Nos. 18-15144, 18-15166, and 18-15255

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

STATE OF CALIFORNIA, *et al.,*

Plaintiffs-Appellees,

v.

ALEX M. AZAR, II, in his official capacity as Secretary of the U.S. Department of Health and Human Services, *et al*.

Defendants-Appellants,

and

THE LITTLE SISTERS OF THE POOR, JEANNE JUGAN RESIDENCE, and MARCH FOR LIFE EDUCATION AND DEFENSE FUND,

Intervenors-Defendants-Appellants

On Appeal from the United States District Court
for the Northern District of California
Case No. 4:17-cv-05783-HSG

AMICUS CURIAE BRIEF OF HEALTH PROFESSIONAL ORGANIZATIONS THE AMERICAN NURSES ASSOCIATION, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN ACADEMY OF NURSING, THE AMERICAN ACADEMY OF PEDIATRICS, PHYSICIANS FOR REPRODUCTIVE HEALTH, and THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(a)(4) of the Federal Rules of Appellate Procedure, *amici curiae* state that they are nongovernmental not-for-profit organizations. None of the *amici curiae* has a parent corporation or a publicly-held corporation that owns 10% of its stock.

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Cruzan by Cruzan v. Dir., Missouri Dep't of Health,
497 U.S. 261 (1990) 23

Doe v. Bolton,
410 U.S. 179 (1973) 23

Harris v. McRae,
448 U.S. 297 (1980) 14

Zubik v. Burwell,
136 S. Ct. 1557 (2016) 26

Other Authorities

American Academy of Pediatrics, *Policy Statement: Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS 827 (2012) 11

American Academy of Pediatrics, *Policy Statement: Contraception and Adolescents*, 120 PEDIATRICS 1135 (2007) 19

American Academy of Pediatrics & American College of Obstetricians & Gynecologists, GUIDELINES FOR PERINATAL CARE, 205 (8th ed. 2017) 13

American College of Obstetricians & Gynecologists, *Access to Contraception,* Comm. Op. 615, Jan. 2015 (reaffirmed 2017) 8

American College of Obstetricians & Gynecologists, *Access to Emergency Contraception,* Comm. Op. 542 (2012) 20

American College of Obstetricians & Gynecologists, *Code of Professional Ethics* 23

American College of Obstetricians & Gynecologists, *Elective Surgery and Patient Choice,* Comm. Op. 578, 122 OBSTET. & GYNECOL. 1134 (2013) 22

American College of Obstetricians & Gynecologists, *Ethical Decision Making in Obstetrics and Gynecology,* Comm. Op. 390, 110 OBSTET. & GYNECOL. 1479 (2007) 23

American College of Obstetricians & Gynecologists, GUIDELINES FOR WOMEN'S HEALTH CARE 343 (4th ed. 2014) ....*passim*

American College of Obstetricians & Gynecologists, *Long-Acting Reversible Contraception: Implants and Inutrauterine Devices,* Practice Bulletin 186, 130 OBSTET. & GYNECOL. e251 (2017) 6

American College of Obstetricians & Gynecologists, *Well-Woman Visit*, Committee Op. 534, 120 OBSTET. & GYNECOL. 421 (2012)....................25

American Medical Association, AMA Code of Medical Ethics Op. 1.1.3, *Patient Rights*....................22

American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements,* Statement 1.4 (2015) 22

American Nurses Association, Revised Position Statement, *Protecting and Promoting Individual Worth, Dignity, and Human Rights In Practice Settings* (2016)....................23

E.A. Aztlan-James et al., *Multiple Unintended Pregnancies in U.S. Women: A Systematic Review,* 27 WOMEN'S HEALTH ISSUES 407 (2017)....................18

Jennifer S. Barber et al., *Unwanted Childbearing, Health, and Mother-Child Relationships*, 40 J. HEALTH AND SOCIAL BEHAVIOR 231 (1999)....................7

Ronald Burkman et al., *Safety Concerns and Health Benefits Associated With Oral Contraception ,* 190 AM. J. OF OBSTET. & GYNECOL. S5 (2004)....................15

Caroline S. Carlin et al., *Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women With Employer Coverage,* 35:9 HEALTH AFFAIRS 1608 (2016) 19

Centers for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, (1999). 14

Centers for Disease Control & Prevention, *Recommendations to Improve Preconception Health and Health Care – United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care* (2006) 24

Centers for Disease Control & Prevention, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010* Vol. 59 (2010) 14

Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta –Analysis,* 295 J. AM. MED. ASS'N 1809 (2006) 13

Agustin Conde-Agudelo & Jose M. Belizan, *Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross Sectional Study,* 321 BRITISH MED. J. 1255 (2000) 12

Kelly R. Culwell & Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995-2002: The Effect of Insurance Status,* 110 OBSTET. & GYN. 1371 (2007) 16

Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives,* 39 PERSP. ON SEXUAL & REPROD. HEALTH 226 (2007) 17

F. Gary Cunningham et al., WILLIAMS OBSTETRICS (23d ed. 2010)....14

Stacie B. Dusetzina et al., *Cost of Contraceptive Methods to Privately Insured Women in the United States,* 23 WOMEN'S HEALTH ISSUES e69 (2013) 18

Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374:9 NEW ENG. J. MED. 843 (2016) 10

Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006,* 84 CONTRACEPTION 478 (2011) 10

Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40:2 PERSP. ON SEXUAL & REPROD. HEALTH 94 (2008) 19

Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, Morbidity & Mortality Wkly. Rep. (Apr. 25, 2014), updated 2017, Morbidity & Mortality Wkly. Rep. (Dec. 22, 2017)....................24

Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 STUD. IN FAM. PLANNING 18 (2008) 10, 13

Rachel Benson Gold, et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Inst. (2009) 9

Rachel Benson Gold, *The Implications of Defining When a Woman is Pregnant*, 8:2 GUTTMACHER POL'Y REV. 7 (2005)..6

Guttmacher Institute, *Memo on Estimation of Unintended Pregnancies Prevented* (2017)..10

Guttmacher Institute, *Sharing Responsibility: Women, Society and Abortion Worldwide* (1999) 9

Guttmacher Institute, *Testimony of Guttmacher Institute Submitted to the Committee on Preventive Services for Women Institute of Medicine* (Jan. 12, 2011)...16, 17

Guttmacher Institute, *Unintended Pregnancy in the United States* (2016)...7, 12, 16

Lina Guzman et al., *Unintended Births: Patterns by Race and Ethnicity and Relationship Type* 42:3 PERSP. ON SEXUAL & REPROD. HEALTH (2010) 13

Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* 104 (2011)...*passim*

Rachel K. Jones & Joerg Dreweke, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, Guttmacher Inst. (April 2011) 9

Megan L. Kavanaugh et al., *Perceived and Insurance-Related Barriers to the Provision of Contraceptive Services in U.S. Abortion Care Settings,* 21 WOMEN'S HEALTH ISSUES S26 (3d Suppl. 2011) 18

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

Gladys Martinez et al., *Use of Family Planning and Related Medical Services Among Women Aged 15-44 in the United States: National Survey of Family Growth, 2006-2010*, Nat'l Health Stat. Rep. (Sept. 5, 2013) 9

Jeffrey P. Mayer, *Unintended Childbearing, Maternal Beliefs, and Delay of Prenatal Care,* 24 BIRTH 247 (1997) 7

Suezanne T. Orr et al., *Unintended Pregnancy and Preterm Birth,* 14 PEADIATRIC AND PERINATAL EPIDEMIOLOGY 309 (2000) 7

Jeffrey Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception,* 120 OBSTET. & GYNECOL. 1291 (2012) 16, 20

Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 CONTRACEPTION 360 (2007) 16

Prakesh S. Shah et al., *Intention to Become Pregnant and Low Birth Weight and Preterm Birth: A Systematic Review,* 15 MATERNAL & CHILD HEALTH J. 205 (2011) 11

Laurie Sobel et al., *The Future of Contraceptive Coverage*, Kaiser Family Foundation Issue Brief (2017) 20, 21

Adam Sonfield & Kathryn Kost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010,* Guttmacher Institute (2015) 8

Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing,* 14 GUTTMACHER POL'Y REV. 7 (2011) 20

Diana Taylor & Evelyn Angel James, *An Evidence-Based Guideline for Unintended Pregnancy Prevention,* 40:6 J. OF OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 782 (2011). 24

U.S. Department of Health and Human Service, Health Resources and Services Administration, & Maternal and Child Health Bureau, *Unintended Pregnancy and Contraception* (2011) 13

Brooke Winner et. al, *Effectiveness of Long-Acting Reversible Contraception*, 366 NEW ENG. J. MED. 1998 (2012) 17

Bao-Ping Zhu, *Effect of Interpregnancy Interval on Birth Outcomes: Findings From Three Recent U.S. Studies,* 89 INT'L J. GYNECOL. & OBSTET. S25 (2005) 13

INTEREST OF AMICI CURIAE[1]

Amici curiae are the leading health professional organizations identified below that share the common goal of improving health for all by, among other things, ensuring access to high quality medical care for women that is comprehensive and evidence-based. *Amici* believe that the overwhelming weight of the evidence establishes that access to the full range of FDA-approved prescription contraceptives is an essential component of effective health care for women and their families. *Amici* submit this brief to highlight for the Court the importance of contraception to women's preventive health care and the grave harms to women's health and public health generally presented by the Interim Final Rules, which, among other things, could have the effect of restricting access to appropriate contraception and seamless care for countless American women.

The American Nurses Association ("ANA") represents the interests of the Nation's 4.0 million registered nurses. With members in every State, ANA is comprised of state nurses associations and individual nurses. ANA is an advocate for social justice with particular attention to preserving the human rights of vulnerable groups, such as the poor, homeless, elderly, mentally ill, prisoners, refugees, women, children, and socially stigmatized groups.

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[1] No counsel for a party authored this brief in whole or in part; no counsel, party, or other person made a monetary contribution intended to fund the preparation or submission of this brief, other than *amici*, their members, or their counsel. All parties have consented to the filing of this brief.

The American College of Obstetricians and Gynecologists (ACOG) is a non-profit educational and professional organization with more than 58,000 members. ACOG's members represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States. As the leading professional association for physicians who specialize in the healthcare of women, ACOG supports access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care and is committed to encouraging and upholding policies and actions that ensure the availability of affordable and accessible contraceptive care and contraceptive methods.

