Nos. 19-454, 19-431

IN THE

Supreme Court of the United States

DONALD TRUMP, PRESIDENT OF THE UNITED STATES, ET AL.,

Petitioners,

v.

COMMONWEALTH OF PENNSYLVANIA, ET AL.,

Respondents.

THE LITTLE SISTERS OF THE POOR SAINTS PETER AND PAUL HOME,

Petitioner,

v.

COMMONWEALTH OF PENNSYLVANIA, ET AL.,

Respondents.

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

BRIEF OF HOWARD UNIVERSITY SCHOOL OF LAW, CIVIL AND HUMAN RIGHTS CLINIC IN SUPPORT OF THE RESPONDENTS

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April 8, 2020

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INTEREST OF AMICUS

The Civil and Human Rights Clinic at Howard University School of Law advocates on behalf of clients fighting for their rights guaranteed by the United States Constitution.[1] The Clinic provides pro bono legal services on a range of civil rights matters, including but not limited to discrimination against African-American women. When such issues arise, the Clinic regularly files amicus briefs with various federal courts,[2] including the United States Supreme Court, as well as directly represents women in trial and appellate courts in the District of Columbia. Recently, the Clinic successfully represented an African-American woman appealing the dismissal of her case alleging gender discrimination, before the United States Court of Appeals for the D.C. Circuit.[3] As discussed below, the proposed exemption threatens to limit the availability of vital health care resources

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[1] Pursuant to Rule 37.3, all parties have consented to the filing of this brief. Pursuant to Rule 37.6, no party or party's counsel authored this brief in whole or in part, or contributed money that was intended to fund its preparation or submission; and no person other than the amicus curiae, its members, or its counsel, contributed money that was intended to fund the preparation or submission of this brief.

[2] *See e.g. Overbey v. Mayor of Baltimore*, 930 F.3d 215 (4th Cir. 2019) (submitting amicus brief in support of the First Amendment rights of an African-American women who was the victim of excessive force by a police officer); *Savage v. Maryland*, 896 F.3d 260 (4th Cir. 2018) (submitting amicus brief in support of African-American police officers who alleged a racially discriminatory work environment).

[3] *See Moore v. District of Columbia*, No. 10–7034, 445 Fed.Appx. 365, 367 (D.C. Cir. Oct. 27, 2011) ("The Court acknowledges and thanks the Howard University School of Law Civil Rights Clinic for its pro bono representation of Moore on this appeal.").

for a large number of African-American women, and thus, presents a grave threat to the communities the Clinic serves.

INTRODUCTION AND SUMMARY OF ARGUMENT

As this Court has acknowledged, both recently and in the past, the United States has a long and unfortunate history of racial discrimination against African-Americans. As a result, many African-American women still struggle to access comprehensive health care, including contraception. The exemption proposed by the federal government builds upon the various barriers that already face African-American women seeking to avail themselves of comprehensive health care and, thus, threatens to exacerbate existing disparities.

Just four years ago, this Court, in *Texas Department of Housing and Urban Development v. Inclusive Communities Project*,[4] acknowledged that the vestiges of racial segregation in housing continue to effect African Americans today.[5] The same is true in various other contexts, as well, including vestiges limiting access to comprehensive and meaningful health care. In some cases, these vestiges are the product of residential segregation; in others, they are the product of analogous explicit discriminatory practices that have had the effect of denying African Americans health care.

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[4] *Tex. Dep't of Housing and Community Affairs v. Inclusive Communities Project, Inc.*, 135 S.Ct. 2507, __ U.S. __ (2005).
[5] *Id*. at 2515.

For example, many African Americans continue to live in neighborhoods that are racially segregated.[6] Often, these neighborhoods are low-opportunity neighborhoods, in that they provide insufficient access to various social services, including schools, employment, and health care centers. The health services that remain often fail to provide the full-range of health services needed to serve their patients.

Even if a woman does not reside in segregated area, she may still have to overcome various other barriers to comprehensive care, including the lack of cultural competency among doctors and nurses, insufficient attention from individual health services providers and insufficient language interpreters. The effect of these limitations is exacerbated by the fact that they build upon a long history of denial, and in some cases outright mistreatment of African Americans seeking access to health care, as well as the failure to afford them bodily autonomy.

