Case No. 19-10754

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

RICHARD W. DEOTTE; YVETTE DEOTTE; JOHN KELLEY; ALISON KELLEY; HOTZE HEALTH & WELLNESS CENTER; BRAIDWOOD MANAGEMENT, INCORPORATED,
Plaintiffs-Appellees,

v.

ALEX M. AZAR, II, SECRETARY,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; STEVEN T. MNUCHIN, SECRETARY, U.S. DEPARTMENT OF TREASURY; EUGENE SCALIA, SECRETARY, U.S. DEPARTMENT OF LABOR; UNITED STATES OF AMERICA,
Defendants,

and

STATE OF NEVADA,
Movant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

BRIEF OF *AMICI CURIAE* MASSACHUSETTS, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, THE DISTRICT OF COLUMBIA, HAWAII, ILLINOIS, MAINE, MARYLAND, MICHIGAN, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, OREGON, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON

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Pursuant to Fifth Circuit Rule 28.2, the undersigned counsel certifies the following governmental entities have joined this *amicus curiae* brief, represented by the following list of counsel. These representations are made so the judges of this court may evaluate potential disqualification or recusal.

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INTERESTS OF AMICI

Like the State of Nevada, the *Amici* States—Massachusetts, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington—have compelling interests in protecting the health, well-being, and economic security of our residents. To promote these interests, the *Amici* States are committed to ensuring that contraception is as widely available and affordable as possible. Access to contraception advances educational opportunity, workplace equality, and financial empowerment for women; improves the health of women and children; and reduces healthcare-related costs for individuals, families, and the States.

The Women's Health Amendment to the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 300gg-13(a)(4), plays a critical role in securing our residents' access to full and equal healthcare coverage, including contraception. Most women receive health care coverage through employer-based health plans. While 29 states including Nevada have laws that require employer-based plans to cover contraception,[1] federal law preempts state regulation of self-

[1] Guttmacher Institute, *Insurance Coverage of Contraceptives* (Dec. 1, 2019), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives.

insured plans, which cover the majority of employees and their dependents.[2] The ACA fills the resulting gap: as part of its mandate that health plans fully cover preventive care for women, it guarantees comprehensive, no-cost coverage for contraception (the "contraceptive mandate"), including to the tens of millions of residents whose plans federal law places beyond the reach of state legislative action. The *Amici* States thus have a strong interest in ensuring that the ACA continues to advance women's health and equality, as the law requires and as Congress intended.[3]

While the *Amici* States also share interests in ensuring that our residents enjoy free exercise of religion under both the U.S. Constitution and our respective state constitutions, the contraceptive mandate, as modified by an accommodation for objecting employers, is fully consistent with those interests. And, as this Court

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[2] *See* U.S. Dep't of Health & Human Services, Medical Expenditure Panel Survey, *Percent of Private-Sector Enrollees That Are Enrolled in Self-Insured Plans at Establishments That Offer Health Insurance by Firm Size and State: United States, 2016* (2019) https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiib2b1.pdf.

[3] Reflecting the *Amici* States' strong interest in the litigation at issue here, a number of the *Amici* States are parties to other litigation concerning whether the federal government's effort to create broad exemptions from the contraceptive mandate is legal. *See Massachusetts v. Dep't of Health & Human Servs. et al.*, No. 17-11930 (D. Mass.), *on remand from* 923 F.3d 209 (1st Cir. 2019); *Pennsylvania et al. v. Trump et al.*, No. 17-4540 (E.D. Pa.), *preliminary injunction aff'd*, 930 F.3d 543 (3d Cir. 2019), *cert. petitions pending*, Nos. 19-431, 19-454; *California et al. v. Dep't of Health & Human Servs. et al.*, No. 17-5783 (N.D. Cal.), *preliminary injunction aff'd*, 941 F.3d 410 (9th Cir. Oct. 22, 2019).

has already concluded, the mandate and accommodation are also consistent with the Religious Freedom Restoration Act ("RFRA"), 42 U.S.C. §§ 2000bb *et seq.* *See E. Tex. Baptist Univ. v. Burwell*, 793 F.3d 449, 463 (5th Cir. 2015), *vacated by Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (*per curiam*).