The American Academy of Nursing (the "Academy") serves the public and the nursing profession by advancing health policy, practice, and science through organizational excellence and effective nursing leadership. The Academy influences the development and implementation of policy that improves the health of populations and achieves health equity including advancing policies that improve ethical and evidence-based standards of care and women's access to safe, quality sexual/reproductive health care without interference with the patient-provider relationship.

The American Academy of Pediatrics (AAP) was founded in 1930 and is a national, not-for-profit professional organization dedicated to furthering the interests of child and adolescent health. Since the AAP's inception, its

membership has grown from 60 physicians to over 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past 88 years, the AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. The AAP has worked with the federal and state governments, health care providers, and parents on behalf of America's children and adolescents to ensure the availability of safe and effective contraceptives.

Physicians for Reproductive Health (PRH) is a doctor-led national not-for-profit organization that relies upon evidence-based medicine to promote sound reproductive health care policies. Comprised of physicians, PRH brings medical expertise to discussions of public policy on issues affecting reproductive health care and advocates for the provision of comprehensive reproductive health services as part of mainstream medical care.

The California Medical Association (CMA) is a non-profit, incorporated professional association for physicians with approximately 43,000 members throughout the state of California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA's physician members practice medicine in all specialties and settings, including providing comprehensive reproductive health services.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act (ACA) made prevention a priority in the nation's health care policy by requiring private health insurance plans to cover various essential preventive care services with no additional cost sharing for the patient. Among the preventive services that the ACA requires be covered, without deductible or co-pay, are screenings for various conditions, such as cholesterol tests and colonoscopy screenings, pediatric and adult vaccinations, as well as women's preventive health services, including FDA-approved contraceptives prescribed by a health care provider. Well-established and evidence-based standards of medical care recommend access to contraception and contraception counseling as essential components of health care for women of childbearing age.

Contraception not only helps to prevent unintended pregnancy, but it also helps to protect the health and well-being of women and their children. The benefits of contraception are widely recognized and include improved health and well-being, reduced maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women. Conversely, the existence of cost and other barriers to access have been shown to reduce the consistent use of appropriate contraception, thereby increasing the risk of unintended pregnancies and all of the attendant

consequences. The contraception coverage requirement recognizes that women of childbearing age have unique health needs and that contraception counseling and services are essential components of women's routine preventive health care.

However, the two interim final rules promulgated by the Department of Health and Human Services (the "IFRs") here at issue threaten to strip from countless women nationwide the no-cost contraceptive coverage required under the ACA. The breadth of the IFRs, which allow any employer or health insurance provider to exclude contraceptive coverage by invoking religious or moral objections, greatly expands the category of persons who may opt their employees out from contraceptive coverage. The IFRs threaten the health of women and families throughout the United States, undermining Congress' very objective in making comprehensive preventive women's healthcare widely accessible and disrupts the seamless provision of health care within the existing patient-provider relationship. As recognized by the District Court, "for a substantial number of women, the 2017 IFRs transform contraceptive coverage from a legal entitlement to an essentially gratuitous benefit wholly subject to their employer's discretion." ER 25-26. Without affirmance of the District Ccourt's ruling, access to a critical component of women's preventive healthcare will be compromised for countless American women – and all without affording parties such as amici notice and an opportunity required by the Administrative Procedure Act, 5 U.S.C. §§ 500 *et seq.*,

to air the substantial public health issues raised here. *Amici*, who include the leading health professionals providing women's health care, therefore urge this Court to affirm.

ARGUMENT

POINT I.

THE CHANGES EFFECTED BY THE IFRS THREATEN THE IMPORTANT PUBLIC INTEREST IN ENSURING THAT WOMEN HAVE ACCESS TO CONTRACEPTIVE INSURANCE COVERAGE AT NO ADDITIONAL COST

A. Contraception is an Essential Component of Women's Preventive Health Care[2]

The ACA's coverage requirement for FDA-approved contraceptives and counseling comports with prevailing standards of care in the medical community. *See, e.g.*, Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 104 (2011) ("IOM Report") (noting recommendation of the use of family planning services as part of preventive care for women by numerous health professional

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[2] Despite the erroneous use of the terms "abortion" and "abortifacients" throughout the Briefs of Appellants and their *amici* (*see, e.g.,* Brief for Intervenor-Appellant-Defendant March for Life at 2, 4, 5, 6, 17, 45; *Amicus Curiae* Brief of Religious Sisters of Mercy at 10; *Amicus Curiae* Brief of Constitutional Law Scholars at 7, 19; *Amicus Curiae* Brief of First Liberty Institute at 24), none of the FDA-approved drugs or devices cause abortion; rather, they prevent pregnancy. Medically speaking, pregnancy begins only upon implantation of a fertilized egg in the uterine lining. *See, e.g.,* Rachel Benson Gold, *The Implications of Defining When a Woman is Pregnant*, 8:2 GUTTMACHER POL'Y REV. 7 (2005); Am. Coll. of Obstetricians & Gynecologists, *Long-Acting Reversible Contraception: Implants and Inutrauterine Devices,* Practice Bulletin 186, 130 OBSTET. & GYNECOL. e251, e252-253 (2017) (available evidence supports that mechanism of action for intrauterine devices is preventing fertilization and not disrupting pregnancy). The terms "abortion" and "abortifacient" refer to – and should only be used in connection with – the termination of a pregnancy, not the prevention of it.