Unsurprisingly, the results of this historic and continued denial can be disastrous for African-American women and their families. Unintended pregnancies not only limit the earning potential of women, but combined with the lack of adequate medical care during pregnancy, place the lives of African-American women in immediate jeopardy.

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[6] William Frey, *Black-White Segregation Edges Downward Since 2000, Census Shows*, Brookings Institution, Dec. 17, 2018, https://www.brookings.edu/blog/the-avenue/2018/12/17/black-white-segregation-edges-downward-since-2000-census-shows/.

The Affordable Care Act (ACA) recognized this harsh reality. Accordingly, in line with Congress' intentions, the ACA's text prohibits the type of broad exemption the Trump Administration argues for here. Were the Court to find that such an exemption were authorized, whether under the ACA's text, or pursuant to the Religious Freedom Restoration Act, it would not only subvert Congressional intention, but, once again, deny African-Americans equal access to health care.

ARGUMENT

I. THE PROPOSED EXEMPTION IS INCONSISTENT WITH THE TEXT OF THE AFFORDABLE CARE ACT, AS WELL AS CONGRESSIONAL INTENT.

The United States Court of Appeals for the Third Circuit properly held that the Women's Health Amendment to the Affordable Care Act (ACA) does not grant the federal government the authority to create broad exemptions excusing organizations from providing insurance coverage for preventive health care services, including contraceptive care.[7] Nothing in the text of the statute grants agencies the authority to "wholly exempt actors of its choosing from providing the guideline services."[8] The enabling plainly states:

> A group health plan and a health insurance issuer offering group or individual health coverage shall, at a minimum provide coverage for and shall

[7] *Pennsylvania v. Trump*, 930 F.3d 543, 555 (3d Cir. 2019).
[8] *Id.* at 570.

> not impose any cost sharing requirements for— …
>
> (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for purposes of this paragraph.[9]

The statute unambiguously mandates that group health plans and health insurance issuers provide "the preventive care services set forth in the HRSA-supported comprehensive guidelines."[10]

The Administration, in response, argues that the ACA authorized it to promulgate regulations exempting large numbers of organizations from the statute's requirements because the statute grants HRSA the authority to determine which types of women's preventive care services are covered.[11] Specifically, it alleges that since Congress authorized the Health Resources and Services Administration to adopt rules implementing the preventive-services provision, that rulemaking authority allows the agency to exempt actors of its choosing from providing otherwise mandatory services.[12]

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[9] 42 U.S.C. §300gg-13(a)(4) (2018).
[10] *Id.*; *see also Trump*, 930 F.3d at 570.
[11] Br. of Petitioners, Donald Trump, President of the United States, et al., at 15.
[12] *Id.*

The argument misreads the plain words of the statute. Under the statute, the authority to issue "comprehensive guidelines" allows HRSA to determine the type of services to be provided, but does not extend that discretion to "undermin[ing] Congress's directive concerning who must provide coverage for these services."[13] The statute's use of the word "shall" imposes a requirement on group health plans and health insurance issuers to provide preventive care services and to do so without cost sharing.[14]

This interpretation is supported by the the preceding paragraph in the statute, regarding preventive care guidelines for children.[15] The earlier provision, which pre-dates the ACA, also requires the provision of "comprehensive" services, but has not been interpreted to allow for the exemption of certain organizations.[16] Congress was aware of this provision, and its interpretation, as it chose to model the relevant provision of the ACA, at issue here, upon the former.[17]

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[13] *Trump*, 930 F.3d at 570.

[14] *Id*.

[15] *See* 42 U.S.C. §300gg-13(a)(3) ("with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the [HRSA].").

[16] *See* U.S. Department of Health and Human Services, Preventive Care Benefits for Children, https://www.healthcare.gov/preventive-care-children.

[17] *See F.A.A. v. Cooper*, 566 U.S. 284, 292 (2012) ("[W]hen Congress employs a term of art, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken." (internal quotation marks and citation omitted)).

