1-1-2011

Seven-Sky v. Holder - Amicus Brief of the National Women's Law Center et al.

National Women's Law Center

CASE NO. 11-5047

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

SUSAN SEVEN-SKY, *et al.*,
Plaintiffs-Appellants,

-vs.-

ERIC H. HOLDER, JR., *et al.*,
***Defendants-Appellees*.**

On Appeal from the United States District Court for the District of Columbia

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BRIEF *AMICUS CURIAE* OF THE NATIONAL WOMEN'S LAW CENTER, AMERICAN ASSOCIATION OF UNIVERSITY WOMEN, AMERICAN MEDICAL WOMEN'S ASSOCIATION, ASIAN AMERICAN JUSTICE CENTER, ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, CALIFORNIA WOMEN LAWYERS, COALITION OF LABOR UNION WOMEN, CONNECTICUT WOMEN'S EDUCATION AND LEGAL FUND, FEMINIST MAJORITY FOUNDATION, LEGAL VOICE, MENTAL HEALTH AMERICA, NATIONAL ADVOCATES FOR PREGNANT WOMEN, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL COALITION FOR LGBT HEALTH, NATIONAL COUNCIL OF JEWISH WOMEN, NATIONAL EDUCATION ASSOCIATION, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH (NLIRH), NATIONAL ORGANIZATION FOR WOMEN FOUNDATION, OLDER WOMEN'S LEAGUE (OWL), PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH, PLANNED PARENTHOOD FEDERATION OF AMERICA, RAISING WOMEN'S VOICES FOR THE HEALTH CARE WE NEED, SARGENT SHRIVER NATIONAL CENTER ON POVERTY LAW, WOMEN'S LAW PROJECT, 9TO5, NATIONAL ASSOCIATION OF WORKING WOMEN IN SUPPORT OF DEFENDANTS-APPELLEES SUPPORTING AFFIRMANCE

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RULE 26.1 CORPORATE DISCLOSURE STATEMENT

The Internal Revenue Service has determined that all *Amici* for this brief are organized and operated exclusively for charitable or educational purposes pursuant to Section 501(c)(3) or (4) of the Internal Revenue Code and are exempt from taxes. None of the *Amici* is a publicly held corporation and no corporation or other publicly held entity owns more than 10% of the stock of any *Amici*.

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), undersigned counsel certifies that:

(A) Parties and *Amici*: All parties, intervenors, and *Amici* appearing before the district court and those that have filed an appearance or notice in this court are listed in the Opening Brief for Appellees.

(B) Rulings Under Review: References to the rulings at issue appear in the Opening Brief for Appellees, and *Amici* are not aware of any other rulings at issue.

(C) Related Cases: This case has not previously been before this Court or any other court than the district court from which this case has been appealed. Counsel for *Amici* are not aware of any related cases pending in this Court within the meaning of Circuit Rule 28. A list of related cases pending in other courts is provided in the Opening Brief for Appellees.

Dated: July 2, 2011

Respectfully submitted,

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CERTIFICATE ON NEED FOR A SEPARATE BRIEF

Pursuant to Circuit Rule 29(d), this separate brief is necessary because the arguments raised here about congressional authority to enact civil rights statutes have not been raised by Appellees and are of particular importance to *Amici* organizations that advocate for protection and advancement of women's legal and civil rights.

Dated: July 2, 2011

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STATEMENT OF IDENTITY, INTEREST AND SOURCE OF AUTHORITY TO FILE

The National Women's Law Center (NWLC) is a nonprofit legal advocacy organization dedicated to the advancement and protection of women's legal rights since its founding in 1972. Women have long faced great difficulty obtaining comprehensive, affordable health coverage due to harmful and discriminatory health insurance industry practices. NWLC is profoundly concerned about the impact that the Court's decision may have on women's access to health insurance.

Statements of interest of 25 additional *amici* organizations committed to removing discriminatory barriers to access to health insurance and health care are set out in the Appendix.

No counsel for a party authored this brief in whole or in part and none of the parties or their counsel, nor any other person or entity other than *amici*, their members or counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

All parties have consented to the filing of this *amicus* brief, pursuant to Federal Rule of Appellate Procedure 29(a) and Circuit Rule 29(b).

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereinafter collectively referred to as the "the Affordable Care Act" or "the ACA"), makes important advances in women's health care, addressing a crisis of discrimination and obstacles to access truly national in scope. Indeed, a major purpose and concern of Congress in passing the ACA was improving women's health and ameliorating the disadvantages and discrimination women have faced in obtaining health care and health insurance. Like the civil rights laws of the past 50 years, the ACA aims at "a moral and social wrong" that itself has profound economic consequences. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 257 (1964).

The law's approach to achieving near-universal health insurance coverage, lowering insurance premiums, and eliminating or reforming an array of widespread practices in the health care market that deny or limit coverage has, and was intended to have, a particularly important effect on women. By requiring insurers to provide coverage to all who seek it, regardless of health status, it remedies long-standing insurer practices of refusing to sell insurance to women with "pre-existing conditions" such as pregnancy, a previous Caesarean section, or a history of having survived domestic abuse. Moreover, the Act explicitly targets practices that

discriminate against or disadvantage women, such as charging women more for insurance coverage based solely on their sex and refusing to cover or overcharging women for essential services such as maternity care.

The authority of the federal legislature to regulate health insurance and the national market for health care services is well settled. An individual responsibility provision, requiring individuals to obtain insurance, has proven central to effective implementation of the requirement that insurance companies make insurance available to all who seek it and cover pre-existing conditions, and thus essential to advancing the ACA's goals of removing barriers to women's participation in the health insurance market. The ACA thus requires that all Americans, unless otherwise exempt, carry some minimum level of insurance as part of its comprehensive regulatory scheme. Like other federal laws, including particularly laws prohibiting discrimination, the Act generally prohibits "opting out" because Congress's legitimate regulatory goals are best served by full participation, given the aggregate economic and social impact of the regulated behavior. As a component of Congress's comprehensive regulatory scheme for addressing failures in the health insurance market and barriers to individuals' participation in that market, the individual responsibility provision is a valid exercise of Commerce Clause power.

Moreover, through its many provisions protecting against discrimination and removing obstacles that women and other disadvantaged groups face in obtaining health insurance and care, the ACA does more than regulate the commercial relationship between insurance companies and individuals. The Act is also a significant piece of civil rights legislation, seeking to address the economic impacts of the disadvantage and discrimination that women face, remove barriers to women's participation in the health insurance market, and advance women's health. Like other major civil rights statutes, the ACA is a valid exercise of Commerce Clause authority in pursuit of a moral and social ideal whose recognition must be national in scope.

ARGUMENT

I. A MAJOR PURPOSE OF THE AFFORDABLE CARE ACT IS IMPROVING WOMEN'S ACCESS TO HEALTH CARE AND HEALTH INSURANCE AND ELIMINATING PRACTICES THAT DISCRIMINATE AGAINST AND DISADVANTAGE WOMEN

The ACA is a comprehensive system of regulation designed to lower health care costs throughout the United States, provide minimum standards of coverage for health insurance and end some of the most significant barriers to inclusive health care access. Many of the ACA's most important provisions were enacted with the express purpose of addressing the myriad ways in which the existing

insurance market has discriminated against and failed to meet the basic needs of women. Congresswoman Barbara Lee explained days before the law's passage:

> While health care reform is essential for everyone, women are in particularly dire need for major changes to our health care system. Too many women are locked out of the health care system because they face discriminatory insurance practices and cannot afford the necessary care for themselves and for their children.