organizations). Indeed, in recommending that contraceptive methods and counseling be included within the preventive services required by the ACA, the Institute of Medicine ("IOM") recognized that the risk of unintended pregnancy affects a broad population and poses a significant impact on health. IOM Report 8. Unintended pregnancies have long been established to have negative health consequences for women and children and contraception services are, therefore, critically important public health concerns. *See, e.g.,* Jeffrey P. Mayer, *Unintended Childbearing, Maternal Beliefs, and Delay of Prenatal Care*, 24 BIRTH 247, 250-51 (1997); Suezanne T. Orr et al., *Unintended Pregnancy and Preterm Birth*, 14 PEADIATRIC AND PERINATAL EPIDEMIOLOGY 309, 312 (2000); Jennifer S. Barber et al., *Unwanted Childbearing, Health, and Mother-Child Relationships*, 40 J. HEALTH AND SOCIAL BEHAVIOR 231, 252 (1999). Reducing the unintended pregnancy rate is a national public health goal. The U.S. Department of Health and Human Services' Healthy People 2020 campaign aims to increase the proportion of pregnancies that are intended by 10% between 2010 and 2020. *See* Guttmacher Inst., *Unintended Pregnancy in the United States,* 2 (2016), https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

The human cost of unintended pregnancy is high: women must either carry an unplanned pregnancy to term and keep the baby or make a decision for

adoption, or choose to undergo abortion. Women and their families may struggle with this challenge for medical, ethical, social, legal, and financial reasons. Am. Coll. of Obstetricians & Gynecologists, *Access to Contraception,* Comm. Op. 615, Jan. 2015 (reaffirmed 2017). Additionally, unintended pregnancies impose significant financial costs as well. Unplanned pregnancies cost approximately $21 billion in government expenditures in 2010. Adam Sonfield & Kathryn Kost, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*. Guttmacher Institute (2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf. As reported by the Institute of Medicine, California alone averted costs of over $5 billion dollars over 5 years attributable to unintended pregnancies through an in-state family planning service. IOM Report at 107. The significant financial costs associated with unintended pregnancies were recognized by the District Court. *See, e.g.*, ER 14 (crediting Plaintiffs' demonstration of financial impact and finding that the IFRs' financial impact on the States corresponds with the impact on their citizens). *See also* ER 168-177 (summarizing, *inter alia*, state-specific fiscal impact of IFRs); Plaintiffs-Appellees' Answering Brief at 55-57 (same).

Access to contraception is a medical necessity for women during approximately thirty years of their lives—from adolescence to menopause. *See* Rachel Benson Gold, et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Inst. (2009), http://www.guttmacher.org/pubs/NextSteps.pdf; *see also* Gladys Martinez et al., *Use of Family Planning and Related Medical Services Among Women Aged 15-44 in the United States: National Survey of Family Growth, 2006-2010*, Nat'l Health Stat. Rep. (Sept. 5, 2013), http://www.cdc.gov/nchs/data/nhsr/nhsr068.pdf. Without the ability to control her fertility during her childbearing years, a woman may experience approximately twelve pregnancies during her lifetime. Guttmacher Inst., *Sharing Responsibility: Women, Society and Abortion Worldwide,* 18 (1999), https://www.guttmacher.org/pubs/sharing.pdf.

Virtually all American women who have had heterosexual sex have used contraception at some point during their lifetimes, irrespective of their religious affiliation. Rachel K. Jones & Joerg Dreweke, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, Guttmacher Inst. (April 2011), http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf. At any given time, approximately two-thirds of American women of reproductive age wish to avoid or postpone pregnancy. Am. Coll. of Obstetricians & Gynecologists,

GUIDELINES FOR WOMEN'S HEALTH CARE 343 (4th ed. 2014) ("ACOG GUIDELINES"). Given their unique reproductive health needs, access to contraception is a basic and essential preventive service for women.

1. Unintended Pregnancy and Short Interpregnancy Intervals Pose Health Risks to Women and Children

Unintended pregnancy remains a significant public health concern in the United States; the unintended pregnancy in the United States is substantially higher than that in other highly industrialized regions of the world. Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006,* 84 CONTRACEPTION 478, 478, 482 (2011); ACOG GUIDELINES at 343. Approximately 45% of all pregnancies in the United States are unintended. Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374:9 NEW ENG. J. MED. 843-852 (2016), http://nejm.org/doi/full/10.1056/NEJMsa1506575; *see also* ACOG GUIDELINES at 343. In 2011, 34% of all unintended pregnancies ended with abortions. Guttmacher Institute, *Memo on Estimation of Unintended Pregnancies Prevented* (2017), https://www.guttmacher.org/sites/default/files/pdfs/pubs/Guttmacher-Memo-on-Estimation-of-Unintended-Pregnancies-Prevented-June-2017.pdf.

Women with unintended pregnancies are more likely to receive delayed prenatal care and to be anxious or depressed during pregnancy. Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health:*

A Review of the Literature, 39 STUD. IN FAM. PLANNING 18, 22, 28-29 (2008). Women with unintended pregnancies are also less likely to breastfeed, which has been shown to have health benefits for the mother and her child. *See* Am. Acad. of Pediatrics, *Policy Statement: Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS 827, 831 (2012) (noting maternal benefits of breastfeeding, including less postpartum blood loss and fewer incidents of postpartum depression and child benefits, including fewer ear infections, respiratory and gastrointestinal illnesses and fewer allergies and lower rate of obesity and diabetes).