Finally, Congress considered and rejected an amendment similar to the promulgated exemption, thus, making clear its intention to not provide for the broad exemption at issue here.[18]

Accordingly, for good reason, circuit courts have agreed that the federal government acted outside of its statutory authority when it promulgated the challenged exemption.[19]

II. THE FAILURE TO ALLOW FOR THE PROPOSED EXEMPTION IS JUSTIFIED GIVEN THE IMPORTANCE OF CONTRACEPTIVES TO WOMEN, INCLUDING AFRICAN-AMERICAN WOMEN.

Congress' failure to allow for the broad exemption proposed by the federal government is justified in light of the impact it would have on women, in particular African-American women across the county. The overwhelming majority of women use or have used contraception. Most women, however, would not be able to afford contraception unless it was provided for by their insurance. The difficulty African-American women and other women of color have accessing contraception is exacerbated by the fact that a series of other barriers – social and economic – limit access to health care, including contraception. Given these barriers, as well as the importance of insurance in facilitating access to contraception, were employers

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[18] 158 Cong. Rec. S1162, 1173-74 (2012).

[19] *See also California v. Dep't of Health & Human Servs.*, 941 F.3d 410 (9th Cir. 2019).

allowed to broadly opt-out of providing contraception coverage, it would have a devastating impact.

A. Contraceptive Use is Nearly Universal.

The Trump Administration has incorrectly stated that only a small number of women will be affected by the proposed exemption to the ACA's contraceptive coverage mandate.[20] In reality, the proposed exemption will dramatically increase the number of employers seeking exemptions, which in turn will increase the number of women without access to basic health care.[21] Given the widespread use of contraceptive care, the consequences could be disastrous.

Most women in the United States currently use contraceptives. Nine out of ten women in the United States use contraceptives at some point in their lives.[22] Specifically, more than 99% of women between the ages of 15 and 44 who have had sexual intercourse

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[20] Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47838, 47844 (to be codified at 26 CFR 54, 29 CFR 2590, 45 CFR 147) (Oct. 13, 2017), https://www.federalregister.gov/documents/2017/10/13/2017-21852/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable.

[21] Shilpa Phadke, et al., *Rhetoric vs. Reality: Why Access to Contraception Matters to Women*, Center for American Progress, Nov. 15, 2017, https://www.americanprogress.org/issues/women/reports/2017/11/15/442808/rhetoric-vs-reality-access-contraception-matters-women/.

[22] *Id*.

have used one form of contraceptive.[23] Of women who are of reproductive age, approximately 60% are currently using contraceptives.[24]

This 60% includes women of all religions, socio-economic backgrounds, and marital statuses. Among American women at risk of unintended pregnancy, 92% that have an income of at least 300% of the federal poverty level and 89% that have an income between 0-149% of the federal poverty level currently use at least one form of contraceptive.[25] Likewise, marriage not only does not decrease the likelihood that women will use contraceptives, but increases it, as 77% of married women use contraceptives.[26]

Just as contraceptive use is widespread among women of all incomes and marital statuses, contraceptive use is also widespread among women of all religious denominations.[27] Very few sexually active women who identify with a religion forgo the use of contraceptives. In fact, only 2% of Catholic women at risk of an unintended pregnancy rely on natural family

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[23] GUTTMACHER INSTITUTE, CONTRACEPTIVE USE IN THE UNITED STATES: FACT SHEET (2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states# [hereinafter GUTTMACHER INSTITUTE], citing Kimberly Daniels, et al., *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, NATIONAL HEALTH STATISTICS REPORTS, Feb. 2013, at 1.

[24] GUTTMACHER INSTITUTE, *supra* note 23.

[25] *Id*., citing 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, Oct. 2012, at 16.

[26] *Id*.

[27] GUTTMACHER INSTITUTE, *supra* note 23.

planning.[28] The number of religious women who use contraceptives far outnumber those who do not. Approximately 99% of Catholic and Protestant women who are sexually active have used a contraceptive method.[29] Among these women, approximately 68% of Catholics, 73% of Protestants, and 74% of Evangelicals use a highly effective contraceptive method, including IUDs, the pill, or other hormonal methods.[30] As such, the percentage of religious women who currently use contraceptives is almost identical to the percentage of all sexually active women in the United States who use contraceptives.

