last visited Jan. 25, 2014).

[11] Stanley K. Henshaw, *Unintended Pregnancy in the United States,* 30 Fam. Plan. Persp. 24, 24 (1998).

[12] Finer & Zolna, *supra* note 9, at S44.

[13] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358, 1366 (2011).

contraception and the United States' high rate of unintended pregnancies. Twice petitioner cites the Guttmacher Institute for the proposition that "89% of women who are at risk of unintended pregnancy are already using contraception."[14] But Conestoga Wood fundamentally fails to appreciate that having access to *some* method is far different than a woman consistently having access to the *best* method for her at a given point in her life.

American women utilize a broad range of contraceptives—on average, three or four methods by age 40.[15] They choose among options based on their specific life circumstances, economic resources, health needs, personal beliefs, and other factors.[16] Some women choose long-acting, reversible contraceptives such as an implant or IUD.[17] Others obtain prescriptions for hormonal-based contraceptives, such as birth-control pills, or shots (known as "injectables") that are administered in the upper arm by a health care provider on a quarterly basis.[18] Still

---

[14] *See* Conestoga Wood Br. 52, 55.

[15] Daniels et al., *supra* note 6, at 4-5.

[16] *See*, *e.g.*, Gold et al., *supra* note 5, at 7 ("Women and couples need a broad range of high-quality contraceptive options, enabling them to select one that—according to their specific life circumstances, sexual behavior and health needs—maximizes their potential for effective use and minimizes the medical side-effects and other drawbacks that can lead to inconsistent use or nonuse").

[17] Jo Jones et al., *Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995*, National Health Statistics Reports No. 60, 14 tbl.1 (2012).

[18] *Id.*

other couples use over-the-counter contraception, such as male condoms or spermicide.[19] Others choose a permanent method, either female or male sterilization.[20] And others attempt to avoid pregnancy by altering their sexual behavior, including through fertility-awareness-based contraception (where couples do not engage in sexual intercourse during certain periods of a woman's fertility cycle) or "withdrawal."[21]

Many women change methods over time or use a combination of methods at the same time, for example, using condoms in addition to birth-control pills to also protect against sexually transmitted diseases.[22] A recent study that assessed the most common methods of contraception ever used by American women concluded that 93% had used male condoms, 82% had used oral contraceptives, and 60% had used withdrawal at some point in their lives.[23]

---

[19] *Id.*

[20] *Id.*

[21] *Id.*

[22] Daniels et al, *supra* note 6, at 5 ("[W]omen may switch methods as their reasons for contraceptive use change, such as delaying a first pregnancy or spacing between one pregnancy and the next, helping prevent sexually transmitted infections, or discontinuing a method due to dissatisfaction"); *see also* David L. Eisenberg et al., *Correlates of Dual-Method Contraceptive Use: An Analysis of the National Survey of Family Growth (2006–2008)*, Infectious Diseases in Obstetrics & Gynecology 1, 4-5 (2012) (7.3% of women of reproductive age use multiple contraceptive methods, most often the condom combined with another method).

[23] *See, e.g.,* Daniels et al., *supra* note 6, at 4.

Some contraceptive methods, however, are far more effective in practice than others. IUDs and implants, for example, are effective for years after they are inserted by a health care provider, and the woman need not worry about contraception on a day-to-day basis.[24] In contrast, birth control pills must be taken each day, at approximately the same time, to maximize protection.[25] And methods of contraception designed to be used during intercourse, such as condoms or spermicide, must be available, accessible, and used properly each time intercourse occurs. In addition, methods such as male condoms and withdrawal require the active participation of male partners, while methods such as IUDs, implants, and oral contraceptives can be employed by the woman alone.[26]

Perhaps not surprisingly, these variations in contraceptive methods translate directly into variable

---

[24] Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 New Eng. J. Med. 1998, 1999 (2012) (noting that long-acting reversible contraceptives' failure rates "rival those with sterilization").

[25] Nearly half of users of birth-control pills who obtained abortions reported that they had forgotten to take their pills; another quarter reported that they did not have ready access to their pills (16% were away from their pills and 10% ran out). Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 Persp. on Sexual & Reprod. Health 294, 300 tbl.6 (2002).

[26] Martha J. Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply,* Q. J. Econ. 289, 295-96 (Feb. 2006) (recognizing the significance of oral contraceptives as compared to prior-available contraceptive methods because they "divorced the decision to use contraception from the time of intercourse").

effectiveness. As reflected in the below table, IUDs and implants boast remarkably low failure rates compared to male condoms, while contraceptive methods such as withdrawal and fertility awareness have high failure rates over one year of typical use.