156 Cong. Rec. H1632 (daily ed. March 18, 2010).[1] As the Speaker stated on the night the House approved the legislation, "It's personal for women. After we pass this bill, being a woman will no longer be a preexisting medical condition." 156 Cong. Rec. H1891-01 (daily ed. March 21, 2010) (Statement of Rep. Pelosi).

The nationwide consequences of the insurance market's failure to meet women's needs are significant. In 2009, immediately prior to the ACA's passage, nearly one in five women ages 18-64 was uninsured. That same year, over two million fewer women had job-based insurance than had the year before. *See 2009 American Community Survey*, U.S Census Bureau, http://factfinder.census.gov. More than half of all women reported forgoing needed health care for financial

[1] *See also, e.g.*, *infra* n. 4; 155 Cong. Rec. S10265(daily ed. Oct. 8, 2009) (statements of Sen. Mikulski) ("[H]ealth care is a women's issue, health care reform is a must-do women's issue, and health insurance reform is a must-change women's issue because . . . when it comes to health insurance, we women pay more and get less."); 155 Cong. Rec. S10262-01 (daily ed. Oct. 8, 2009) (statement of Sen. Boxer) ("Women have even more at stake. Why? Because they are discriminated against by insurance companies, and that must stop, and it will stop when we pass insurance reform."); 156 Cong. Rec. H1854-02 (daily ed. March 21, 2010) (statement of Rep. Maloney) ("Finally, these reforms will do more for women's health . . . than any other legislation in my career.").

reasons. Sheila D. Rustgi *et al.*, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* 52, The Commonwealth Fund (May 11, 2009), *at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf; *see also* 155 Cong. Rec. S13674 (daily ed. Dec. 21, 2009) (statement of Sen. Boxer) (same); *Comprehensive Health Care Reform: An Essential Prescription for Women*, 2009 Joint Economic Report, H.R. Rep. 111-388 at 77-81 (2009) (describing women's difficulties in accessing medical care). "Compared with men, women require more health care services during their reproductive years (ages 18 to 45), have higher out-of-pocket medical costs, and have lower average incomes." Rustgi, *supra*, at 1. In enacting the ACA, Congress recognized the need for uniform national legislation to address some of the most significant discriminatory practices and their consequences for women.

A. Women's Stake in the Ban on Pre-Existing Condition Exclusions and the Guaranteed Issue Requirement

As Congress recognized in passing the ACA, women have been sharply affected by insurers refusing to sell health coverage in the individual market to those with a pre-existing condition.[2] First, women are especially affected by

[2]For a few examples of numerous such references in the Congressional debates, see, *e.g.*, 156 Cong. Rec. H1637(daily ed. March 18, 2010) (Statement of Rep. Moore) ("Health care reform here will provide women the care that they need [and] . . . ban the insurance practice of rejecting women with a preexisting

preexisting condition denials because they are more likely than men to suffer from chronic conditions requiring ongoing treatment, like asthma or diabetes. H.R. Rep. 111-388 at 70 (2009). Second, several pre-existing conditions excluded by insurers exclusively or primarily affect women.

For example, women have been charged significantly more for coverage because they had previously given birth by Caesarean section. *See, e.g.*, *What Women Want: Equal Benefits for Equal Premiums*, Hearing before the Senate Comm. On Health, Education, Labor and Pensions, 111th Congress (October 15, 2009) (testimony of Marcia D. Greenberger, President, National Women's Law Center), *at* http://help.senate.gov/imo/media/doc/Greenberger.pdf. Other women have been denied coverage altogether unless they have been sterilized or are no longer of child-bearing age, or have been subject to an exclusionary period during which the insurer will not cover costs related to Caesarean sections or pregnancy. *See, e.g.*, *What Women Want: Equal Benefits for Equal Premiums. supra* (testimony of Peggy Robertson), *at* http://help.senate.gov/imo/media/doc/Robertson.pdf; 155 Cong. Rec. S10264 (daily ed. Oct. 8, 2009) (statement of Sen. Shaheen); 155 Cong. Rec. S11930 (daily ed. Nov. 21, 2009) (statement of Sen. Franken). These exclusions have a broad impact, as nearly one-third of births in the United States are

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condition."); 155 Cong. Rec. H12368 (daily ed. Nov. 5, 2009) (Statement of Rep. Hirono) ("Nine States allow private plans to refuse coverage for domestic violence survivors. . . . In many policies, a previous C-section and being pregnant are considered preexisting conditions.").

by Caesarean section. Faye Menacker and Brady Hamilton, *Recent Trends in Cesarean Delivery in the United States*, NCHS Data Brief No. 35 (March 2010), *at* http://www.cdc.gov/nchs/data/databriefs/db35.pdf.

Some insurers deny coverage to women who have survived domestic violence. *See* Jenny Gold, *Domestic Abuse Victims Struggle with Another Blow: Difficulty Getting Health Insurance*, Kaiser Health News (October 7, 2009), http://www.kaiserhealthnews.org/Stories/2009/October/07/Domestic-Abuse.aspx. As Congresswoman Betty McCollum recounted in the days before the passage of the ACA:

> In 2006, attorney Jody Neal-Post tried to get health insurance but was rejected. Why? Because of treatment she received after a domestic abuse incident. Her insurer told her that her medical history made her a higher risk, more likely to end up in an emergency room and need care. 1.3 million American women are victims of physical assault by an intimate partner each year, and 85 percent of domestic violence victims are women. We can help the one out of every four women who are victims of domestic violence by stopping them from being victimized again by their insurance companies.

156 Cong. Rec. H1659 (daily ed. March 19, 2010); *see also, e.g.*, 156 Cong. Rec. H1873 (daily ed. March 21, 2010) (statement of Rep. Woolsey), 155 Cong. Rec. S10264 (daily ed. Oct. 8, 2009) (statement of Sen. Shaheen); 155 Cong. Rec. S12462 (daily ed. Dec. 5, 2009) (statement of Sen. Harkin).

Other women have been denied health insurance coverage because they have previously received treatment for sexual assault. For instance, insurance agent

Chris Turner received anti-HIV preventative medication after she was sexually assaulted in 2002. As a result, she could not obtain health insurance for three years; insurers refused to extend coverage based on the anti-HIV medication, even though she tested negative for HIV. Danielle Ivory, *Rape Victim's Choice: Risk AIDS or Health Insurance?*, Huffington Post (March 18, 2010), *at* http://www.huffingtonpost.com/2009/10/21/insurance-companies-rape-n_328708.html. Other women report being denied insurance coverage because of a diagnosis of post-traumatic stress disorder stemming from a previous assault. *Id.*

Women also have been routinely denied health insurance in the private market on the basis of pregnancy. In 2010 the House Committee on Energy and Commerce investigated pre-existing condition denials by the four largest private for-profit health insurers in the country and found that all four identified pregnancy as a health condition requiring automatic denial of coverage. Chairman Henry A. Waxman and Rep. Bart Stupak, *Maternity Coverage in the Individual Health Insurance Market*, Memorandum to House Committee on Energy and Commerce, 111th Cong., at 3-4 (October 12, 2010), *at* http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Maternity.Coverage.Individual.Market.2010.10.12.pdf; *see also, e.g.*, 156 Cong. Rec. H1719 (daily ed. March 19, 2010) (statement of Rep. Woolsey) (decrying treatment of pregnancy as pre-existing condition); 155 Cong. Rec. S10263 (daily

ed. Oct. 8, 2009) (statement of Sen. Stabenow) (same); 155 Cong. Rec. S11934, S11947 (daily ed. Nov. 21, 2009) (statements of Sen. Levin, Sen. Kaufman) (same).