ARGUMENT

The State of Nevada moved to intervene in the District Court to ensure that its interests in its residents' access to cost-free contraceptive care and services, interests shared by all the *Amici* States and secured by the ACA, are represented in this litigation spanning nationwide plaintiff-classes. Especially under the "unique" circumstances of this case recognized by the District Court itself, *DeOtte v. Azar*, 332 F.R.D. 173, 181-82 (N.D. Tex. 2019)—namely, the federal government's abandonment of its years-long defense of the ACA's contraceptive mandate against RFRA challenges, a defense that had previously prevailed in this very Court—the District Court should have granted Nevada's motion.

The requisite "practical analysis of the facts and circumstances" readily demonstrates that Nevada was entitled to intervene as of right under Fed. R. Civ. P. 24. *Brumfield v. Dodd*, 749 F.3d 339, 342 (5th Cir. 2014). Nevada's motion was timely filed "without undue delay" after the federal government's switch of position, as the District Court below found. *DeOtte*, 332 F.R.D. at 181-82. And, for the reasons further described below, Nevada also met Rule 24's three other criteria.

See Brumfield, 749 F.3d at 341. First, Nevada has strong interests, shared by the *Amici* States, in the subject of this action: our residents' access to full and equal health coverage is critical to their health, well-being, and economic security, and the ACA's contraceptive mandate serves a key role in guaranteeing this access. Second, an adverse outcome in this nationwide class action would, "as a practical matter, impair or impede [Nevada's] ability to protect" these shared interests, *id.* (quotation omitted), and, indeed, would inflict broad harms on the States and their residents: potentially causing thousands of women to lose access to contraceptive coverage as well as imposing costs on the States from increased reliance on state-funded programs that provide contraception and from unintended pregnancies. Third and finally, the existing parties could not—or, in the federal government's case, expressly declined to—adequately represent the interests of Nevada and all the *Amici* States in upholding this ACA provision.

I. The States, Including Nevada, Have a Common Interest in Ensuring the Contraceptive Mandate Remains in Effect.

States have a legally protected interest in safeguarding public funds, securing the health and safety of their residents, and in ensuring that those residents are not improperly denied rights and benefits provided by federal law. *See Texas v. United States*, 805 F.3d 653, 659 (5th Cir. 2015) (an interest is sufficient to support intervention "if it is of a type that the law deems worthy of protection, even if the intervenor does not have an enforceable legal entitlement [to

the relief sought]”). As Congress concluded in passing the Women’s Health Amendment, access to contraception is critical to the health, well-being, and economic security of the States’ residents, and the ACA plays an essential part in ensuring that access.[4] The *Amici* States and Nevada thus share a common interest in protecting their residents’ access to “full and equal health coverage, including contraceptive coverage,” *Zubik*, 136 S. Ct. at 1560, as guaranteed by the ACA: a “direct, substantial, and legally protected interest,” and a “stake in the matter” sufficient to support intervention. *Texas*, 805 F.3d at 657 (internal quotation marks omitted).

A. Access to full and equal health coverage, including contraceptive coverage, is critical to the health, well-being, and economic security of the States’ residents.

More than 38 million women of child-bearing age reside in the *Amici* States and Nevada.[5] Access to contraception, and particularly to no-cost contraception,

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[4] *See* Brief of Massachusetts et al. as *Amici Curiae*, *California v. U.S. Dep’t of Health & Human Servs.*, No. 19-15072, 2019 WL 1937360 (9th Cir. Apr. 22, 2019) (collecting legislative history demonstrating Congress’ intent for women to receive full and equal coverage for preventive care and services, including contraceptive coverage in particular); *see, e.g.*, 155 Cong. Rec. S12027 (Dec. 1, 2009) (describing discrepancies in coverage and care suffered by women, including that “women of child-bearing age spend 68 percent more in out-of-pocket health care costs than men”).