Contraceptive Method	**Failure Rate Based on One Year of Typical Use**[27]
IUDs and implants	Less than 1%
Injectables	6%
Oral contraceptives	9%
Male condoms	18%
Withdrawal	22%
Fertility-awareness-based contraception	24%
Spermicide	28%

This chart vividly illustrates that use of different methods of contraception can have an enormous impact on the rate of unintended pregnancy. Compared with a couple relying on the hormonal IUD (with a failure rate of 0.2%), a couple relying on condoms is 90 times as likely to have an unintended pregnancy in one year, and a couple relying on oral contraceptives is 45 times as likely. Extrapolating to the 24 million U.S. women using reversible contraceptive methods, if they all used the hormonal IUD, 49,000 of them would become pregnant in a year, compared with more than two million if they all relied on oral contraception, and more than four million if they all relied on condoms.

---

[27] *See* R.A. Hatcher et al., *Contraceptive Technology*, tbl.3-2 (20th ed. 2011); *see also* Winner, *supra* note 24, at 1999.

It is important to remember these data reflect the average effectiveness among women using each method. Some women are more successful at consistently and correctly using a method than others. And there are myriad reasons beyond ease of use why method choice matters, and why choice helps women use their method most effectively. For example, women's contraceptive method choices are influenced by concerns about side effects and drug interactions, how frequently they expect to have sex, their perceived risk of sexually transmitted infections, and the nature of their intimate relationship(s).

A woman's satisfaction with her choice of method matters to its effectiveness. Those who are not completely satisfied are more likely to put themselves at high risk for unintended pregnancy (e.g., 30% of neutral or dissatisfied users have had a gap in use while they were at risk, compared with 12% of completely satisfied users).[28] Moreover, dissatisfaction with one's method is associated with incorrect or inconsistent use.[29] This explains why women need complete information about and access to the full range of available contraceptive options.

2. As we have shown, women's ability to choose from among the full range of contraceptive methods has a huge impact on their risk of unintended pregnancy. The next question is whether cost to the patient constrains her choice of contraceptive methods.

---

[28] Jennifer J. Frost et al., Guttmacher Inst., *Improving Contraceptive Use in the United States,* In Brief, 2008 Series, No. 1, at 4 (2008).

[29] *Id*.

The answer is yes. Contrary to Conestoga Wood's efforts to minimize the connection as "marginal,"[30] a woman's choice among the various available contraceptive methods, of widely varying effectiveness and appropriateness for her, is significantly constrained by cost.

Conestoga Wood again misunderstands the data when it cites a Guttmacher publication for a finding that "only" 12% of women in one study cited cost as a reason for not using contraceptives.[31] For those women, the impact can be enormous: In any given year, 85% of sexually active women not using a contraceptive method will become pregnant.[32] Moreover, the 12% figure does not include the many more women who use less effective methods or forgo their desired method, due to cost.

Extensive empirical evidence demonstrates what common sense would predict: eliminating the fees for contraception leads to more effective and continuous use of contraception. While some contraceptive methods—such as male condoms and spermicide—can be purchased over the counter at a neighborhood drugstore for a comparatively low cost,[33] all highly effective methods are available only with a prescription and often at a substantial cost.[34]

---

[30] *See* Conestoga Wood Br. 52-53.

[31] *Id.* at 56.

[32] James Trussell, *Contraceptive Failure in the United States*, 83 Contraception 397, 399 (2011).

[33] James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 Contraception 5, 10 (2009).

[34] Hatcher et al., *supra* note 27.

- *Long-acting reversible contraception, such as implants and IUDs.* The average wholesale cost of these devices ranges from $718 to $844, exclusive of costs relating to the insertion procedure,[35] and the total cost of initiating one of these long-acting methods generally exceeds $1,000.[36] To put that in perspective, beginning to use one of these devices costs nearly a month's salary for a woman working full time at minimum wage.[37] These costs are prohibitive for many women; one recent study concluded that only 25% of women who request an IUD have one placed after learning the associated costs.[38] And women who face out-of-pocket IUD costs in excess of $50 are one-tenth as likely to obtain an IUD as women with access to the device for less than $50.[39] Yet as explained above, these devices are dramatically more effective in preventing pregnancy than methods of contraception with lower up-front costs, and in fact, they are among the most cost-effective methods over

---

[35] David Eisenberg et al., *Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 J. Adolescent Health S59, S60 (2013).

[36] *Id.*

[37] The federal minimum wage is $7.25 an hour. 29 U.S.C. § 206(a)(1)(C). At 40 hours a week, that amounts to $290 a week, before any taxes or deductions.

[38] Aileen M. Gariepy et al., *The Impact of Out-of-Pocket Expense on IUD Utilization Among Women with Private Insurance*, 84 Contraception e39, e40 (2011).