The ACA makes this discriminatory conduct a thing of the past by prohibiting insurance companies from denying coverage based on pre-existing conditions. *See* 42 U.S.C. §§ 300gg, 300gg-1. In addition, the law adopts "guaranteed issue," requiring that insurers sell policies to any person or employer who wishes to purchase a policy. *Id.* These provisions are made possible by the individual responsibility provision challenged in this case. As explained by the United States, empirical evidence shows that the ACA's ban on pre-existing conditions and guaranteed issue requirement will not work effectively without the full participation that the individual responsibility provision works to ensure. Br. for Appellees at 30-36. In states that have tried to enact the former without the latter, costs of insurance have skyrocketed. Under such a regulatory regime, people who are healthy may forgo insurance until they are sick and purchase insurance just at the moment when the insurer will have to spend most on their care, without having previously paid premiums that would cover some portion of these costs. In order to make up for these losses, insurance companies must substantially increase premium rates for everyone. When premiums increase, there is even greater

incentive for healthy individuals not to purchase insurance, leaving only the truly sick in the insurance pool. This is referred to as a "death spiral." *Making Health Care Work for American Families*, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong. (Mar. 17, 2009) (testimony of Princeton University Professor Uwe Reinhardt).

To avoid that spiral, the ACA included its individual responsibility provision. *See* 26 U.S.C. § 5000A. If all people have minimum coverage, regardless of their health at a particular moment, then when they do need care, they will have been paying into the system. The balanced and relatively predictable income into the system makes it possible for insurers to cover all comers, including people with pre-existing conditions. *See* 42 U.S.C. § 18091(a)(2) (congressional findings on need for individual responsibility provision). Thus, one of the centerpieces of the regulatory system envisioned in the ACA, and a key measure for ending gender inequities in health access and outcomes, turns on the full participation that the individual responsibility provision seeks to achieve.

B. The ACA's Comprehensive Approach to Women's Health

The ban on pre-existing condition exclusions and the guaranteed issue requirement will significantly improve women's access to health insurance and care. In addition, the ACA includes a range of other provisions designed to end

discrimination against women in health insurance. The District Court's decision would strike down all of these policies in their entirety.

1. Ending gender rating

The widespread insurer practice of "gender-rating"—charging women higher premiums than men of the same age—has long made insurance prohibitively costly for women in the individual market and for small businesses that employ significant numbers of women. When Congress considered the ACA, the overwhelming majority of states still permitted this discriminatory practice; in these states, 95 percent of surveyed best-selling plans charged a 40-year-old woman more than a 40-year-old man for identical coverage. *What Women Want: Equal Benefits for Equal Premiums*, *supra*; Bridget Courtot *et al.*, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition*, National Women's Law Center, 5-6 (2009), *at* http://www.nwlc.org/resource/still-nowhere-turn-insurance-companies-treat-women-pre-existing-condition. Almost none of these plans included maternity coverage (as discussed below), and thus costs associated with pregnancy and childbirth did not explain this difference. *Id.* Rather, the differences in premiums were arbitrary and highly variable. In Arkansas, premiums among the ten best-selling plans ranged from 13 to 63 percent more for women. Lisa Codispoti *et al.*, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, National Women's Law Center, 10 (June 9,

2008), *at* http://www.nwlc.org/resource/nowhere-turn-how-individual-health-insurance-market-fails-women-1 (appended to Greenberger testimony, *supra*). An insurer in Missouri charged 40-year-old women 140 percent more than men of the same age. *Id.* One small employer with a predominantly female workforce estimated that she paid $2,000 more per employee for health coverage due to her company's gender makeup. Jenny Gold, *Fight Erupts Over Health Insurance Rates for Businesses with More Women*, Kaiser Health News (October 25, 2009), *at* http://www.kaiserhealthnews.org/Stories/2009/October/23/gender-discrimination-health-insurance.aspx.

As Representative Jackie Speier queried on the floor of the House of Representatives:

> Is a woman worth as much as a man? One would think so, unless, of course, one was considering our current health care system, a system where women pay higher health care costs than men. Now, believe it or not, in 60 percent of the most popular health care plans in this country, a 40-year-old woman who has never smoked will pay more for health insurance than a 40-year-old man who has smoked.

156 Cong. Rec. H1637 (daily ed. March 18, 2010); *see also* Still Nowhere to Turn, *supra*, at 6. Ending gender rating was an important purpose of the ACA,[3] which

[3] *See, e.g.*, 156 Cong. Rec. H1894, H1898, H1909 (daily ed. March 21, 2010) (statements of Reps. DeLauro, Sanchez, and Velazquez); 155 Cong. Rec. S9524 (daily ed. Sept. 17, 2009) (statement of Sen. Casey); 155 Cong. Rec. S12870 (daily ed. Dec. 10, 2009) (statement of Sen. Baucus); 155 Cong. Rec. S13595 (daily ed. Dec. 21, 2009) (statement of Sen. Harkin).

makes gender-rating illegal in every state—as applied to both individuals and small employers. *See* Pub. L. No. 111-148, § 1201.

2. Making maternity coverage available to all

Approximately 85 percent of women in the United States have given birth by age 44, and maternity care is one of the most common types of medical care that women of reproductive age receive. But the vast majority of individual market insurance plans in 2009 did not offer any maternity coverage; others required women to pay high supplemental fees to obtain even limited coverage. A 2009 study of 3600 individual market plans around the United States found that only 13 percent included any coverage for maternity care**.** *See* Still Nowhere to Turn, *supra*, at 6; *see also, e.g.*, 155 Cong. Rec. S10265 (daily ed. Oct. 8, 2009) (statement of Sen. Mikulski) ("I think people would find it shocking, good men would find it shocking that maternity care is often denied as a basic coverage. . ."); 155 Cong. Rec. S12027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) ("Some of the most essential services required by women are currently not covered by many insurance plans, such as childbearing . . . ."). In some instances, women in the individual market had an option to purchase supplemental maternity benefits for an additional premium (known as a rider), but coverage was often expensive and limited in scope. *See* Nowhere to Turn, *supra*, at 11; *What Women Want: Equal Benefits for Equal Premiums*, *supra* (testimony of Amanda Buchanan). For

instance, maternity riders in Kansas and New Hampshire cost over $1,100 *per month* in 2008. Nowhere to Turn, *supra*, at 11. Other maternity riders limited total maximum benefits to $3,000 to $5,000 in 2008, when the average cost for an uncomplicated hospital-based vaginal birth was $7,488 in 2006, not including prenatal or postpartum care. *Id.* Moreover, an investigation by the House Energy and Commerce Committee found that insurer business plans intended specifically to reduce or eliminate coverage of maternity expenses in order to reduce costs; for example, company executives for one insurer noted the "risk" that "by offering a maternity rider we would be attractive to potential members who are likely to have children." Waxman & Stupak, *supra*, at 6-8. Uninsured pregnant women are considerably less likely to receive proper prenatal care and are thus at risk of complications that could be prevented or managed given appropriate care. *See* Amy Bernstein, *Insurance Status and Use of Health Services by Pregnant Women*, Alpha Center (1999), *at* www.marchofdimes.com/berstein_paper.pdf; Susan Egerter *et al.*, *Timing of Insurance Coverage and Use of Prenatal Care Among Low-Income Women*, 92 Am. J. Pub. Health 423-27 (March 2002).