[5] *See* Kaiser Family Foundation, *Health Insurance Coverage of Women Ages 15-49* (2018), https://www.kff.org/other/state-indicator/health-insurance-coverage-of-women-ages-15-49.

not only affects myriad aspects of these women's lives and their families' well-being, but also enhances public health and our States' economies more broadly.

Contraception reduces the risk of unintended pregnancies, adverse pregnancy outcomes, and other negative health consequences.[6] And by enhancing women's control over their bodies, contraception gives them the power to choose if and how they pursue educational, employment, and other opportunities. For this reason, access to contraception is essential for "women to participate equally in the economic and social life of the Nation." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992).

Overwhelming empirical evidence shows that, in turn, access to contraception improves public health and contributes to the growth of States' economies. For example, access to contraception increases educational attainment, workforce participation, and household income, and it decreases the incidence of many physical and mental health problems, particularly in women and children.[7]

The benefits of contraception are maximized by providing no-cost access to

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[6] *See* Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps, at 103, 105-107 (2011).

[7] A. Sonfield et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, Guttmacher Institute (Mar. 2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

a range of contraceptive options.[8] When cost is not a barrier, women choose, and consistently use, more effective and reliable forms of contraception.[9] At full cost, many methods of contraception are prohibitively expensive. Long-acting reversible contraceptives such as IUDs, which are among the most effective methods of contraception, have upfront costs in excess of $1,000.[10] To put this in perspective, the cost of an IUD is nearly equal to a month's salary for a full-time worker earning the federal minimum wage. Less expensive methods of contraception still cost about $50 per month (or $600 per year) if not covered by insurance. And research shows that costs of as little as a few dollars deter use of contraception and lead to increased risks of unintended pregnancy.[11]

Access to affordable contraception, then, is an "essential component" of

[8] Guttmacher Institute, *Improving Contraceptive Use in the United States* 4-5 (May 2008), https://www.guttmacher.org/sites/default/files/report_pdf/improvingcontraceptiveuse_0.pdf.

[9] L. Sobel et al., *The Future of Contraceptive Coverage*, Kaiser Family Foundation (Jan. 2017), https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/.

[10] D. Eisenberg et al., *Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 J. ADOLESCENT HEALTH S59-S60 (2013).

[11] *See* J. Gruber, *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*, Kaiser Family Foundation (Oct. 2006), https://www.kff.org/wp-content/uploads/2013/01/7566.pdf.

health care for women and plays a critical role in advancing the overlapping economic, social, and public health interests of the States, as the federal government has acknowledged. Respondents' Br. 29-30, 55-56, *Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (No. 14-1418).

B. The ACA plays a vital role in guaranteeing access to full and equal health coverage, including contraceptive coverage.

Because of these well-established economic, social, and public health benefits, the *Amici* States have made a commitment to improving access to contraceptive care and services for their residents. For example, many States have adopted contraceptive coverage requirements,[12] expanded access to contraceptive services under Medicaid by relaxing income-eligibility requirements, and implemented Title X and other family planning programs to provide subsidized contraceptive services to low-income residents, *see* Part II.B, *infra*. Nevada, along with several *Amici* States, have enacted laws that require all state regulated health plans to include no-cost contraceptive coverage.[13] States can only go so far on their own, however, and the ACA's contraceptive mandate therefore plays a key role in guaranteeing access to contraceptive coverage.

Among other factors, the Employee Retirement Income Security Act of 1974

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[12] *See supra* at note 1.