A woman's unintended pregnancy may also have lasting effect on her child's health; low birth weight and preterm birth, which have long term sequela, are associated with unintended pregnancies. Prakesh S. Shah et al., *Intention to Become Pregnant and Low Birth Weight and Preterm Birth: A Systematic Review*, 15 MATERNAL & CHILD HEALTH J. 205, 205-206 (2011).

Contraception is undeniably effective at reducing unintended pregnancy. The approximately 68% of U.S. women at risk for unintended pregnancies who use contraceptives consistently and correctly throughout the course of any given year account for only 5% of all unintended pregnancies. By contrast, the 18% of women at risk who use contraceptives inconsistently or incorrectly account for 41% of all unintended pregnancies. The remaining 14% of women at risk for unintended pregnancies who do not practice contraception at all or who have gaps

of a month or more during the year account for 54% of all unintended pregnancies. Guttmacher Inst., *Unintended Pregnancy in the United States* 2 (September, 2016), https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

Contraception not only helps to avoid unwanted pregnancies, but it also helps women plan their pregnancies and determine the optimal timing and spacing of them, which improves their own health and the well-being of their children. Pregnancies that are too frequent and too closely spaced, which are more likely when contraception is more difficult to obtain, put women at significantly greater risk for permanent physical health damage. Such damage can include: uterine prolapse (downward displacement of the uterus), rectocele (hernial protrusion of the rectum into the vagina), cystocele (hernial protrusion of the urinary bladder through the vaginal wall), rectus muscle diastasis (separation of the abdominal wall) and pelvic floor disorders. Additionally, women with short interpregnancy intervals are at greater risk for third trimester bleeding, premature rupture of membranes, puerperal endometritis, anemia, and maternal death. Agustin Conde-Agudelo & Jose M. Belizan, *Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross Sectional Study*, 321 BRITISH MED. J. 1255, 1257 (2000).

Inadequate spacing between pregnancies can also be detrimental to the child. Studies have linked unintended childbearing with a number of adverse prenatal and perinatal outcomes, including inadequate or delayed initiation of prenatal care, prematurity, low birth weight, absence of breastfeeding, poor maternal mental health, and reduced mother-child relationship quality. U.S. Department of Health and Human Service, Health Resources and Services Administration, & Maternal and Child Health Bureau, *Unintended Pregnancy and Contraception* (2011), http://www.mchb.hrsa.gov/whusa11/hstat/hsrmh/pages/227upc.html Gipson, *supra;* Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta -Analysis,* 295 J. AM. MED. ASS'N 1809, 1821 (2006); Bao-Ping Zhu, *Effect of Interpregnancy Interval on Birth Outcomes: Findings From Three Recent U.S. Studies*, 89 INT'L J. GYNECOL. & OBSTET. S25, S26, S31 (2005); Am. Acad. Of Pediatrics & Am. Coll. of Obstetricians & Gynecologists, GUIDELINES FOR PERINATAL CARE, 205-206 (8th ed. 2017). Some studies find that children born as a result of unintended pregnancies, particularly when the birth is unwanted, have poorer physical and mental health and have mother-child relationships that are less close, as compared with children from pregnancies that were intended. Gipson, *supra*; Lina Guzman et al., *Unintended Births: Patterns by Race and Ethnicity and Relationship Type*, 42:3 PERSP. ON SEXUAL & REPROD. HEALTH 176-185 (2010).

Because of these recognized benefits of contraceptives, the Centers for Disease Control and Prevention identified family planning as one of the greatest public health achievements of the twentieth century, finding that smaller families and longer birth intervals contribute to the better health of infants, children, and women, as well as improving the social and economic roles of women. Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, (1999), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm.

2. For Women with Certain Medical Conditions or Risks, Contraception Is a Medical Necessity

Contraception also helps protect the health of those women for whom pregnancy can be hazardous, or even life-threatening. Ctrs. for Disease Control & Prevention, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010* Vol. 59 (2010), http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf. Women with certain chronic conditions such as heart disease, diabetes mellitus, hypertension and renal disease, are at risk for complications during pregnancy. Other chronic conditions complicated by pregnancy include sickle-cell disease, cancer, epilepsy, lupus, rheumatoid arthritis, hypertension, asthma, pneumonia and HIV. *See generally*, F. Gary Cunningham et al., WILLIAMS OBSTETRICS 958-1338 (23d ed. 2010); ACOG GUIDELINES at 187; *see also Harris v. McRae*, 448 U.S. 297, 339 (1980) (Marshall, J., dissenting) ("Numerous conditions—such as cancer, rheumatic fever, diabetes, malnutrition, phlebitis, sickle cell anemia, and heart disease—substantially

increase the risks associated with pregnancy or are themselves aggravated by pregnancy."). Contraception allows women with these and other conditions to care for their own health and avoid complications for themselves or their fetuses because of an unintended pregnancy. *See* ACOG GUIDELINES at 187.