The ACA addresses this problem. Beginning in 2014, new health plans in the individual and small-group markets must cover maternity and newborn care as "essential health benefits." Pub. L. No. 11-148, § 1302(b)(D). Moreover, health plans will no longer be permitted to require prior approval for women seeking

obstetric or gynecological care. *Id*. at§2719(A)(d). This will ensure greater access to prenatal care that is essential to healthy pregnancy and birth.

3. Prohibiting sex discrimination in health care and health insurance

The ACA prohibits discrimination on the basis of sex, race, national origin, disability, or age in health programs or activities receiving federal financial assistance, as well as discrimination by programs administered by executive agencies or any entity established under Title I of the ACA (such as the Health Insurance Exchanges, the "insurance marketplaces" where individuals and small employers will be able to compare and purchase health plans). *See* 42 U.S.C. § 18116.This nondiscrimination provision (which in design mirrors Title IX, the federal law prohibiting sex discrimination in education) is the first time federal law has ever broadly prohibited sex discrimination in health care and health insurance. It provides a groundbreaking legal remedy to individual women who experience discrimination at the hands of health insurers or providers.

4. Expanding Medicaid eligibility

Medicaid, the national health insurance program for low-income people, plays a critical role in providing health coverage for women. Women comprise about three-quarters of the program's non-elderly adult beneficiaries, and one in ten women receives coverage through Medicaid. *Women's Health Insurance*

Coverage, Kaiser Family Foundation, 1 (Oct. 2009), *at* http://www.kff.org/womenshealth/upload/6000-08.pdf. Nevertheless, even women living in extreme poverty are currently unlikely to qualify for Medicaid unless they are also pregnant, parenting, or disabled. *Id.* Under the ACA, Medicaid will cover up to an additional 8.4 million women by 2014, because eligibility will be expanded to those earning up to 133 percent of the poverty level, or roughly $30,000 a year for a family of four. Sarah Collins *et al.*, *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010*, The Commonwealth Foundation, 9 (2010), *at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Jul/1429_Collins_Women_ACA_brief.pdf. *See also* H.R. Rep. 111-388, at 91 (2009) ("Medicaid expansions will disproportionately benefit women, who are more likely to be poor").

5. Supporting nursing mothers

Breastfeeding provides important health benefits to both mother and child, including reduced risks of type 2 diabetes, breast cancer, ovarian cancer and postpartum depression for mothers, and of ear infections, diarrhea, lower respiratory infections, asthma, diabetes, obesity, childhood leukemia, and other conditions in children. Stanley Ip *et al.*, *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*, U.S. Dep't of Health and Human Services, Agency for Health Research and Quality (April 2007), *at*

http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf. The ACA seeks to make these benefits more widely available by making it easier for working mothers to continue to breastfeed. Under the ACA, employers with more than 50 employees must provide employees break times and a private location other than a bathroom for expressing breast milk. 29 U.S.C. § 207(r)(1).

6. Providing Pap tests and mammograms without copayments

Women need more preventative care on average than men, but are more likely than men to forgo essential preventative services, such as cancer screenings, because of their cost. *See, e.g.*, H.R. Rep. 111-388 at 79-81 (October 8, 2009); Steven Asch *et al.*, *Who Is at Greatest Risk for Receiving Poor-Quality Health Care?*,354 New Eng. J. Med. 1147, 1151 (2006). In 2007, more than half of women reported difficulty in obtaining needed medical services because of the cost of such basic care. Rustgi, *supra,* at 3. The ACA requires that new plans cover recommended preventative services and screenings at no cost to the individual. *See* 42 U.S.C. § 300gg-13. Many women who otherwise would not be able to get basic screening like Pap tests and mammograms will have access to this potentially life-saving medical care as a consequence of the new law. *See* 155 Cong. Rec. S11987 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski) (explaining need to remove barriers to preventive care for women); 155 Cong. Rec. S12025-S12030 (daily ed. Dec. 1, 2009) (same).

7. Making private health insurance more affordable

Under the ACA, beginning in 2014, subsidies will be available to help an additional 11 million low- and middle-income women pay for health insurance in the individual market and out-of-pocket health care costs. Because women are poorer on average than men, are more likely to hold low-wage or part-time jobs that do not offer employer-sponsored health benefits, and struggle more with medical debt, *see* H.R. Rep. 111-388, at 68-86 (2009); Elizabeth M. Patchias & Judy Waxman, *Issue Brief: Women and Health Coverage: The Affordability Gap* 5 (2007), *at* http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2007/Apr/Women-and-Health-Coverage-The-Affordability-Gap.aspx, these reforms are essential for addressing continuing gender health disparities and insurance coverage disparities in the United States.

Given the ACA's importance for removing obstacles to women's equal treatment in the insurance market and in making health care available to women, it is appropriately understood as following in the tradition of our nation's civil rights laws, protecting the right to fair treatment and equal access to services fulfilling basic needs.

II. AS A REASONABLE COMPONENT OF A COMPREHENSIVE PLAN RESPONDING TO A NATIONAL CRISIS IN THE HEALTH INSURANCE MARKET AND TO WOMEN'S COVERAGE NEEDS, THE INDIVIDUAL RESPONSIBILITY PROVISION FALLS WELL WITHIN COMMERCE CLAUSE AUTHORITY

Through the ACA, Congress adopted a comprehensive regulatory plan designed to address a national economic crisis in health care, with a particular focus on the disadvantage and discrimination that women and others have faced in the insurance market. Addressing this crisis is well within Congress's power, given the settled authority that the Commerce Clause permits regulation of both the insurance industry and health care services. *See, e.g., United States v. Southeastern Underwriters' Ass'n*, 322 U.S. 533 (1944).

The district court was correct in its conclusion that the individual responsibility provision is within Congress's Commerce Clause. On numerous previous occasions, exercising its Commerce Clause power in efforts to address behavior with broad consequences for the national economy and remove barriers to full economic participation by women and other disadvantaged groups, Congress has required individuals to engage in private commercial activity in instances where those individuals preferred to remain "inactive." For example, Title II of the Civil Rights Act of 1964 required hotel and restaurant owners to serve customers they did not want to serve and thus engage in commercial activities that they wished to avoid. *See* 42 U.S.C. §§ 2000a -2000a-6. In upholding that law, the

Supreme Court rejected the argument that a local motel owner should be able to deny service to African-American customers because that local decision was unrelated to interstate commerce. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258 (1964). The same analysis underlies Congress's power to prohibit employers from refusing to employ an individual on the basis of her sex or race, thus requiring employers to enter into unwanted economic relationships in certain circumstances. *See, e.g., U.S. v. Gregory*, 818 F.2d 1114, 1119 (4th Cir. 1987) (noting that Title VII was enacted under the Commerce Clause); *Nesbit v. Gears Unlimited, Inc.*, 347 F.3d 72, 81 (3d Cir. 2003) (same). Similarly, the Fair Housing Act, 42 U.S.C. §§ 3601-3614(a), passed pursuant to Congress's Commerce Clause power, prohibits refusing to rent or sell housing to an individual on the basis of her sex, familial status, race, or disability, and thus compels owners of real estate to engage in commercial activities they would otherwise have avoided. *See, e.g., Groome Res. Ltd v. Parish of Jefferson*, 234 F.3d 192, 209 (5th Cir 2000).