[39] *Id.* at e41.

time.[40] They are also associated with particularly high rates of user satisfaction and continuation.[41]

- *Oral contraceptives*. In 2006, the average annual cost of oral contraceptives for an uninsured woman was approximately $344.[42] While less than the out-of-pocket cost associated with IUDs and implants, the expense nonetheless represented two-thirds of an uninsured woman's annual total out-of-pocket healthcare expenditures.[43] Moreover, these costs are incurred year after year. And for a woman paid only the federal minimum wage, for example, the monthly cost could mean the difference between an empty gas tank and the ability to travel to work each day.

The large up-front costs of these highly effective methods present an obstacle to use. Almost one-third of women report that they would change their contraceptive method if cost were not an issue.[44]

---

[40] James Trussell, *Update on and Correction to the Cost-Effectiveness of Contraceptives in the United States*, 85 Contraception 611, 611 (2012).

[41] Gariepy et al., *supra* note 38, at e39; Hatcher et al., *supra* note 27, tbl.3-2.

[42] Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills Between 1996 and 2006*, 83 Contraception 528, 531 (2011).

[43] *Id.*

[44] Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 Persp. on Sexual & Reprod. Health 94, 98 (2008).

This figure is particularly high among women relying on male condoms and other less effective methods like withdrawal; significant numbers of these women report that they would prefer to switch methods if cost were not a concern.[45] And uninsured women are less likely to use the most expensive, but most effective, contraceptive methods, such as IUDs, implants, and oral contraceptives,[46] and more likely than insured women to report using no contraceptive method at all.[47]

Concerns relating to the cost of effective contraception are particularly acute for women experiencing financial hardship. In a survey of women with household incomes of less than $75,000, conducted at the height of the recession in summer 2009, nearly

---

[45] *Id.* at 99. Although Conestoga Wood stresses that a large number of women who had health insurance prior to the Affordable Care Act had plans that covered contraceptives (Conestoga Wood Br. 52), it does not acknowledge or differentiate among the plans that did not cover certain methods such as implants or IUDs. For example, approximately 43% of privately insured women surveyed in a 2007-2008 study had coverage plans that did not include IUDs. *See* Gariepy, *supra* note 38, at e41. Moreover, it does not acknowledge that prior to the Affordable Care Act, few plans covered contraceptive methods without cost sharing. *See* Lawrence B. Finer et al., *Changes in Out-of-Pocket Payments for Contraception by Privately Insured Women During Implementation of the Federal Contraceptive Coverage Requirement*, 89 Contraception 97, 98 (2014).

[46] Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 Persp. on Sexual & Reprod. Health 226, 228 (2007).

[47] *Id.*; *see also* Kelly R. Culwell & Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995–2002: The Effect of Insurance Status*, 110 Obstetrics & Gynecology 1371, 1375-76 (2007).

half of respondents noted that they wanted to reduce or delay their childbearing because of the economy, and 64% agreed with the statement: "With the economy the way it is, I can't afford to have a baby right now."[48] Unfortunately, many of the surveyed women also reported that financial constraints had caused them to cut corners with regard to contraception. Indeed, 23% reported a more difficult time affording contraception than in prior years.[49] For example, 25% of women who were struggling financially and used oral contraceptives had resorted to using contraception inconsistently as a means of saving money.[50]

Twenty-eight states require private insurers that cover prescription drugs to provide coverage of the full range or almost the full range of FDA-approved contraceptive drugs and devices.[51] Experience from these states demonstrates that removing financial barriers to health care access is key to realizing increased access to effective contraception. Privately insured women living in states that required private insurers to cover prescription contraceptives were 64% more likely to use some contraceptive method during each month a sexual encounter was reported than women living in states with no such require-

---

[48] Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* 3 (2009).

[49] *Id.* at 6.

[50] *Id.* at 5.

[51] Guttmacher Inst., *State Policies in Brief: Insurance Coverage of Contraceptives* 2 (Jan. 1, 2014), *available at* http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.

ment, even after accounting for differences including education and income.[52]

Although these state policies reduced women's up-front costs, eliminating out-of-pocket costs entirely, as the new federal policy does, has even greater potential to increase effective contraceptive use. For example, when Kaiser Permanente Northern California eliminated patient cost-sharing requirements for IUDs, implants, and injectables, the use of these devices increased substantially, with IUD use more than doubling.[53] Another example comes from a study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice (i.e., any method other than sterilization) at no cost for two to three years, and were "read a brief script informing them of the effectiveness and safety of" IUDs and implants.[54] Three-quarters of those women chose long-acting methods (i.e., IUDs or implants), a level far higher than in the general population.[55]

Publicly funded family planning services provide more evidence that reducing or eliminating cost barriers to women's contraceptive choices matters.