[13] *Id.*

("ERISA") preempts the States from regulating the most common type of employer provided health plans, called "self-funded" or "self-insured" plans. *See* 29 U.S.C. §§ 1144(a), (b)(2)(A). Nationwide, approximately 61% of workers with employer-sponsored insurance are covered by these plans[14]—meaning that federal law places tens of millions of Americans beyond the reach of State regulation.

For this reason, the ACA plays a critical role in ensuring access to contraception in all States, even those with no-cost contraceptive coverage laws like Nevada's. The ACA's contraceptive mandate, as implemented with an accommodation for religious entities that oppose providing coverage for some or all forms of contraception, guarantees seamless, cost-free access to our States' residents, including those covered by self-insured plans. *See E. Tex. Baptist Univ.*, 793 F.3d at 452-54 (describing mandate and accommodation). Nevada and the *Amici* States therefore share a strong interest in ensuring that the contraceptive mandate is enforced and is not improperly undermined based upon claims this Court has already decisively rejected. *See id.* at 459-63 (rejecting claim that accommodation process itself imposes substantial burden on plaintiffs' exercise of religion).

[14] *See* Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey* 12 (2018), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.

The States' interests are all the more evident from the fact that a decision in this case authorizing employers to exempt themselves from the ACA would potentially undermine state-obtained injunctions issued in litigation against new rules that created broad new religious exemptions to the contraceptive mandate—injunctions that currently protect Nevada and the *Amici* States. *See California v. U.S. Dep't of Health and Human Servs.*, 941 F.3d 410 (9th Cir. 2019) ("*California II*") (upholding preliminary injunction covering plaintiff states); *Pennsylvania v. Trump*, 930 F.3d 543 (3d Cir. 2019) (upholding nationwide preliminary injunction), *cert. petitions pending*, Nos. 19-431, 19-454; *see also Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act*, 83 Fed. Reg. 57536 (Nov. 15, 2018) ("Religious Exemption Rule"). In affirming preliminary injunctions barring enforcement of federal regulations that would have exempted the plaintiffs and other objecting employers from the contraceptive mandate, both the Third and Ninth Circuits have, consistent with this Court's holding in *East Texas Baptist University*, held that RFRA neither requires nor authorizes such exemptions. *See Pennsylvania*, 930 F.3d at 572-74; *California II*, 941 F.3d at 426-30. A decision in the plaintiffs' favor here would sow confusion and uncertainty about the extent to which women throughout the country who are insured by objecting employers are entitled to free and seamless contraceptive coverage, thus making it significantly "more difficult

and burdensome" for Nevada and the *Amici* States to pursue and protect their interests. *Crossroads Grassroots Policy Strategies v. Fed. Election Comm'n*, 788 F.3d 312, 320 (D.C. Cir. 2015) (party has a sufficient interest to intervene where litigation may result in a ruling that "would make the task of reestablishing the status quo . . . more difficult," including by complicating any future enforcement action (internal quotation marks and alterations omitted)); *see also Sierra Club v. Espy*, 18 F.3d 1202, 1207 (5th Cir. 1994) (party has sufficient interest to intervene if "an adverse resolution of the action would impair their ability to protect their interest" including through "the *stare decisis* effect" of any ruling).

At bottom, it would run contrary to the "very purpose of intervention" to compel the States to "wait on the sidelines" while the courts consider claims that are so clearly "contrary to their interests." *Brumfield*, 749 F.3d at 344-45; *see also Espy*, 18 F.3d at 1207 (the interest requirement "is primarily a practical guide to disposing of lawsuits by involving as many apparently concerned persons as is compatible with efficiency and due process").

II. Weakening the ACA's Contraceptive Mandate Will Harm the States.

The relief the plaintiffs seek in this litigation—a decision permitting any employer in the country, now or in the future, to exempt itself from the contraceptive mandate based on a religious objection—would impair the States' interests, including Nevada's. In short, the judgment below, if upheld, will harm

women in our States by depriving them of seamless access to contraceptive coverage through the established accommodation process if their employer objects to providing coverage; lead many of these women to rely on programs funded by the States to obtain their alternative contraceptive coverage, thus inflicting costs on the States; and increase the States' costs associated with unintended pregnancies.