Congress realized in passing these laws and others like them, from the Equal Credit Opportunity Act to the Family and Medical Leave Act, that a national crisis of discrimination could only be solved through legislation reaching individual refusals to transact. Similarly, Congress understood in 2010 that legislation addressing a national crisis in the health insurance market would only work with near-universal participation and thus must reach individual refusals. As Congress is

regulating within an area of its authority—and the health insurance and health care markets are unquestionably areas of appropriate national authority—there is no prohibition against the federal government requiring individuals to participate in economic transactions they might otherwise avoid.

Judge Kessler correctly recognized that the choice to purchase health insurance or pay for health care some other way is commercial activity. JA 147. Just as a hotel's decision not to rent rooms to African-Americans is not a decision that removes the hotel from the market for lodging, but rather is a decision about how to engage in that market, the choice not to purchase health insurance is not a decision that avoids participation in the health care market, but is simply a decision about when and how to pay for the costs of health care. Moreover, like decisions to discriminate, the cumulative impact of decisions to eschew health insurance has significant consequences for the larger health care market and other participants in it. *Cf. Katzenbach v. McClung*, 379 U.S. 294, 299-301 (1964). In 2005 alone, 48 million uninsured Americans incurred $43 billion in medical costs that they could not pay, which were in turn passed to the broader public. *See* 42 U.S.C. §§ 18091(a)(2). Refusing to obtain health insurance is an economic choice, with economic consequences, under even a limited definition of "commercial" or "economic," just as a decision to refuse to provide lodging to an individual because

of her race is an economic choice, with economic consequences.[4] *See Katzenbach*, 379 U.S. at 303-4 ("[W]here we find that the legislators, in light of the facts and testimony before them, have a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce, our investigation is at an end.").

Even if the decision to defer medical costs until after they are incurred, and the concurrent decision to shift the risk of inability to pay these costs to the broader market, were somehow construed not to be an economic activity, the individual responsibility provision would still be within congressional authority to enact as a "necessary and proper" part of a complex regulatory scheme. *See Gonzales v. Raich*, 545 U.S. 1, 22 (2005). Congress has the authority to use any "means that is rationally related to the implementation of a constitutionally enumerated power" that is not otherwise prohibited by the Constitution. *United States v. Comstock*, 130 S.Ct. 1949, 1956-57 (2010). As this court recently recognized: "the regulated activity need not be commercial in nature, rather the only relevant inquiry is whether the *effect* on interstate commerce is substantial." *Navegar, Inc. v. U.S.*, 192 F.3d 1050, 1057 (D.C. Cir. 1999). *See also National Ass'n of Homebuilders v.*

[4]Given the direct economic impact of these decisions in the aggregate, they easily come within Congress's Commerce Clause power to regulate, in contrast to the far more attenuated and speculative link that would be presented were Congress to regulate, for example, personal nutritional decisions, as hypothesized by appellants. *See Opening Brief of Plaintiffs-Appellants* at 53. *Cf. Gonzales v. Raich*, 545 U.S. 1, 36 (2005) (Scalia, J., concurring) (Commerce Clause does not reach noneconomic activity based on "remote chain of inferences" regarding impact on commerce).

Babbitt, 130 F.3d 1041, 1047-50 (D.C. Cir. 1997) (upholding Endangered Species Act as constitutional even applied to a purely local conflict); *Terry v. Reno*, 101 F.3d 1412, 1413 (D.C. Cir. 1996) (concluding that the Freedom of Access to Clinic Entrances Act appropriately regulates local activities that substantially affect interstate commerce).

Congress certainly had a rational basis for its conclusion that the individual responsibility provision was necessary to effective implementation of important elements of the ACA, including Congress's purpose in addressing health insurer practices that excluded women from coverage. *See* 42 U.S.C. §§18091(a) (findings on need for individual responsibility provision). Uninsured individuals shift billions of dollars of costs onto third parties. *Key Issues in Analyzing Major Health Proposals*, Cong. Budget Office 114 (Dec. 2008), *at* http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf. The individual responsibility provision addresses this cost-shifting and forms a key part of the ACA's reforms. It is a reasonable provision permitting the ban on pre-existing condition exclusions, including insurers' exclusion of women from insurance coverage because of pregnancy, past Caesarean-sections, cervical or breast cancer, or past domestic or sexual abuse.

III. AS LEGISLATION INTENDED TO PROMOTE WOMEN'S HEALTH AND END GENDER DISCRIMINATION, THE ACA FOLLOWS IN A LONG TRADITION OF CIVIL RIGHTS LAWS FIRMLY WITHIN CONGRESS'S COMMERCE CLAUSE POWER.

Throughout the congressional debate over the ACA, the law's significant impact on women was of paramount concern. The Congressional Record is rich with statements recognizing that "[h]ealth care reform here will provide women the care that they need; the economic security they need; prohibit plans from charging women more than men; ban the insurance practice of rejecting women with a preexisting condition; and include maternity services." 156 Cong. Rec. H1637 (Statement of Rep. Moore).[5]

As Congresswoman Jackie Speier explained in casting her vote for the Act:

> The fact is that women's health care premiums cost, on average, more than 145 percent of the price of a similar man's policy. Even then, women are more likely to be denied coverage for a pre-existing condition, including for things as common as getting pregnant (or the inability to get pregnant), having a C-section, even being a survivor of

[5] *See also, e.g.*, 155 Cong. Rec. H12368 (statement of Rep. Hirono) ("Fifty-two percent of women reported postponing or foregoing medical care because of cost. Only 39 percent of men report having had those experiences. Nine States allow private plans to refuse coverage for domestic violence survivors. Eighty-eight percent of private insurance plans do not cover comprehensive maternity care."); S. Res. 6, 111th Cong. (2009) (enacted) (women pay 68 percent more than men for out-of-pocket medical costs; 13 percent of all pregnant women are uninsured, making them less likely to seek prenatal care in the first trimester, less likely to receive the optimal number of prenatal health care visits, and 31 percent more likely to experience an adverse health outcome after giving birth; heart disease is leading cause of death for women and men, but women are less likely to receive lifestyle counseling, diagnostic and therapeutic procedures, and cardiac rehabilitation and are more likely to die or have a second heart attack).

> domestic violence. With the passage of this health care reform bill, these practices will be tossed on the ash-heap of history atop corsets, chastity belts, and other limitations on women's rights and equality. In fact, with this bill, American's mothers, wives and sisters will finally enjoy the same health care coverage that their fathers, sons and brothers have.

155 Cong. Rec. H12878.

The ACA should thus be recognized as following not only a long tradition of economic regulatory laws appropriately enacted pursuant to the Commerce Clause, but also a long tradition of antidiscrimination legislation that has removed barriers to full economic participation by disadvantaged groups. Here, too, the Commerce Clause has been understood to provide the congressional authority to address the impact on interstate commerce that arises from these discriminatory exclusions and simultaneously to forward goals of equality and inclusion.