---

[52] Brianna M. Magnusson et al., *Contraceptive Insurance Mandates and Consistent Contraceptive Use Among Privately Insured Women*, 50 Med. Care 562, 565 (2012).

[53] Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 Contraception 360, 363 (2007).

[54] Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 Obstetrics & Gynecology 1291, 1292 (2012).

[55] *See id.* at 1293.

Among women who obtain contraceptive services from publicly funded reproductive-health providers, 64% use hormone-based contraceptive methods, 11% use implants or IUDs, and 8% use sterilization.[56] In the absence of these publicly supported services, it is estimated that more than half of those women would substitute their current contraception with male condoms or other non-prescription methods, and 30% would use no contraception at all.[57] This lack of access would result in a fivefold increase in the rate of unintended pregnancies among this group of women.[58]

In sum, ensuring the availability of the full array of contraceptive methods—without regard to cost, so that a woman can choose and use the method that works best for her—is crucial to preventing unintended pregnancies. This is exactly what the contraceptive-coverage provision at issue in this case does.

B. Reducing Unintended Pregnancy Reduces the Need for Abortion and Promotes the Educational, Economic, and Social Advancement of Women.

The briefs submitted to this Court by the Solicitor General and various other amici curiae detail the enormous, varied benefits to women, their families, and society when women are afforded the means to avoid unintended pregnancies. By allowing women to plan the number and timing of pregnancies and

---

[56] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2010*, 19 (July 2013).

[57] *Id.*

[58] *Id.* at 19-20.

births, the contraceptive-coverage provision will advance women's health; this is a direct benefit that alone provides compelling reason for the coverage. Indeed, because of its numerous benefits to the health of women and children, the Centers for Disease Control and Prevention included the development of and improved access to methods of family planning among the ten great public health achievements of the 20th century.[59] Effective family planning especially benefits women with health conditions that heighten the risk of pregnancy and childbirth, and allows women with preexisting or underlying health conditions to plan the timing of pregnancy consistent with their health needs and medical care.[60] Allowing women to better space and time their pregnancies also enables them to have healthier babies.[61]

---

[59] Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Family Planning*, 48 Morbidity & Mortality Wkly. Rep. 1073 (1999).

[60] *See*, *e.g.*, Hal C. Lawrence, Testimony Before the Institute of Medicine Committee on Preventative Services for Women at 11 (Jan. 12, 2011), *available at* http://www.iom.edu/~/media/Files/Activity%2520Files/Women/PreventiveServicesWomen/Lawrence_ACOG.pdf ("An unintended pregnancy may have significant implications for a woman's health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease."); ACOG Br. at I.A (explaining that many chronic conditions, including "sickle-cell disease, cancer, epilepsy, lupus, rheumatoid arthritis, hypertension, asthma, pneumonia, and HIV," can be complicated by pregnancy).

[61] *See*, *e.g.*, Agustin Conde-Agudelo et al., *Birthspacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 JAMA 1809, 1821 (2006) (inter-pregnancy intervals shorter

In addition to these important and most obvious individual and public health benefits, enabling women to avoid unintended pregnancies through access to effective and appropriate contraception serves at least two additional vital ends. First, reducing the rate of unintended pregnancy is the most effective and most widely acceptable way to reduce the need for and incidence of abortion. Second, being able to determine whether and when to have a child promotes the educational, economic, and social advancement of women and their families.

1. The relationship between affordable, accessible, and effective contraception, on the one hand, and abortion rates, on the other, is undeniable. The vast majority of abortions are preceded by an unintended pregnancy, and therefore obviously could be prevented by effective contraceptive use. In fact, the two-thirds of women at risk of unintended pregnancy who consistently and correctly practice contraception account for only five percent of unintended pregnancies.[62]

---

than 18 months are significantly associated with increased risk of several adverse perinatal outcomes, including preterm birth and low birth weight); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18, 23-25 (2008); Amanda Wendt et al., *Impact of Increasing Inter-Pregnancy Interval on Maternal and Infant Health*, 26 (Supp. 1) Paediatric & Perinatal Epidemiology 239, 248 (2012) (an inter-pregnancy interval of less than 12 months increases the risk of, among other things, stillbirth and early neonatal death).

[62] Gold et al., *supra* note 5, at 6.