Likewise, contraceptive use is widespread among women of every race and ethnicity. 83% of African-American women, 91% of white and Hispanic women and 90% of Asian women use contraceptives.[31] While slightly fewer African-American women use contraceptives than white or Hispanic women, this is due to the barriers they face in accessing contraception.[32] The proposed exemption, by limiting access to these services, will reduce the number of women able to obtain the contraceptives they need.

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[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *See* Emily M. Johnson & Stacey McMorrow, *The Relationship Between Insurance Coverage and Use of Prescription Contraception by Race and Ethnicity: Lessons From the Affordable Care Act*, 30-2 WOMEN'S HEALTH ISSUES 73, 74 (2020) ("Several studies have found that differences in insurance coverage by race and ethnicity are important drivers of disparities in access to care, contributing to poor access for both Black and Hispanic adults.").

B. Many Women, Including African-American Women, Would Not Be Able to Afford Contraceptives Without Assistance from Insurance.

The proposed exemption to the Affordable Care Act (ACA) will mainly serve to disadvantage women, including African-American women, who would no longer be able to afford the contraceptives they rely on. The three primary goals of the ACA were to make affordable public and private healthcare available to more people, to expand Medicaid to cover more adults with low incomes, and to support innovative methods of medical care delivery that lowered the cost of health care generally.[33]

Within these goals, with regards to women specifically, the ACA intended to improve women's access to reliable and comprehensive healthcare coverage, including contraceptive care. The ACA's contraceptive coverage mandate requires private health insurance providers to cover a designated list of FDA-approved contraceptive methods and services without out-of-pocket costs to the consumer.[34] The ACA also expanded women's access to preventive screening, increased maternity coverage, and improved and increased funding to community health centers, which are typically located in disenfranchised

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[33] U.S. Department of Health and Human Services, Affordable Care Act (ACA), https://www.healthcare.gov/glossary/affordable-care-act/.

[34] GUTTMACHER INSTITUTE, *supra* note 23, citing U.S. Department of Health and Human Services, Health Resources and Services Administration, Women's Preventive Services Guidelines (2016), https://www.hrsa.gov/womens-guidelines-2016/index.html.

communities and serve large numbers of African Americans.[35]

These actions were taken in large part because the ACA's drafters identified a gap in the availability of health care services between white and African-American women. By acknowledging and addressing this gap, the ACA not only sought to improve women's access to quality and affordable healthcare, but also to reduce inequalities within our nation's healthcare system.[36] The expectation was that reducing racial and ethnic disparities in insurance coverage would also break down barriers to access contraceptives and reduce racial and ethnic differences in the use of contraceptives.[37]

Since the passage of the ACA's contraceptive coverage mandate, more than 62 million woman have received access to contraception, which saved women $1.4 billion in healthcare costs in 2013 alone.[38] These 62 million women rely on private insurance and the ACA to have access to contraceptive methods because the current cost of contraceptives is so great that the average American woman cannot afford contraceptives out-of-pocket.[39]

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[35] Cynthia Prather, et al., *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2 HEALTH EQUITY 249, 256 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6167003/.
[36] Johnson & McMorrow, *supra* note 32, at 80.
[37] *Id*.
[38] Phadke, at al., *supra* note 21.
[39] GUTTMACHER INSTITUTE, *supra* note 23.

Due to the high cost of contraceptives, an exemption, as broad as that proposed by the Administration, would force many women, including many African-American women, to go without contraceptives completely. While the most effective and long acting contraceptive methods can cost hundreds of dollars out-of-pocket, even relatively inexpensive methods like condoms can cost a substantial amount over the course of a year and, even more so, over the thirty years a woman of reproductive age may be avoiding pregnancy.[40] Before the ACA's contraceptive coverage mandate was adopted, it is estimated that contraceptives cost between 30 and 44% of the average woman's total out-of-pocket health care expenses.[41]

Accordingly, women, without health insurance, experiencing economic hardship are less likely to obtain contraception.[42] Of American women between the ages of 18 and 44, one out of three said that they could only afford to spend $10 per month for contraceptives if they had to pay out-of-pocket today.[43]

As a result, many women who work for employers that take an exemption will either be financially burdened in a manner that no man will be or forced to forgo or discontinue the use of contraceptives.