In enacting a broad range of federal civil rights laws over the past 50 years, Congress has determined that the problem of discrimination against and exclusion of disfavored groups is one that cannot be left to local solutions, given its national scope and impact. Like civil rights laws such as the Civil Rights Act of 1964, the Equal Pay Act, and the Family and Medical Leave Act, the ACA recognizes that inequality and sex discrimination themselves have a significant economic impact and that addressing these economic consequences requires confronting inequality and discrimination. Thus, by regulating commerce in health insurance and health care, the ACA also takes an important step to ensuring equality of access to health

care—forwarding fundamental civil rights principles of equal treatment and equal opportunity.[6] This only enhances Congress's Commerce Clause power to enact the law.

In the famous cases upholding the constitutionality of the Civil Rights Act of 1964, *Heart of Atlanta* and *Katzenbach v. McClung*, the Supreme Court acknowledged "the overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse." *Heart of Atlanta*, 379 U.S. at 257; *see also Katzenbach*, 379 U.S. at 303-304. The far-reaching gender inequities that have pervaded the market for health insurance and health care have been similarly disruptive to interstate commerce.

Specifically, women have been prevented from obtaining adequate insurance coverage, and thus have faced obstacles to accessing needed health care goods and services, including those moving in interstate commerce**.** *See, e.g.*, H.R. Rep. 111-388 at 78 (2009) (68 percent of underinsured women, compared to 49 percent of

[6]*See generally, e.g.*, *United States v. Virginia*, 518 U.S. 515, 532 (1996) (noting fundamental principle that is violated when "women, simply because they are women" are denied the "equal opportunity to aspire, achieve, participate in and contribute to society based on their individual talents and capacities"); *Roberts v. U.S. Jaycees*, 468 U.S. 609, 626 (1984) (noting "the changing nature of the American economy and the importance, both to the individual and to society, of removing the barriers to economic advancement and political and social integration that have historically plagued certain disadvantaged groups, including women"); *see also Newport News Shipbuilding Co. v. EEOC*, 462 U.S. 669, 676 (1983) (denying pregnancy coverage to female health insurance beneficiaries discriminates on the basis of sex).

underinsured men, have difficulty obtaining needed health care); Bernstein, *supra* (describing uninsured pregnant women's lower likelihood of obtaining prenatal care); Egerter, *supra* (same); Asch, *supra*, at 1147-56 (describing women's greater propensity to forego preventative care because of cost). When women cannot purchase insurance, or when the insurance available does not cover basic costs such as maternity expenses or imposes high out-of-pocket costs for preventive care, their health care expenses will be significant, thus restricting their ability to purchase other goods and services in interstate commerce. *See, e.g.*, H.R. Rep. 111-388 at 84 (37 percent of women, compared to 29 percent of men, report problems paying medical bills); *id.* at 70 (over half of medical bankruptcies impact a woman); Elizabeth Warren *et al.*, *Medical Problems and Bankruptcy Filings*, Norton's Bankruptcy Adviser 10 (May 2000), *at* http://bdp.law.harvard.edu/pdfs/papers/Warren/Med_Problem_Bankruptcy.pdf ("the number of women filing alone who identify a medical reason for their bankruptcies is nearly double that of men filing alone"). Finally, when uninsured or underinsured women are unable to pay for the health care they require, those costs are passed onto third parties through increased health care and health insurance costs, including increased costs for goods and services moving in interstate commerce. *See generally* 42 U.S.C. § 18091(a)(2)(F) (finding that the

American public has paid tens of millions of dollars to cover the costs of health care for uninsured Americans).

Because of the economic impact of discrimination and the need for national solutions to the problems it poses, in cases upholding a range of federal civil rights legislation, the courts of appeals have recognized that, far from being an impediment to the exercise of Commerce Clause authority, "civil rights … are traditionally of federal concern." *United States v. Allen*, 341 F.3d 870, 881 (9th Cir. 2003) (upholding federal hate crimes legislation under Commerce Clause). So, for example, in *Groome Resources*, the Fifth Circuit, upholding the Fair Housing Amendments Act (FHAA), "emphasize[d] that in the context of the strong tradition of civil rights enforced through the Commerce Clause… we have long recognized the broadly defined "economic" aspect of discrimination." 234 F.3d at 209.

Recognizing the significant federal responsibility for addressing persistent discrimination and inequality, this court and others have upheld a wide range of federal civil rights laws as appropriately enacted under the Commerce Clause. *See, e.g., EEOC v. Wyoming*, 460 U.S. 226, 234, 243 (1982) (Age Discrimination in Employment Act); *Terry v. Reno*, 101 F. 3d 1412, 1413 (D.C. Cir. 1996) (Freedom of Access to Clinic Entrances Act); *United States v. Miss. Dep't of Public Safety*, 321 F.3d 495, 500 (5th Cir. 2003) (Americans with Disabilities Act); *United States v. Gregg*, 226 F.3d 253, 262 (3d Cir. 2000) (Freedom of Access to Clinic

Entrances Act); *United States v. Dinwiddie*, 76 F.3d 913. 921 (8th Cir. 1996) (same); *United States v. Soderna*, 82 F.3d 1370, 1374 (7th Cir. 1996) (same); *Cheffer v. Reno*, 55 F.3d 1517, 1520-21 (11th Cir. 1995) (same); *Oxford House-C v. City of St. Louis*, 77 F.3d 249, 251 (8th Cir. 1996) (FHAAA); *Morgan v. Sec'y of Hous.& Urban Dev.*, 985 F.2d 1451, 1455 (10th Cir. 1993) (same); *Seniors Civil Liberties Ass'n v. Kemp*, 965 F.2d 1030, 1034 (11th Cir. 1992) (same).

The ACA, like these other statutes, is an appropriate exercise of federal Commerce Clause authority. It is unquestionably a law that regulates commerce—the health insurance and health care markets make up 17.5 percent of our nation's gross domestic product. In particular, the ACA corrects fundamental gender inequities in the health insurance and health care markets and bars discrimination against women in multiple forms, thus alleviating the severe economic consequences of such inequities and discrimination. In taking this legislative action, Congress was continuing "the strong tradition of civil rights enforced through the Commerce Clause." *Groome*, 234 F.3d 209.

Conclusion

For these reasons, this court should affirm the district court's decision and uphold the ACA as an appropriate exercise of Congress's Commerce Clause authority.

Dated: July 2, 2011

Respectfully Submitted,

s/*Melissa Hart*

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CERTIFICATE OF COMPLIANCE
WITH TYPEFACE AND LENGTH

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6931 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2.This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in Times New Roman, 14 point font.

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CERTIFICATE OF SERVICE

I hereby certify that on July 5, 2011, I filed this Brief and Motion for Leave to File the Brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit.

I hereby certify that on July 5, 2011, the foregoing document was served on all parties or their counsel of record by electronic mail:

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APPENDIX

AMICI STATEMENTS OF INTEREST

American Association of University Women

For 130 years, the American Association of University Women (AAUW), an organization of over 100,000 members and donors, has been a catalyst for the advancement of women and their transformations of American society. In more than 1000 branches across the country, AAUW members work to break through barriers for women and girls. AAUW plays a major role in mobilizing advocates nationwide on AAUW's priority issues, and chief among them is increased access to quality affordable health care. Therefore, AAUW supports efforts to ensure patient protection, equitable treatment of all consumers, coverage of preventive care, and other initiatives to improve the collective health of the American people.