Dramatic evidence of the impact of effective contraception on the need for abortion can be found in the recent study of more than 9,000 St. Louis-region women who were offered the reversible contraceptive method of their choice at no cost.[63] During the study period, the number of abortions performed at St. Louis Reproductive Health Services declined by 20%, and study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[64] The study concluded that similar nationwide changes in contraception access could prevent more than half of abortions performed annually.[65]

International evidence also shows that the increased use of modern contraceptives is associated with a decline in abortion rates. An analysis of trends in central Asia and eastern Europe, for example, found that as use of modern contraceptive methods increased rapidly in those regions during the 1990s, abortion rates declined significantly, even as fertility rates and the number of children desired also declined.[66] Meanwhile, the United States lags behind: while unintended pregnancy rates declined

---

[63] Peipert et al., supra note 54, at 1295.

[64] *See id.* at 1294-95.

[65] *Id.* at 1296.

[66] *See generally* Charles F. Westoff, *Recent Trends in Abortion and Contraception in 12 Countries*, DHS Analytical Studies No. 8 (Feb. 2005).

in every other region of the world between 1995 and 2008,[67] the rate in the United States actually increased.[68] U.S. rates of unintended pregnancy,[69] abortion,[70] and teen pregnancy[71] are far higher than those in western European countries—at least in part due to the higher cost barriers to effective contraception that American women face.

---

[67] Susheela Singh et al., *Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes*, 41 Stud. Fam. Plan. 241, 245 (2010).

[68] Guttmacher Inst., *Unintended Pregnancy*, *supra* note 10.

[69] The U.S. unintended pregnancy rate in 2008 was 54 per 1,000 women 15–44. *See* Finer & Zolna, *supra* note 9, at S43. By comparison, the rate in Western Europe in 2008 was 32. *See* Singh et al., *supra* note 67.

[70] The U.S. abortion rate in 2008 was 20 per 1,000. *See* Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 43 (2011). By comparison, the rate in Western Europe in 2008 was 12. *See* Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 Lancet 625, 628 (2012).

[71] The most recent available comparison is for 1995, when the U.S. teen pregnancy rate was 84 per 1,000 females 15-19; by comparison, "most western European countries ha[d] very low or low pregnancy rates (under 40 per 1,000)"; the rate in the Netherlands and Spain was 12. Susheela Singh & Jacqueline E. Darroch, *Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries*, 32 Fam. Plan. Persp. 14, 14, 16 (2000). The most recent available U.S. teen pregnancy rate is for 2008, when it was 68. Kathryn Kost & Stanley Henshaw, Guttmacher Inst., *U.S. Teenage Pregnancies, Births and Abortions, 2008: National Trends by Age, Race and Ethnicity* 2 (2012), *available at* http://www.guttmacher.org/pubs/USTPtrends08.pdf.

2. Effective family planning also promotes women's continued educational and professional advancement, contributing to the enhanced economic stability of women and their families. The advent of widespread access to effective reversible contraception (starting with oral contraceptives) in the 1960s gave women the ability to confidently plan for and delay pregnancy, and thereby allowed them to invest in higher education at a significantly increasing rate. In fact, early access to oral contraceptives is estimated to account for one-third of the increase in women's college enrollment during the 1970s.[72] Similarly, another study estimated that the initial increase in access to the pill accounted for more than 30% of the historic increase in the proportion of women in skilled careers from 1970 to 1990.[73]

A narrowing of the gender-based compensation gap soon followed. Indeed, one-third of the total wage gains for women born between the mid-1940s and mid-1950s is attributed to women's ability to reliably delay pregnancy through oral contraception.[74]

---

[72] Heinrich Hock, *The Pill and the College Attainment of American Women and Men* 19 (Oct. 9, 2007) (unpublished study, Florida State University); *see also* Elizabeth Oltmans Ananat & Daniel M. Hungerman, *The Power of the Pill for the Next Generation: Oral Contraception's Effects*, 94 Rev. Econ. & Stat. 37, 50 (2012) (observing that early access to the pill increased the likelihood that a child had a college-educated, married mother).

[73] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions*, 110 J. Pol. Econ. 730, 749 (2002).

[74] Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages* 26 (Nat'l Bureau of Econ. Research, Working Paper No. 17922, Mar. 2012).

Nor was oral contraceptives' impact limited to the years immediately following their widespread availability. Thirty-one percent of the narrowing of the gender-based hourly wage gap during the 1990s is attributed to oral contraceptives.[75] And it is estimated that as of 2000, more than 250,000 women over the age of 30 obtained a bachelor's degree because they could obtain contraception as late adolescents.[76]

The ability to prevent or delay pregnancy until after attaining educational, economic, and career goals remains critically important to the advancement of today's American women. Among the reasons for using contraceptives that most women characterize as "very important" are (i) "financial constraints," (ii) the sentiment that "having a baby would make it hard to keep my job or get a better job" or "stay in school," and (iii) a desire to provide the "best future" possible for the children that they already have.[77]

Delaying the birth of a first child has been widely found to contribute to a family's economic stability. The pill and subsequent methods of contraception have been shown to enhance women's earning potential by enabling delayed childbearing, thereby allowing young women to invest in education and obtain crucial early work experience in order ultimately to

---

[75] *Id.* at 27.