A. Thousands of women will lose contraceptive coverage.

As a direct result of the ACA's contraceptive mandate, more than 45 million women now receive comprehensive, no-cost coverage for contraceptive care and services through their employer-sponsored health plans.[15] Out-of-pocket expenditures for contraception have fallen by more than 70%.[16] And use of more effective (and more expensive) forms of contraception, such as IUDs, has increased significantly.[17] Any decision that weakens the ACA threatens these important advances—and will thereby harm women and families in our States.

Thousands of women will lose their contraceptive coverage if employers with religious objections are allowed to exempt themselves from the contraceptive mandate under the judgment entered below. Notably, this judgment applies to

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[15] *See* 82 Fed. Reg. 47792, 47821 (Oct. 13, 2017).

[16] *See* 82 Fed. Reg. 47805.

[17] *See* A. Snyder et al., *The Impact of the Affordable Care Act on Contraceptive Use and Costs among Privately Insured Women*, 28 WOMEN'S HEALTH ISSUES 219-23 (May-June 2018), https://www.whijournal.com/article/S1049-3867(17)30527-3/pdf.

"[e]very current *and future* employer in the United States that objects" on religious grounds to providing contraceptive coverage. *DeOtte v. Azar*, 393 F. Supp. 3d 490, 513 (N.D. Tex. 2019) (emphasis added). Approximately three million people currently receive health insurance through employers that have already notified the government of their religious objections to providing coverage for contraceptive care and services.[18] In promulgating the challenged Religious Exemption Rule,[19] the government concluded that most of these objecting employers will claim an exemption if one became available. *See Massachusetts v. U.S. Dep't of Health and Human Servs.*, 923 F.3d 209, 224-25 (1st Cir. 2019). As a result, between approximately 70,500 and 126,400 women nationwide will immediately lose coverage for their chosen method of contraception. *See Pennsylvania*, 930 F.3d at 562. And as time goes on, tens of thousands more women will be affected.[20]

[18] *See* 83 Fed. Reg. 57575-78 (stating that approximately 2,907,000 people "were covered in plans using the accommodation under the previous regulations").

[19] The figures discussed are taken from the regulatory impact analysis ("RIA") provided in the Religious Exemption Rule. The RIA is the federal government's official, legally mandated explanation of anticipated costs, benefits, and broader effects of expanding religious exemptions to the contraceptive mandate. *See* 83 Fed. Reg. 57573; *see also* Executive Order 13563, § 1(c), 76 Fed. Reg. 3821 (Jan. 18, 2011) (RIA must "use the best available techniques to quantify anticipated present and future benefits and costs [of regulatory action] as accurately as possible").

[20] Although the federal government's own figures thus demonstrate that thousands of women will be affected, it will be difficult if not impossible to determine conclusively how many women and families are adversely affected by the District Court's order below, because, under the court's order, employers can

Women living in Nevada and the *Amici* States will be among those who lose contraceptive coverage. Given the federal government's analysis of how its expansion of exemptions to the ACA will impact coverage for contraceptive services nationwide, it is simply implausible to suggest that Nevada (or any other State) will be peculiarly unaffected. *See Massachusetts*, 923 F.3d at 224 n.12. Moreover, the administrative record produced in Religious Exemption Rule litigation included documents in which the government listed employers it had identified as likely to use an expanded religious exemption if one became available. *See Pennsylvania*, 930 F.3d at 562; *Massachusetts*, 923 F.3d at 217; *California v. Azar*, 911 F.3d 558, 572 (9th Cir. 2018) ("*California I*"). These companies collectively employ hundreds of thousands of people across nearly every State in the country, including Nevada and the *Amici* States. For example, the government identified Hobby Lobby Stores, Inc. as likely to make use of an exemption if permitted to do so. *See Massachusetts*, 923 F.3d at 224. Hobby Lobby employs more than 13,000 people at locations nationwide, *id.* at 224 n.11, including five stores in Nevada.[21]

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opt out of the congressional mandate without notice to the court itself, the class representative, or the federal government, and without any additional notice to the employee. *Cf. DeOtte*, 393 F. Supp. 3d at 513 (recounting and rejecting federal government's argument that this lack of notice puts the federal government at risk of contempt).