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[40] *Id*.
[41] Laurie Sobel, et al., *The Future of Contraceptive Coverage*, Kaiser Family Foundation, Jan. 9, 2017, https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/.
[42] Phadke, et al., *supra* note 21.
[43] *Id*.

C. Other Barriers Limit Contraceptive Access for Women, in Particular, African-American Women.

While insurance coverage is one major factor limiting access to contraception, unfortunately for vulnerable populations, such as women of color, access is also affected by additional social and systemic factors beyond a patient's control, namely a long, national history of displacement and discrimination. While some of those historic barriers have fallen, economic and environmental obstacles continue to limit access to contraceptives for many women. The Affordable Care Act, in particular the contraceptive mandate, was a vital step in abating this disparity in treatment. The broad exemptions proposed by the federal government threaten to exacerbate, rather than reduce these problems.

1. Historic and Social Barriers Limit Access to Contraception for African-American Women.

Many of the health and wellness issues African-American women face in the United States stem from the generational perpetuation of racial bias. These historic and systemic issues limit African-American women's access to contraception by impacting their interactions with medical professionals and the quality of medical treatment provided to them.[44]

African-American women, historically, have not only been denied access to health care, but repeatedly,

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[44] Prather, et al., *supra* note 35, at 250.

have been denied the right to control their bodily decisions. Beginning with their enslavement, African-American women were subjected to rape/sexual assault, forced childbearing (for profit), and experimental reproductive surgeries.[45] During the Jim Crow era, many states only outlawed rape against white women, leaving black women vulnerable without legal protection for their bodily autonomy.[46] Furthermore, 30 states supported formal eugenics programs controlling the black population.[47] In some states, African-American women were subject to compulsory sterilization until the 1970's.[48] Many were threatened with denial of medical care or termination of welfare if they refused.[49]

This history of trauma, combined with prior negative experiences with the health care system, and a lack of cultural competency among providers continue to limit African-American women's access to reproductive care.[50]

For example, the Tuskegee Syphilis experiment, a medical program in which vital medical treatment for sexually transmitted infections (STI) was intentionally withheld from black men in Tuskegee,

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[45] *Id.* at 251-52.
[46] *Id.* at 252.
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] Usha Ranji, et al., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities*, Kaiser Family Foundation, Nov. 4, 2019, https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

AL, who were told they were being treated, generated severe distrust among African-American women as many wives also acquired the infections and some of their children suffered complications, as a result.[51] In nearby Selma, AL, mistrust in medicine and a lack of female clinicians of color, both barriers resulting from past racial discrimination, remain major issues for women of color in the area attempting to access healthcare. [52]

A history of discrimination in health care, as well as its lingering effects, affect other women of color, as well. For example, women of the Crow Tribe, a Native American tribe in Montana, were subject to forced sterilization through much of the 1960s and 70s.[53] These past negative experiences continue to discourage women and teens from exploring family planning services.[54]

Together, these examples demonstrate how centuries of abuse, exploitation, and mistreatment have created a lack of trust among portions of the population that continue to limit access to treatment and care.

While these historic barriers discourage women of color from seeking contraceptive care, others limit their access once they attempt to access it. For example, communication issues can strain the doctor-patient relationship, thus interfering with access to

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[51] Prather, et al., *supra* note 35, at 252.
[52] Ranji, et al., *supra* note 50.
[53] *Id.*
[54] *Id.*

contraception.[55] Black non-Hispanic, Asian, and Hispanic women are all more likely than white women to report that their medical provider did not listen, respect what they had to say, or spend enough time with them.[56] Many women reported feeling pressured and deluded with outdated research regarding their choice of contraception.[57] A study of California, home of the country's largest state department of human services, showed that Black women are less likely than white or Latina women to receive postpartum contraception.[58] Furthermore, when they do receive it, they are less likely to receive a highly effective method.[59]