American Medical Women's Association

The American Medical Women's Association is an organization which functions at the local, national, and international level to advance women in medicine and improve women's health. We achieve this by providing and developing leadership, advocacy, education, expertise, mentoring, and

through building strategic alliances.

AMWA supports the Affordable Care Act as its members believe it provides more complete care for women and families and advances the medical careers of women doctors with its provisions to increase primary care physicians and other support healthcare workers. This Act is the most important advance in healthcare since Medicare/Medicaid. It can be strengthened, certainly not repealed.

The Asian American Justice Center

The Asian American Justice Center (AAJC) is a national nonprofit, nonpartisan organization whose mission is to advance the civil and human rights of Asian Americans and to promote a fair and equitable society for all. A member of the Asian American Center for Advancing Justice, AAJC engages in litigation, public policy, advocacy, and community education and outreach on a range of civil rights issues, including access to healthcare. AAJC's longstanding interest in healthcare matters that impact Asian Americans and other underserved communities has resulted in the organization's participation in amicus curiae briefs in both state and federal courts.

Asian & Pacific Islander American Health Forum

The Asian & Pacific Islander American Health Forum ("APIAHF") influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs). AA and NHPIs face numerous barriers to attaining quality health care, including high rates of uninsurance and limited English proficiency. For these reasons, APIAHF is concerned about the impact the Court's decision may have on AA and NHPI access to health insurance and quality care.

California Women Lawyers

California Women Lawyers ("CWL") represents a broad range of lawyers throughout California. Throughout its thirty-year history, CWL has promoted its mission of advancing women's interests, extending universal equal rights, and eliminating bias. In pursuing its values of social justice and gender equality, CWL often joins amici briefs challenging discrimination by private and governmental entities, weighs in on proposed California and federal legislation, and implements programs fostering the appointment of women and other qualified candidates to the bench.

The Coalition of Labor Union Women

The Coalition of Labor Union Women (CLUW) is America's only national membership organization for all union women based in Washington, DC with chapters throughout the country. Founded in 1974 its focus is to empower women in the workplace, advance women in their unions, encourage political and legislative involvement, organize women workers into unions and promote policies that support women and working families. From its inception CLUW has advocated to strengthen the role and impact of women in every aspect of their lives. CLUW focuses on public policy issues such as equality in employment and educational opportunities, affirmative action, pay equity, national health care, labor law reform, family and medical leave, reproductive freedom, and increased participation of women in unions and in politics. Through its 47 chapters throughout the United States, CLUW members work to end discriminatory laws and policies and practices adversely affecting women through a broad range of educational, political and advocacy activities. Promoting quality, affordable health care for women and families has long been a priority of the Coalition of Labor Union Women. We support the National Women Law Center's amicus brief to uphold the Affordable Care Act.

The Connecticut Women's Education and Legal Fund

The Connecticut Women's Education and Legal Fund (CWEALF) is a non-profit women's rights organization dedicated to empowering women, girls and their families to achieve equal opportunities in their personal and professional lives. CWEALF defends the rights of individuals in the courts, educational institutions, workplaces and in their private lives. Since its founding in 1973, CWEALF has provided legal education and advocacy and conducted research and public policy work to advance women's rights.

The Feminist Majority Foundation

The Feminist Majority Foundation, a 501(c)(3) non-profit organization founded in 1987, is dedicated to the pursuit of women's equality, utilizing research and action to empower women economically, socially, and politically. FMF advocates for full enforcement of laws ending discrimination and advancing equality for women, including the Affordable Care Act, which ends discrimination in health insurance rates, reduces barriers to coverage, and expands the number of U. S. women who will be able to obtain health care.

Legal Voice

Legal Voice is a regional non-profit public interest organization that works to advance the legal rights of all women through litigation, legislation, education and the provision of legal information and referral services. Since its founding in 1978, Legal Voice has been involved in both litigation and legislation aimed at ending all forms of discrimination against women – including discrimination in health care services. Toward that end, Legal Voice has participated as counsel and as *amicus curiae* in cases throughout the Northwest and the country when women's health is at stake. Women's health and economic security are threatened in an unregulated insurance market which routinely treats their gender as a preexisting condition. Legal Voice seeks to ensure that all women have access to health insurance so they can get the care they need and deserve.

Mental Health America

Mental Health America (MHA) is a national non-profit advocacy and public policy organization that that has been working since 1909 to advance the rights of individuals with mental health conditions and improve the mental health of all Americans. Individuals with mental health conditions, including those suffering from depression, anxiety, post traumatic stress, and other illnesses that disproportionately affect women, have long faced great difficulty obtaining comprehensive, affordable health coverage due to harmful and discriminatory

health insurance industry practices. MHA is profoundly concerned about the impact that the Court's decision may have on access to health insurance for all Americans, especially women and individuals with mental illnesses.

National Advocates for Pregnant Women

National Advocates for Pregnant Women ("NAPW") is a non-profit organization that works to ensure the human rights, health, and dignity of all pregnant and parenting women, especially the most vulnerable including low income and women of color. NAPW advocates for reproductive justice, including the right to an abortion, the right to decide whether, when, and how to carry a pregnancy to term, access to culturally-appropriate and evidence-based medical care, and the right to parent the children one bears without unnecessary state intrusion and family disruption. NAPW joins this case as amicus to explain to the court the importance of affordable healthcare in assuring the best health outcomes for women, the infants they give birth to, and the children they care for.

National Asian Pacific American Women's Forum

NAPAWF is the only national, multi-issue Asian and Pacific Islander (API) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. Access to

quality, comprehensive primary and reproductive health care is an important founding platform for NAPAWF. As such, NAPAWF is a co-leader of the Women of Color United for Health Care Reform (WOCUHR) coalition, co-chair of the National Council of Asian Pacific Americas (NCAPA) Health Committee, and a member of numerous national coalitions seeking to ensure access to health care for immigrants and access to comprehensive reproductive health care for women. Successful implementation of the Affordable Care Act is essential for our members.

National Association of Social Workers (NASW)

Established in 1955, the National Association of Social Workers (NASW) is the largest association of professional social workers in the world with 145,000 members and 56 chapters throughout the United States and internationally. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the NASW Code of Ethics, conducts research, publishes books and studies, promulgates professional criteria, and develops policy statements on issues of importance to the social work profession. NASW's statement, Health Care Policy, supports "efforts to increase health care coverage to uninsured and underinsured people until universal health and mental

health coverage is achieved" and "efforts to eliminate racial, ethnic, and economic disparities in health service access, provision, utilization, and outcomes."(NASW, SOCIAL WORK SPEAKS, 167, 169, 8th ed., 2009). NASW recognizes that discrimination and prejudice directed against any group are not only damaging to the social, emotional, and economic well-being of the affected group's members, but also to society in general. NASW has long been committed to working toward the elimination of all forms of discrimination against women. The NASW Code of Ethics directs social workers to "engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully." NASW's policies support "access to adequate health and mental health services regardless of financial status, race and ethnicity, age, or employment status, which would require universal health care coverage…" NATIONAL ASSOCIATION OF SOCIAL WORKERS, Women's Issues, SOCIAL WORK SPEAKS, 367, 371 (8th ed., 2009). Accordingly, given NASW's policies and the work of its members, NASW has expertise that will assist the Court in reaching a proper resolution of the questions presented in this case.