[21] *See* https://www.hobbylobby.com/store-finder.

The fact that many of the *Amici* States have enacted contraceptive equity laws will not insulate them from harm. According to the federal government, many—and probably most—people who receive health insurance through objecting employers are covered by self-insured plans.[22] Hobby Lobby, for example, sponsors a self-insured plan. *See Massachusetts*, 923 F.3d at 224. Because these plans are exempt from State regulation due to ERISA preemption, state laws will not protect women employed by these companies. *Id*.

B. Women who lose coverage will receive contraceptive care and services through state-funded programs.

The District Court's conclusion that RFRA entitles the certified employer class to a sweeping religious exemption to the contraceptive mandate will also impose direct financial costs on the States—a direct economic interest plainly sufficient to support intervention. *See Wal-Mart Stores, Inc. v. Texas Alcoholic Beverage Comm'n*, 834 F.3d 562, 568 (5th Cir. 2016). As Nevada explained in the District Court, a ruling in the plaintiffs' favor will cause thousands of women nationwide to lose the comprehensive contraceptive coverage guaranteed by the ACA. Many of these women will qualify for and receive free or subsidized contraception through state-funded programs. *See Pennsylvania*, 930 F.3d at 562-63; *Massachusetts*, 923 F.3d at 225-27; *California I*, 911 F.3d at 572-73. The

[22] *See* 83 Fed. Reg. 57577.

direct cost of providing replacement contraceptive care for all women affected will be tens of millions of dollars annually, and Nevada and the *Amici* States will bear a significant share of this cost. *See, e.g.*, *Massachusetts*, 923 F.3d at 222-27.

In Nevada and the *Amici* States, eligibility limits for state-funded programs extend up to 300% of the Federal Poverty Level ("FPL") (and in limited circumstances beyond), with many programs falling in the range of 200% to 250% of FPL.[23] With the 2019 FPL set at $21,330 for a family of three, $25,750 for a family of four, and higher for larger families, *see* 84 Fed. Reg. 1167 (Feb. 1, 2019), this means that many women earning more than $50,000 per year, and even women earning over $75,000 per year, will be eligible for these programs. State programs typically fall into three categories: Medicaid, Medicaid Family Planning Expansion, and Title X/State Family Planning.[24] Employer-sponsored insurance generally does not make women ineligible for these programs, particularly where the employer refuses to cover the specific family-planning services provided by

[23] *See* Addendum, *infra*, at 27-29.

[24] Federal law requires States to provide coverage for family planning services, including contraception, as part of their Medicaid programs. *See* 42 U.S.C. § 1396d(a)(4)(C). States are responsible for paying 10% of all sums expended "offering, arranging, and furnishing . . . of family planning services and supplies." *Id.* § 1396b(a)(5). Many States have expanded eligibility for their family planning services under their Medicaid program. *See* Guttmacher Institute, *Medicaid Family Planning Eligibility Expansions* (Dec. 1, 2019), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

these programs. *See, e.g.*, *Massachusetts*, 923 F.3d at 217-18, 226. Accordingly, a significant number of women *with employer-sponsored insurance* will be income-eligible for coverage under State programs when their employers choose to avail themselves of exemptions to the contraceptive mandate. *See* Addendum, *infra*, at 27-29 (collecting data for 23 States regarding the number of income-eligible women). Overall, in Nevada and the *Amici* States, there are at least 4,407,016 women who are income eligible for state-funded programs and who receive health insurance through plans that are not subject to any state-imposed contraceptive mandate. *See id*.