[76] Hock, *supra* note 72, at 19.

[77] *See* Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics*, 87 Contraception 465, 468 (2013).

achieve greater income stability than those who started their families at a younger age.[78] Indeed, the evidence overwhelmingly demonstrates that women who wait to have children until their late 20s or 30s generally fare better economically than women who have children in their earlier years, at least in part due to their increased likelihood of having more advanced schooling and early employment experience.[79]

In sum, affording women the full range of contraceptive options facilitates the use of more effective and reliable methods of contraception, advances the health of women and families, reduces the need for abortion, and promotes women's educational and economic advancement. For these reasons and consistent with the best scientific evidence, federal law now entitles privately insured women, with rare ex-

---

[78] Amalia R. Miller, *The Effects of Motherhood Timing on Career Path*, 24 J. Population Econ. 1071, 1097 (2011); *see also* McKinley L. Blackburn et al., *Fertility Timing, Wages, and Human Capital*, 6 J. Population Econ. 1, 23 (1993) ("Fertility timing is strongly associated with differences in wages, as well as differences in education, experience, and tenure."); David S. Loughran & Julie M. Zissimopoulos, *Why Wait?: The Effect of Marriage and Childbearing on the Wages of Men and Women*, 44 J. Hum. Res. 326, 346 (2009) (explaining that the first birth of a child lowers female wages two to three percent); Hiromi Taniguchi, *The Timing of Childbearing and Women's Wages*, 61 J. Marriage & Fam. 1008, 1014 (1999).

[79] *See* Elizabeth Ty Wilde et al., *The Mommy Track Divides: The Impact of Childbearing on Wages of Women of Differing Skill Levels* 26 (Nat'l Bureau of Econ. Research, Working Paper No. 16582, Dec. 2010); *see also* Catalina Amuedo-Dorantes & Jean Kimmel, *The Motherhood Wage Gap for Women in the United States: The Importance of College and Fertility Delay*, 3 Rev. Econ. Household 17, 40 (2005).

ception, to preventive health care that includes the full range of FDA-approved contraceptive methods at no out-of-pocket cost to the woman.

II. THE RELIGIOUS EXEMPTION SOUGHT BY PLAINTIFFS WOULD SUBSTANTIALLY BURDEN WOMEN'S ABILITY TO MAKE CHILDBEARING DECISIONS IN ACCORD WITH THEIR OWN RELIGIOUS AND MORAL BELIEFS, HEALTH NEEDS, AND FAMILY RESPONSIBILITIES.

The scope of permissive religious accommodations generally depends not only upon the nature of the burden on the religious claimant and the existence of a compelling governmental interest, but also upon whether granting an exemption would impose burdens on third parties. As this Court stated in *Cutter v. Wilkinson*, with respect to a federal religious accommodation statute materially identical to and patterned upon RFRA, "courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries," and therefore a religious accommodation under the law "must be measured so that it does not override other significant interests."[80] This is especially so where, as here, accommodating the religious preferences of a corporate employer's owners would impose on specif-

---

[80] 544 U.S. 709, 720, 722 (2005) (citing *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703 (1985)). As the *Cutter* Court's citations to *Caldor* demonstrate, if the statute were, instead, construed to impose significant burdens on third parties, it would at a minimum raise serious Establishment Clause questions. Such questions are avoided if RFRA is properly construed to be sensitive to the government's compelling interest in not imposing such third-party burdens.

ic third parties not only direct financial and health constraints, but in some instances difficult religious and moral burdens as well.

Allowing for-profit corporations a religious exemption from the virtually universal federal guarantee of contraceptive coverage would preclude many thousands—perhaps millions—of American women from having the access to preventive health care intended by federal law. Highly effective methods of contraception are frequently the subject of employers' religious objections, including by plaintiffs Hobby Lobby and Conestoga Wood.[81] To give those objections legal force would allow employers to deny their employees and their employees' covered family members unimpeded access to a full range of contraceptive methods. Every time a woman and her health care provider contemplate a method of contraception, they would have to consult the specific choices made by the employer of the primary insured party—typically, the woman herself, her spouse, or her parent—to learn which methods were available for reimbursement under the relevant insurance plan.[82] Depending on the employer's beliefs, a wom-

---

[81] Hobby Lobby objects to at least four specific methods: Plan B, ella, and two types of IUDs. *See Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1124-25 (10th Cir. 2013). Conestoga Wood objects to any drugs or devices that "prevent the implantation of a human embryo into its mother's uterus after its fertilization," which it suggests include, at a minimum, "Plan B, Ella, and certain intrauterine devices (IUDs)." Conestoga Wood Br. 4.