National Coalition for LGBT Health

The National Coalition for LGBT Health ("the Coalition") is a nationwide coalition of more than 75 organizations committed to improving the health and well-being of the lesbian, gay, bisexual, and transgender (LGBT) community through federal health policy advocacy. Because LGBT people and their families are regularly discriminated against in employment, relationship recognition, and insurance coverage, the LGBT population faces significant disparities in health status and insurance coverage. The Affordable Care Act is a key component of health system reform that seeks to eliminate these disparities, and the Coalition is deeply concerned about the negative effect that the Court's decision may have on the health and well-being of millions of LGBT individuals and their families. // Corporate Disclosure Statement // The Internal Revenue Service has determined that the National Coalition for LGBT Health is organized and operated exclusively for charitable or educational purposes pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax.

National Council of Jewish Women

The National Council of Jewish Women (NCJW) is a grassroots organization of 90,000 volunteers, advocates, and supporters who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the

quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW's Resolutions state that the organization endorses and resolves to work to for "quality, comprehensive, confidential, nondiscriminatory health-care coverage and services, including metal health, that are affordable and accessible for all." Consistent with our Resolutions, NCJW joins this brief.

National Education Association

The National Education Association (NEA) is a nationwide employee organization with more than 3.2 million members, the vast majority of whom are employed by public school districts, colleges and universities. NEA strongly supports adequate health care for all members of our society and to this end opposes constitutional attacks on the Patient Protection and Affordable Care Act.

National Latina Institute for Reproductive Health (NLIRH)

The National Latina Institute for Reproductive Health ("NLIRH") works to ensure the fundamental human right to reproductive health for Latinas, our families, and our communities. Latinas suffer from large health disparities in most of the major health concerns in our country including cancer, heart disease, obesity and sexually transmitted diseases. In addition, Latinas are one of the populations least likely to have access to health insurance. The issues addressed in this case will profoundly

affect Latinas' health and access to care and therefore are a central concern to our organization.

The National Organization for Women Foundation

The National Organization for Women Foundation is a 501(c)(3) organization devoted to furthering women's rights through education and litigation. Created in 1986, NOW Foundation is affiliated with the National Organization for Women, the largest grassroots feminist organization in the United States, with hundreds of thousands of contributing members in hundreds of chapters in all 50 states and the District of Columbia. For decades, the NOW Foundation has advocated for recognition of health care as a fundamental human right, and to that end we support efforts to make comprehensive, affordable health care coverage available to all women.

Older Women's League (OWL)

OWL is a national grassroots membership organization that focuses solely on improving the status and quality of life for midlife and older women. For the past thirty years, OWL has worked toward the goal of comprehensive, accessible healthcare that is publicly administered and financed. OWL has consistently advocated for a single-payer health care system. As the momentum for health care

reform legislation gathered speed, OWL worked with a diverse set of organizations to foster change that addressed persistent problems including millions of Americans without insurance, ever-rising costs, lack of affordable long-term care coverage and inequities in the health insurance industry. OWL took a strong leadership position on gender and age rating of health insurance premiums and moved the dialogue forward on this topic despite strong opposition. As a result, the Patient Protection and Affordable Care Act (PPACA) essentially eliminated gender rating, and insurers are restricted to a 3 to 1 age ratio (rather than a 5 to 1 ratio). Maintaining these important provisions in the PPACA are key to the quality of life for midlife and older women and compels OWL to support this brief.

Physicians for Reproductive Choice and Health

PRCH is a doctor-led national advocacy organization. We use evidence-based medicine to promote sound reproductive health policies. As physicians, we believe every American deserves unfettered access to all reproductive health care. The health of our country depends on it. The Affordable Care Act is a valid use of congressional authority and means that millions of Americans will finally have the health coverage they need.

Planned Parenthood Federation of America

Planned Parenthood Federation of America (PPFA) is the nation's largest and most trusted voluntary reproductive health care organization. PPFA's 84 affiliates operate 815 healthcare centers nationwide. In addition to providing reproductive health care, PPFA and its affiliates are among the nation's most active and widely recognized advocates for increased access to comprehensive reproductive health services and education. PPFA is committed to promoting and preserving full reproductive choice for all people, and to providing access to high quality, confidential, reproductive health services.

Raising Women's Voices for the Health Care We Need

Raising Women's Voices for the Health Care We Need (RWV) is a national initiative working to make sure women's voices are heard in the health reform debate and women's concerns are addressed by policymakers developing national and state health reform plans. RWV has a special focus on engaging women of color, low-income women, immigrant women, young women, women with disabilities and members of the lesbian, gay, bisexual and transgender community. In addition to bringing the concerns of these constituencies to federal advocacy forums, RWV has 22 regional coordinators in 20 states who do community

organizing, advocacy and public education with women at the state and local levels.

RWV and the women it represents recognize that the Affordable Care Act (ACA) makes a real and significant difference in the lives of millions of our families, neighbors and communities. By prohibiting insurance companies from denying coverage to people with pre-existing conditions, like breast cancer or having a c-section delivery, and from charging women more than men for the same policies, it has increased our health security. Women will also gain from the availability of affordable health insurance for millions more families, from the guarantee that maternity care will be covered and from the availability of screening and preventive services without any cost-sharing barriers. With the promise of access to quality, affordable health care that meets the needs of women and our families the ACA has the potential to bring equity and fairness for women to the health care arena where it has been lacking for too long.

Sargent Shriver National Center on Poverty Law

The Sargent Shriver National Center on Poverty Law (Shriver Center) champions social justice through fair laws and policies so that people can move out of poverty permanently. Our methods blend advocacy, communication, and strategic leadership on issues affecting low-income people. National in scope, the Shriver

Center's work extends from the Beltway to state capitols and into communities building strategic alliances. The Shriver Center works on issues related to women's health and access to quality health care and insurance coverage. Discriminatory policies and practices have a negative impact on women's immediate and long-term health, and in turn, a negative impact on their economic well-being. The Shriver Center has a strong interest in the eradication of unfair and unjust health insurance policies and practices that limit women's access to quality care and serve as a barrier to leading healthy lives and economic equity.

Women's Law Project

The Women's Law Project (WLP) is a nonprofit legal advocacy organization dedicated to creating a more just and equitable society by advancing the rights and status of all women throughout their lives. To this end, we engage in high impact litigation, advocacy, and education. The WLP has a long and effective track record working to improve access to comprehensive, quality, and affordable health care for women. Since 1994, the Women's Law Project (WLP) has engaged in extensive advocacy on the federal and state levels to eliminate insurance practices that deny insurance coverage to victims of domestic violence. We advocated for adoption of the Affordable Care Act to reduce the significant barriers to health care

that confront women in the existing insurance market and have a strong interest in full implementation of the ACA.

9to5, National Association of Working Women

9to5, National Association of Working Women is a national membership-based organization of low-wage women working to achieve economic justice and end discrimination. 9to5's members and constituents are directly affected by lack of access to health care and health insurance, by discriminatory health insurance industry practices, and by the long-term negative effects of lack of access and discriminatory practices on their and their families' economic well-being. Our toll-free Job Survival Helpline fields thousands of phone calls annually from women facing these and related problems. The issues of this case are directly related to 9to5's work to end discrimination and our work to promote policies that aid women in their efforts to achieve economic security. The outcome of this case will directly affect our members' and constituents' access to health care and their long-term economic well-being and that of their families.