In addition to preventing pregnancy, contraception has other scientifically recognized health benefits for many women. Hormonal birth control helps address several menstrual disorders, helps prevent menstrual migraines, treats pelvic pain from endometriosis, and treats bleeding from uterine fibroids. Ronald Burkman et al., *Safety Concerns and Health Benefits Associated With Oral Contraception*, 190 AM. J. OF OBSTET. & GYNECOL. S5, S12 (2004). Oral contraceptives have been shown to have long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, protecting against pelvic inflammatory disease and certain benign breast disease and short-term benefits in protecting against colorectal cancer. *Id.* *See also* IOM Report at 107.

B. Providing Contraceptive Coverage At No Additional Cost Promotes Use of Effective and Medically Appropriate Contraception

The rate of unintended pregnancy among poor women (those with incomes below the federal poverty level) was 112 per 1,000 in 2011. Guttmacher Inst., *Unintended Pregnancy in the United States*, 2 (September 2016), https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-

us_0.pdf. In 2014, publicly funded family planning services helped women avoid two million unintended pregnancies, which would likely have resulted in nearly 700,000 abortions. *Id*.

Insurance coverage has been shown to be a "major factor" for a woman when choosing a contraceptive method and determines whether she will continue using that method. Kelly R. Culwell & Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995-2002: The Effect of Insurance Status*, 110 OBSTET. & GYN. 1371, 1378 (2007). *See also* Guttmacher Inst., *Testimony of Guttmacher Institute Submitted to the Committee on Preventive Services for Women Institute of Medicine,* 8 (Jan. 12, 2011), http://www.guttmacher.org/pubs/CPSW-testimony.pdf ("Guttmacher Testimony") ("Several studies indicate that costs play a key role in the contraceptive behavior of substantial numbers of U.S. women."); Jeffrey Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTET. & GYNECOL. 1291, 1291 (2012) (when over 9,000 study participants were offered the choice of any contraceptive method at no cost, 75% chose long-acting methods, such as the intrauterine device ("IUD") or implant); Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 CONTRACEPTION 360, 360 (2007) (elimination of cost-sharing for contraceptives at Kaiser Permanente Northern California resulted in significant increases in the use of the most effective forms of contraceptives);

Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives,* 39 PERSP. ON SEXUAL & REPROD. HEALTH 226, 226 (2007) (study reveals that uninsured women were 30% less likely to use prescription contraceptives than women with some form of health insurance).

Women regularly identify insurance coverage as having an impact on their choice of a method of contraception. Approximately one-third of women using contraception report that they would change their contraceptive method if cost were not an issue. Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills Between 1996 and 2006*, 83 CONTRACEPTION 528, 531 (2011). Lack of insurance coverage deters many women from choosing a high-cost contraceptive, even if that method is best for her, and may result in her resorting to an alternative method that places her more at risk for medical complications or improper or inconsistent use, with the attendant risk of unintended pregnancy. The IUD, for example, a long-acting reversible contraceptive ("LARC") that does not require regular action by the user, is among the most effective forms of contraception, but it has up-front costs of between $500 and $1000.[3] IOM Report at 108; *see also* Brooke Winner et. al, *Effectiveness of Long-Acting Reversible Contraception*, 366 NEW ENG. J. MED. 1998, 2004-05

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[3] The IUD, as well as sterilization and the implant have failure rates of 1% or less. Failure rates for injectable or oral contraceptives are 7% and 9% respectively, due to some women skipping or delaying an injection or pill. Guttmacher Testimony at 2.

(2012) (a study of 7,486 participants found that participants who used oral contraceptive pills, the patch or vaginal ring had a risk of contraceptive failure that was 20 times as high as the risk among those using LARC, and a failure rate of 4.55 per 100 participants, as compared with .27 for those using LARC and that study participants who were younger than 21, using oral contraception, the patch or ring, had almost twice the risk of unintended pregnancy as older women using the same methods); Megan L. Kavanaugh et al., *Perceived and Insurance-Related Barriers to the Provision of Contraceptive Services in U.S. Abortion Care Settings*, 21 WOMEN'S HEALTH ISSUES S26, S26 (3d Suppl. 2011) (finding that cost can be a barrier to the selection and use of LARCs and other effective forms of contraceptives, such as the patch, pills, and the ring); E.A. Aztlan-James et al., *Multiple Unintended Pregnancies in U.S. Women: A Systematic Review*, 27 WOMEN'S HEALTH ISSUES 407 (2017). The out-of-pocket cost for a woman to initiate LARC methods was 10 times higher than a 1-month supply of generic oral contraceptives. Stacie B. Dusetzina et al., *Cost of Contraceptive Methods to Privately Insured Women in the United States,* 23 WOMEN'S HEALTH ISSUES e69, e70 (2013). A study of women at high risk of unintended pregnancy who had free access to and used highly effective methods of contraception had much lower rates of unintended pregnancy than did those who used other methods, including commonly used methods such as the oral contraceptive pill. Among adolescents,

oral contraceptives have been found to be less effective due to faulty compliance (*e.g.,* not taking the pill every day or at the right time of day), and therefore more passive contraceptive methods like IUDs and other LARCS are often preferable, but they have forbidding up-front costs. Am. Acad. of Pediatrics, *Policy Statement: Contraception and Adolescents*, 120 PEDIATRICS 1135, 1136 (2007).