The *Amici* States' experience confirms that women who cannot utilize existing health care coverage to obtain services they need (particularly when it comes to reproductive health) routinely seek coverage from state-funded programs, including at community health centers. In Massachusetts, for example, the Commonwealth's Medicaid program, MassHealth, already covers more than 150,000 residents who also have commercial insurance. *Massachusetts*, 923 F.3d at 218. Thus, many women who lose employer-based contraceptive coverage as a result of expanded religious exemptions will already have a connection to state programs. For these already-enrolled women, there will be no need to "seek out" state-funded care if their employer cuts off contraceptive coverage; they will automatically receive replacement coverage through MassHealth, and the State

will be responsible for its share of those costs. *See id.*

C. The States will also bear increased costs associated with unintended pregnancies.

Notwithstanding the alternative health coverage available through various state-funded programs to women who are eligible and obtain that coverage, any reduction in access to contraception will also lead to an increase in unintended pregnancies and negative health outcomes for women and children. *See Massachusetts*, 923 F.3d at 217, 226-27. As the federal government has repeatedly acknowledged, there is no effective substitute for the seamless, no-cost coverage guaranteed by the ACA. *See, e.g.*, 78 Fed. Reg. 39870, 39888 (July 2, 2013). The medical research underpinning the contraceptive mandate shows that even "minor obstacles"—like having to find, access, or pay for alternative sources of care, distinct from a woman's regular doctor—significantly deter use of contraception, and that, in turn, reduced access to contraception leads to an increase in the rate of unintended pregnancies. *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 238, 261-62 (D.C. Cir. 2014), *vacated by Zubik*, 136 S. Ct. 1557. States already spend billions of dollars annually on medical care related to unintended pregnancies.[25]

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[25] A. Sonfield et al., *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 (Feb. 2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.

The fact that women who lose employer-sponsored contraceptive coverage will retain coverage for other services does not insulate States from harm. Increased costs of pre-natal and post-natal care will be passed on to the States through programs that provide free or subsidized care, as well as Medicaid and other programs that provide wraparound coverage and reimbursement for deductibles, co-insurance, emergency care, and other amounts not covered by primary insurance.[26] These are significant costs. For example, the average employer-sponsored plan has an annual deductible of $1,573 for individuals and, depending on the type of plan, up to $4,527 for families. Most plans impose additional cost-sharing fees for emergency room and hospital care.[27]

In sum, according to the federal government's own analysis, expanding religious exemptions to the contraceptive mandate will impose significant costs on Nevada and the *Amici* States. First, authorizing objecting employers to exempt themselves from the mandate will—by design—"cause women . . . to lose their contraceptive coverage." *Massachusetts*, 923 F.3d at 223. Second, "some of these women will then obtain state-funded contraceptive services." *Id.* And third, other

[26] *See, e.g.*, 130 Code Mass. Regs. 450.317 (MassHealth's wraparound insurance regulations).

[27] *See* Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey* 103, 114 (2018), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018.

women will receive state subsidized "prenatal and postnatal care for unintended pregnancies." *Id.*

D. These harms to the States, including Nevada, both support Nevada's right to intervene and establish its Article III standing.

The impact on the States of a decision in the plaintiffs' favor here not only supports Nevada's right to intervene in this case, *see Wal-Mart Stores*, 834 F.3d at 566, but it also establishes the "substantial risk" of harm Nevada must show to demonstrate Article III standing. *Stringer v. Whitley*, 942 F.3d 715, 721 (5th Cir. 2019); *see also U.S. House of Representatives v. Price*, No. 16-5202, 2017 WL 3271445, at *1-2 (D.C. Cir. 2017) (*per curiam*) (States established both right to intervene and standing based on the "substantial risk" that the termination of subsidy payments to insurers would lead "to an increase in insurance prices [for consumers], which in turn will increase the number of uninsured individuals for whom the States will have to provide health care").