When doctors do devote enough time, language barriers create an additional hinderance straining access to healthcare, including contraception.[60] Undocumented immigrants additionally must confront the danger that they may be placed in deportation proceedings in the event that Immigrations and Customs Enforcement raids healthcare facilities such as Domestic Violence Centers.[61] Other barriers to open dialogue between vulnerable communities and healthcare professionals can stem from a lack of education and health

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[55] NATIONAL INSTITUTES OF HEALTH, WOMEN OF COLOR HEALTH DATA BOOK 119 (4th ed., 2014) [hereinafter WOMEN OF COLOR HEALTH DATA BOOK].
[56] *Id.*
[57] Ranji, et al., *supra* note 50.
[58] NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, BLACK WOMEN'S MATERNAL HEALTH: A MULTIFACETED APPROACH TO ADDRESSING PERSISTENT AND DIRE HEALTH DISPARITIES 2 (2018).
[59] *Id.*
[60] Ranji, et al., *supra* note 50.
[61] *Id.*

awareness, which themselves result from the country's history of systemic discrimination.[62]

Research continues to reveal how barriers continue to limit access to contraception for women of color. The ACA, including the contraception mandate, sought to address the effects of these barriers by increasing the affordability of contraceptive coverage for women previously denied access to health care. The proposed exemption, by contrast, will only exacerbate these historic and systemic barriers to accessing quality healthcare, family planning options, and contraception.

2. The Lack of Access to Healthcare Facilities Limits Access to Contraception for African-American Women.

The lack of access to healthcare facilities, in segregated neighborhoods, also affect women of color's access to contraception and family planning. Areas with a high residential concentration of African Americans experience public hospital closures and fewer primary care physicians.[63] The "safety net hospitals" meant to fill this gap in access are often under financial burden and thus their limited care restricts patient outcomes and treatment options.[64]

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[62] Prather, et al, *supra* note 35, at 253-54.

[63] Julia Caldwell et al., *Racial and Ethnic Residential Segregation and Access to Health Care in Rural Areas*, 43 HEALTH PLACE 104, 107 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5285374/.

[64] Vann Newkirk II, *America's Health Segregation Problem*, THE ATLANTIC, May 18, 2016,

Hispanics also experience similar issues when they move into predominately African American neighborhoods.[65] Overall, racial minorities in segregated neighborhoods receive less healthcare and of a lower quality of care where compared to their white counterparts.[66]

These disparities are even greater in rural areas.[67] Even when controlling for factors such as income and health insurance, the number of African- American and Hispanic women in rural areas with a regular source of healthcare is lower than that of non-Hispanic whites.[68] More than 65% of rural counties in the United States are either entirely or partially Health Primary Shortage Areas, a special healthcare designation to encourage providers to practice there.[69] These shortage areas are particularly common in counties that are predominantly Hispanic or African Americans.[70]

Access to healthcare facilities affects patient access to contraceptive care because without the proper institutions providing spaces for treatment and checkups, these women are stripped of the option to access contraception.

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https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219.

[65] Caldwell, et al., *supra* note 63, at 107.

[66] *Id.*

[67] *Id*. at 112.

[68] *Id.*

[69] *Id.* at 3.

[70] *Id.*

3. Economic Barriers Limit Access to Contraception for African-American Women.

Another harsh reality for some women of color seeking to access health care is that transgenerational poverty limits access to contraception.[71] Many disadvantaged women report that socioeconomic stresses often result in them prioritizing food and shelter above preventive health care and family planning.[72] One interviewee noted that multi-generational poverty locks women in situations that prevent them from making their own choices.[73]

Other economic conditions, such as reliance on limited means of transportation, create logistical complications preventing access to contraception.[74] Particularly in rural communities, women recounted that their utilization of family planning and contraception services was impeded by the long distances needed to be traveled to reach healthcare facilities.[75] Focus group participants in Selma, AL described having to pay friends or family to drive them to a clinic.[76] The extended travel is also a major contributor in the termination or intermittent use of contraceptive services.[77]

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[71] Prather, et al., *supra* note 35, at 253.
[72] Ranji, et al., *supra* note 50.
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*