[82] *See generally* U.S. Br. 57-58. In a nation like ours that relies heavily on a system of private health insurance, the case for universal insurance coverage that reflects the best prevention science is especially strong.

an might be denied coverage for the method that best serves her health and family needs and is most consistent with her own beliefs.[83]

Shifting the burden of religious accommodation to women and their families would be particularly problematic because it could create conflicts with women's religious and moral beliefs. Many women do not agree that the contraceptives at issue in these cases are objectionable. Some women seeking to use these highly reliable methods of contraception have religious objections to abortion. For all women and families that face these choices, whatever their views about abortion, denying access to affordable, effective contraception can work a profound interference with their ability to exercise individual moral autonomy.

In *United States v. Lee*, this Court rejected an employer's attempt to seek a Free Exercise exemption from the Social Security statute because such an exemption would "operate[] to impose the employer's religious faith on the employees."[84] There could hardly be a more striking example of a religious accommodation that "override[s] other significant interests"[85] than a case in which the grant to one party

---

[83] Depriving women of the protections afforded them under the law would create a disconnect between the terms of coverage and scientific evidence of effectiveness, even though health insurance financing seeks to eliminate financial barriers as a consideration in access to health care of proven effectiveness. *See* Michael E. Chernew et al., *Value-Based Insurance Design*, 26 Health Aff. W195 (2007).

[84] 455 U.S. 252, 261 (1982).

[85] *Cutter*, 544 U.S. at 722.

of a religious exemption from a neutral law of general applicability imposes both moral and health burdens upon others.

This exemption is particularly inappropriate given that the burden on the corporate owners is only an indirect one. They are not required to provide contraceptive coverage because they are not required to offer employee health insurance at all. They would, however, prefer to offer their employees compensation in the form of insurance rather than compensation in some other form, such as wages (which would also foreseeably be used by numerous employees to purchase "objectionable" contraception).[86] Accommodation to what is at best an indirect burden on religion does not justify the burden imposed upon women's own moral and medical choices.[87]

---

[86] U.S. Br. 8, 26-31; Marty Lederman, Hobby Lobby *Part III—There Is No "Employer Mandate,"* Balkinization (Dec. 16, 2013), http://balkin.blogspot.com/2013/12/hobby-lobby-part-iiitheres-no-employer.html, *cited in Hotze v. Sebelius*, 2014 WL 109407, at *1 n.5 (S.D. Tex. Jan. 10, 2014). As explained by Lederman, "a central component of plaintiffs' own RFRA arguments is that a 'less restrictive' means for the government to further its interests *without substantially burdening plaintiffs' religious exercise* would be for the government to use its own revenues to subsidize contraceptive use by Hobby Lobby and Conestoga Wood employees. Well, that is exactly what would occur if those employers were to choose to make a [tax] payment rather than offering their employees access to an employer plan" as expressly allowed under the Affordable Care Act. *Id.*

[87] *See, e.g.*, *Braunfeld v. Brown*, 366 U.S. 599, 602-07 (1961) (plurality opinion) (legislation that imposed an indirect burden on the exercise of religion—such as making the practice of religious beliefs more expensive—did not violate Free Exercise Clause). Under a proposed alternative here, in which the gov-

Allowing such restrictions on women's covered contraceptive methods would also substantially and directly burden women's health. Among the host of factors that inform a woman's decision about which contraceptive method is right for her, several involve protecting her physical health, such as health and medical conditions that counsel for or against particular methods, potential drug interactions, or the woman's stage of life.[88] In addition, health care providers often prescribe forms of contraception to treat medical conditions unrelated to pregnancy avoidance

---

ernment would itself provide cost-free contraception to women who do not receive coverage under their employers' plans as a result of a RFRA accommodation, employers who decide to exclude contraceptive coverage could reap a financial windfall given the relationship between the use of effective contraceptives and subsequent health care costs.

If an employer covers contraception, this cost is balanced out by savings from averted pregnancy-related care. *See* 78 Fed. Reg. 39,870, 39,877 (July 2, 2013) (observing that "[s]everal studies have estimated that the costs of providing contraceptive coverage are balanced by cost savings from lower pregnancy-related costs and from improvements in women's health"); *see also, e.g.,* Nat'l Business Group on Health, *Investing in Maternal and Child Health: An Employer's Toolkit* (Kathryn Phillips Campbell ed. 2007), *available at* http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/mch_toolkit.pdf. But under the proposed plan, the government (that is, the taxpayers) would incur all of the direct costs of contraceptive coverage while the employer-sponsored health plan would reap all of the savings from the averted pregnancy-related care. This might actually be an incentive to employers to opt out of providing contraceptive coverage for their employees.