A study of nearly 30,000 women and girls showed that compliance with the ACA's requirement that contraception be covered with no cost-sharing significantly increased the probability that a woman would choose a long-term contraceptive. The estimates resulting from that study predict that eliminating out of pocket spending on contraception increases the overall rate of choosing prescription contraceptives, and long term options in particular. Caroline S. Carlin et al., *Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women With Employer Coverage*, 35:9 HEALTH AFFAIRS 1608-1615 (2016).

Women and couples are more likely to use contraception successfully when they are given their contraceptive method of choice. Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40:2 PERSP. ON SEXUAL & REPROD. HEALTH 94, 103 (2008). A national survey conducted in 2004 found that one-third of women using contraception would switch methods if cost was not a factor. *Id*. A more

recent study of over 9,000 adolescents and women desiring reversible contraception, for which all participants received their choice of contraceptive at no cost, resulted in a significant reduction in abortion rates and teenage birth rates. The study concluded that "unintended pregnancies may be reduced by providing no-cost contraception and promoting the most effective contraceptive methods." Peipert et al., 120 OBSTET. & GYNECOL. at 1291. When relieved of cost-sharing, women choose these methods more often, with significant implications for the rate of unintended pregnancy and associated costs of childbirth. Laurie Sobel et al., *The Future of Contraceptive Coverage*, Kaiser Family Foundation Issue Brief (2017), https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/

Even seemingly insubstantial additional cost requirements can dramatically reduce women's use of health care services. Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing,* 14 GUTTMACHER POL'Y REV. 7, 10 (2011). Pre-ACA conventional coverage alone has been shown to be insufficient, as co-pays and deductibles required by insurance plans may still render the most effective contraception unaffordable. *See* Am. Coll. of Obstetricians & Gynecologists, *Access to Emergency Contraception,* Comm. Op. 542 (2012), 120 OBSTET. & GYNECOL. 1250, 1251 (2012) (citing Jodi Nearns, *Health Insurance Coverage and Prescription Contraceptive Use Among*

Young Women at Risk for Unintended Pregnancy, 79 CONTRACEPTION 105 (2009)) (financial barriers, including lack of insurance, or substantial co-payments or deductibles, may deprive women of access to contraception). By 2013, most women had no out-of-pocket costs for their contraception, as median expenses for most contraceptive methods, including the IUD and the pill, dropped to zero. Sobel et al, *supra*.

Data compiled over several decades demonstrate the significant health benefits to women and children when a woman can delay the birth of her first child and plan the spacing of any subsequent children. The government has a compelling interest in reducing unintended pregnancies by facilitating access to the full range of FDA-approved contraceptives so that women who choose to use contraception can make their decisions based on evidence-based policies and standards of care, rather than ability to pay.

POINT II.

THE IFRS RESTRICT ACCESS TO CARE AND COMPROMISE THE PATIENT PROVIDER RELATIONSHIP BY DIVORCING REPRODUCTIVE HEALTH FROM OTHER PREVENTIVE HEALTH CARE

By establishing additional exemptions that allow individual employers to opt out of contraceptive coverage, including on the basis of moral convictions not based in any particular religious belief, the IFRs will undeniably result in less coverage for contraceptives for those women who want it. If an employee is

covered under a family plan from which the employer opts out of contraception coverage, that would jeopardize contraception access for both adolescent and adult dependents covered under the same plan. Additionally, by making the existing accommodation a voluntary alternative to outright exemption, the IFRs not only limit access to contraceptive coverage under a woman's current health plan, but may also limit access to contraception coverage entirely. The IFR provides no accommodation or other solution for women whose employer claims a moral objection to access contraception, aside from purchasing a separate contraceptive care plan on their own. The IFRs, thus, threaten access to seamless care for a countless number of women, resulting in grave harm to the public health.

A. The IFRs Undermine the Patient-Provider Relationship

The patient-provider relationship is essential to all health care. The health care professional and the patient share responsibility for the patient's health, and the well-being of the patient depends upon their collaborative efforts. Am. Med. Ass'n, AMA Code of Medical Ethics Op. 1.1.3, *Patient Rights,* *https://www.ama-assn.org/delivering-care/patient-rights/* *See also* Am. Coll. of Obstetricians & Gynecologists, *Elective Surgery and Patient Choice,* Comm. Op. 578, 122 OBSTET. & GYNECOL. 1134, 1135 (2013) ("The goal should be decisions reached in partnership between patient and physician."); Am. Nurses Ass'n, *Code of Ethics for Nurses with Interpretive Statements,* Statement 1.4 at 2-3 (2015) (Patients are

to "be given necessary support throughout the decision-making and treatment process, …[including] the opportunity to make decisions with family and significant others and to obtain advice from expert, knowledgeable … health professionals.").