The ACA's requirements, including its requirement that women receive contraceptive care as part of their health insurance, improved these conditions. Before the Affordable Care Act's passage, women of color constituted 37% of the U.S. female population; yet, they represented nearly three-fifths (56%) of uninsured women in the United States.[78] Nationwide, low-income women reported fewer cost-related barriers to care after the implementation of the ACA's coverage provisions: the share reporting unmet need for care because of cost declined 9.5 percentage points from 57.6% during the summer of 2013 to 48.1% during the winter of 2014 and 2015.[79]

Nonetheless, women of color continue to confront harsh realities beyond their control when it comes to accessing contraception. From sentiments of mistrust and poor communication to housing segregation, and economic hardship, contraceptive access requires overcoming many hurdles. Were the Court to approve the exemption at issue, it would only add to these problems.

D. Given the Barriers to Contraceptive Access for African-American Women, as Well as Their Importance, the Proposed Exemption Would Have a Devastating Impact.

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[78] WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 55, at 115.
[79] ADELE SHARTZER, ET AL., HEALTH POLICY CENTER, CHANGES IN INSURANCE COVERAGE, ACCESS TO CARE, AND HEALTH CARE AFFORDABILITY FOR WOMEN OF CHILDBEARING AGE 5 (2015).

Contraceptives are pivotal to the health, economic, educational and professional life of women. Accordingly, broad legislative exemptions that limit access to contraception will expose women of color to costly medical, social, and economic harms.

Without access to contraception, women who otherwise would be active in utilizing family planning measures may instead become unintentionally pregnant. Adverse family planning outcomes such as unintended pregnancy, unintended births and teen pregnancies can have a severe impact on women of color.[80] Before the ACA's passage, approximately 69% of pregnancies among Black women and 54% among Hispanic women were unintended, due in large part to the lack of readily available contraception.[81]

The pregnancies themselves, in the absence of adequate health care, pose a serious threat to the health and safety of women. Depending on where they live in the United States, black women are 2 to 6 times more likely to die from complications of pregnancy than white women.[82] While 13 white women die for every 100,000 live births, African American women experience 42.8 deaths for every 100,000 live births

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[80] Christine Dehlendorf, et al., *Disparities in Family Planning*, 202 AMERICAN JOURNAL OF OBSTETRIC AND GYNECOLOGY 214, 216 (2010).

[81] *Id.*

[82] Mary Beth Flanders-Stepans, *Alarming Racial Differences in Maternal Mortality*, 9 J. PERINATAL EDUC. 50, 50 (2000).

and Native American/Alaska Native women experience 32.5 deaths for every 100,000 live births. [83]

Conversely, increased contraceptive access can provide many benefits to women and their families. Improved access to oral contraceptives for women has been found to increase their rate of higher education.[84] In studies analyzing the effects of previous increases in contraceptive access, women both enrolled in and graduated from college in greater numbers.[85] Men were also found to experience increased educational attainment after the introduction of birth control.[86] For children, their parents' increased access to contraception reduced the probability that they lived in poverty.[87] Finally, accessing contraception increased women's investments in their careers and ultimately increased their income.[88]

Accordingly, allowing employers to curtail these successes would not only have a disastrous effect on

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[83] Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, N.Y TIMES, May 7, 2019, https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html.

[84] ANNA BERNSTEIN & KELLY JONES, THE ECONOMIC EFFECTS OF CONTRACEPTIVE ACCESS: A REVIEW OF THE EVIDENCE 5 (The Center on The Economics of Reproductive Health ed., 2019), https://iwpr.org/wp-content/uploads/2019/09/B381_Contraception-Access_Final.pdf.

[85] *Id.*

[86] Martha J. Bailey, *Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception*, BROOKINGS PAPERS ON ECONOMIC ACTIVITY, Spring 2013, at 341, 359 https://www.brookings.edu/wp-content/uploads/2016/07/2013a_bailey.pdf.

[87] *Id.* at 379.

[88] Bernstein, *supra* note 84, at 5.

the reproductive health of women, but their ability secure a sounder future for themselves and their families.

CONCLUSION

For the reasons stated, Amicus Howard University School of Law Civil and Human Rights Clinic respectfully requests that the Court affirm the decision of the United States Court of Appeals for the Third Circuit.

Respectfully submitted,

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