[88] *See* ACOG Br. Section I.C.

or for a combination of contraceptive and non-contraceptive indications.[89] Employers could refuse to cover any or all of these drugs if the Court recognizes the religious exemption that plaintiffs seek.

These particular plaintiffs argue that they are objecting to merely a few contraceptive options and that coverage of the remaining options in their plans would mean that their employees would not be materially burdened. But plaintiffs fail to acknowledge that contraceptive methods are not interchangeable—due not only to differences in effectiveness, as described in part I above, but also to differences relevant to each women's health needs. Indeed, the U.S. medical eligibility criteria for contraceptive use written by the Centers for Disease Control and Prevention require more than 80 pages to analyze the advantages and disadvantages of specific methods for women in specific circumstances.[90] For example, for those women unable to tolerate hormonal contraception, the copper IUD is the only highly effective reversible method available. Other employers, of course—including many of those with RFRA claims pending—object to covering any method of contraception.[91] The logic of plaintiffs' RFRA claims thus

---

[89] *Id.*; *see also* Rachel K. Jones, Guttmacher Inst., *Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills* 3 (2011).

[90] *See generally* Ctrs. for Disease Control & Prevention, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010,* 59 Morbidity & Mortality Wkly. Rep. 1 (2010), *available at*, http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf.

[91] *E.g.*, *Korte v. Sebelius*, 735 F.3d 654, 663-64 (7th Cir. 2013) (objecting to all forms of contraception); *Autocam Corp. v. Sebelius*, 730 F.3d 618, 621 (6th Cir. 2013) (same).

portends a much more substantial intrusion on the benefits to women nationwide.

Moreover, many employers—including the plaintiffs here—object not just to contraceptive methods but also to counseling and education about those methods.[92] If that argument were to prevail, a woman attempting to seek advice from her health care provider regarding contraception would have to choose between forfeiting insurance coverage for her visit and receiving only information about the methods of contraception (if any) approved by her employer. That limitation would fundamentally undermine the health care provider-patient relationship, deprive women of the ability to provide fully informed consent, and prevent a woman from selecting what she believes to be the best method for her.[93]

---

[92] Hobby Lobby Compl. ¶ 8 (objecting to rule that "forc[es]" the employer "to provide health insurance coverage for abortion-inducing drugs and devices, as well as related education and counseling."); Conestoga Wood Compl. ¶ 4 (objecting to the provision that "force[s] Plaintiffs to pay for and otherwise facilitate the insurance coverage and use of contraception with an abortifacient effect and related education and counseling."); *id.* ¶ 30.

Many other plaintiffs object to counseling and education as well. *See also, e.g.*, *Korte*, 735 F.3d at 663 n.5 (company's "ethical guidelines" provide that it "cannot arrange for, pay for, provide, facilitate, or otherwise support employee health plan coverage for contraceptives . . . or related education and counseling."); *Autocam*, 730 F.3d at 621 (similar).

[93] Full and accurate information is critical to the effective selection and use of contraception. Ctrs. for Disease Control & Prevention, *supra* note 90.

The exemption plaintiffs seek would cause direct financial harm to women, skew medical decisions, lead to higher rates of unintended pregnancy, and interfere with women's moral and religious decisions about contraception and abortion. The Religious Freedom Restoration Act should not be interpreted to require religious exemptions that would impose these profound burdens on those who do not share the claimants' religious beliefs.

CONCLUSION

For the foregoing reasons, the Court should hold that the Religious Freedom Restoration Act does not require the exemptions plaintiffs seek.

Respectfully submitted,

DAWN JOHNSEN
INDIANA UNIVERSITY
MAURER SCHOOL OF LAW
211 South Indiana Ave.
Bloomington, IN 47405
(812) 855-3942

ANTON METLITSKY
LEAH GODESKY
LUCY E. HILL*
O'MELVENY & MYERS LLP
7 Times Square
New York, NY 10036
(212) 326-2000

WALTER DELLINGER
(*Counsel of Record*)
wdellinger@omm.com
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, DC 20006
(202) 383-5300

ANNA-ROSE MATHIESON
O'MELVENY & MYERS LLP
Two Embarcadero Center
28th Floor
San Francisco, CA 94111
(415) 984-8700

*Not yet admitted; supervised by principals of the firm.

January 2014