Within the patient-provider relationship, the provider's obligation to patient autonomy is fundamental. Am. Coll. of Obstetricians & Gynecologists, *Code of Professional Ethics,* http://www.acog.org/About_ACOG/~/media/Departments/National%20Officer%20Nominations%20Process/ACOGcode.pdf. "In medical practice, the principle of respect for autonomy implies personal rule of the self that is free . . . from controlling interferences by others." Am. Coll. of Obstetricians & Gynecologists, *Ethical Decision Making in Obstetrics and Gynecology,* Comm. Op. 390, 110 OBSTET. & GYNECOL. 1479, 1481 (2007). *Cf. Doe v. Bolton*, 410 U.S. 179, 197 (1973) (recognizing a "woman's right to receive medical care in accordance with her licensed physician's best judgment . . ."); *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 289 (1990) (O'Connor, J., concurring) (recognizing "patient's liberty, dignity, and freedom to determine the course of her own treatment"); Am. Nurses Ass'n. Revised Position Statement, *Protecting and Promoting Individual Worth, Dignity, and Human Rights In Practice Settings* (2016), https://www.nursingworld.org/~4ad4a8/globalassets/docs/ana/nursesrole-

ethicshumanrights-positionstatement.pdf (emphasizing the patient's right to self-determination, "including the right to choose or decline care").

The decision as to whether to use contraception, and if so, the best form for the patient, should, therefore, take place within this established relationship. This is particularly true given the intimate nature of the reproductive health and family planning services that are at issue here. CDC Guidelines, health professional organizations and women's health experts have recommended tools and guidelines for effective education and counselling for reproductive life planning and unintended pregnancy prevention. *See, e.g.*, Ctrs. for Disease Control & Prevention, *Recommendations to Improve Preconception Health and Health Care – United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care* (2006), http://www.cdc.gov/mmwr/pdf/rr/rr5506.pdf; *see also* Diana Taylor & Evelyn Angel James, *An Evidence-Based Guideline for Unintended Pregnancy Prevention,* 40:6 J. OF OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 782-793 (2011). An evidence-based report issued by the CDC in 2014 and updated in 2017 demonstrates the importance of effective patient-provider communication about reproductive life planning. *See* Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, Morbidity & Mortality Wkly. Rep. (Apr. 25, 2014),

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w, *updated* 2017, Morbidity & Mortality Wkly. Rep. (Dec. 22, 2017), http://dx.doi.org/10.15585/mmwr.mm6650a4.

Prescribing birth control is typically far more intimate and intrusive than simply signing a prescription pad; in addition to medical screening to ensure that a particular birth control method is not contraindicated, a pelvic exam is required when prescribing a diaphragm or cervical cap or inserting an IUD. A pelvic exam may also be warranted before prescribing other types of contraceptives, based on the woman's medical history. Am. Coll. of Obstetricians & Gynecologists, *Well-Woman Visit*, Committee Op. 534, 120 OBSTET. & GYNECOL. 421, 422 (2012). Women should be able to make these personal decisions – decisions that often require sharing intimate details of their sexual history and family planning – with providers they have sought out and trust. These decisions should not be influenced by a patient's employers' particular moral beliefs.

B. At Best, the IFRs Create a Two-Tiered System that Undermines Seamless and Equal Access to Care for Women

For many women of reproductive age, their well-woman visits are their primary, if not exclusive contact with the health care system. ACOG GUIDELINES at 201. Yet, the IFRs could remove contraceptive care from coverage under a woman's health insurance plan that applies to her other routine health services, or

could remove from coverage the form of contraception that is most appropriate for her. This would require her to use a two-tiered system of access and coverage, assuming such option is even available – one for her overall health needs and one limited to contraceptive care – or to pay out of pocket for these services. *See, e,g.,* Brief of Federal Appellants at 27 (asserting no cognizable injury if women whose employers seek an exemption under the IFR can obtain the desired contraceptive coverage under another plan or if they "simply pay[] out of pocket for contraception"); Brief of Appellant March for Life at 40 (noting that the universe of women affected by the IFRs are "women with health insurance" who are "more likely [ ] able to bear the cost of contraceptives"). Even if such two-tiered system were available and utilized, requiring women to obtain additional coverage for what should be a routine health care service falls far short of the express directive of the Supreme Court that women covered by insurance plans of any employer objecting to the provision of contraceptive coverage still "receive full and equal health coverage, including contraceptive coverage." *Zubik v. Burwell*, 136 S. Ct. 1557, 1560 (2016). As Justice Sotomayor aptly recognized in her concurring opinion in that case:

> Requiring standalone contraceptive-only coverage would leave in limbo all of the women now guaranteed seamless preventive-care coverage under the Affordable Care Act. And requiring that women affirmatively opt into such coverage would 'impose precisely the kind of barrier to

> the delivery of preventive services that Congress sought to eliminate.

Id. at 1561(noting that lower courts could "consider only whether existing or modified regulations could provide *seamless contraceptive coverage* 'to petitioners' employees through petitioners' insurance companies . . .") (emphasis added). The IFRs impermissibly deny women access to the full range of preventive services to which they are entitled under the ACA. The IFRs represent a significant step backwards in achieving the goals of the ACA of, among other things, expanding access to and improving preventive care services for women and reducing the gender disparities with respect to the cost of health care services.

CONCLUSION

Amici respectfully urge that the judgment of the District Court be affirmed.

Dated: May 29, 2018

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29, I certify that the within brief is proportionally spaced, has a typeface of 14 points, and complies with the word count limitations set forth in Fed. R. App. P. 29(a)(5). This Brief has 5,722 words, excluding the portions exempted by Fed. R. App. P. 32, as determined by the word count feature of Microsoft Word used to generate this Brief.

Dated: May 29, 2018

By: s/ Bruce H. Schneider
Bruce H. Schneider

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the within brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on May 29, 2018. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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