The Court need not start from a blank slate. In the litigation over the Religious Exemption Rule, the First, Third, and Ninth Circuits have held that expanding religious exemptions to the contraceptive mandate creates a "substantial risk of fiscal injury" to the States because they will be forced to pay for services for women who lose coverage—for the identical reasons Nevada has advanced in this case. *Massachusetts*, 923 F.3d at 223; *see also Pennsylvania*, 930 F.3d at 561-63; *California I*, 911 F.3d at 571-73.

Echoing and expressly declining to part from these courts, this Court, too, has recently reaffirmed that a state like Nevada has standing if it can demonstrate that the State will "incur significant costs." *Texas v. United States*, No. 19-10011, __ F.3d __, 2019 WL 6888446, at *15 n.30 (5th Cir. Dec. 18, 2019) (quoting *Texas*, 809 F.3d at 155 and citing *Massachusetts*, 923 F.3d at 225; *California I*, 911 F.3d at 572; and *Pennsylvania*, 930 F.3d at 564). Accordingly, Nevada "need not point to a specific person" who will avail herself of such a state-funded program in the future; it is sufficient that, based on the evidence presented by Nevada and discussed above, Nevada will incur these significant costs. *Id.* (quoting *Massachusetts*, 923 F.3d at 225).

III. The Federal Government Has Refused to Defend the Contraceptive Mandate and Does Not Adequately Represent the States' Interests in This Case.

Finally, the federal government does not represent the interests of States in this case because the federal government has declined to defend the ACA's statutory protection for contraceptive access against the plaintiffs' RFRA claim.

In the District Court, the federal government took the unusual step of refusing to defend against the plaintiffs' RFRA claims *at all* on the merits. Even though the federal government had for years argued that RFRA does not entitle objecting employers to a blanket exemption from the contraceptive mandate, the government reversed course in this case and refused to muster any defense to the

plaintiffs' theory that RFRA requires exemptions for the certified employer class. *See* Defts.' Response to Pltfs.' Mot. for Summ. J. and Permanent Injunction, No. 4:18-cv-00825, ECF No. 38, at 3 (N.D. Tex. Apr. 15, 2019) ("Defendants are not raising a substantive defense of the Mandate or the accommodation process with respect to Plaintiffs' [RFRA] challenge."). The government made that choice notwithstanding the fact that it previously successfully argued to eight federal courts of appeals, including this Court, that RFRA does not require the exemptions demanded by the plaintiff class and awarded by the District Court below. *See Eternal Word Television Network, Inc. v. Sec'y of Health & Human Servs.*, 818 F.3d 1122, 1141-42, 1148 (11th Cir. 2016); *Mich. Catholic Conf. & Catholic Family Servs. v. Burwell*, 807 F.3d 738, 749-55 (6th Cir. 2015); *Catholic Health Care Sys. v. Burwell*, 796 F.3d 207, 218 (2d Cir. 2015); *Little Sisters of the Poor Home for the Aged v. Burwell*, 794 F.3d 1151, 1180 (10th Cir. 2015); *E. Tex. Baptist Univ.*, 793 F.3d at 463; *Univ. of Notre Dame v. Burwell*, 786 F.3d 606, 615 (7th Cir. 2015); *Geneva Coll. v. Sec'y of Health & Human Servs.*, 778 F.3d 422, 442 (3d Cir. 2015); *Priests for Life*, 772 F.3d at 252.[28]

Because the federal government wholly abandoned any merits-based defense

[28] Although *Zubik* vacated all of the court of appeals decisions before the Court, nothing in *Zubik* undercut these courts' reasoning. *See Zubik*, 136 S. Ct. at 1560 ("express[ing] no view on the merits of the cases").

of the ACA's contraceptive mandate, the State of Nevada is the only entity in this litigation that can represent the interests of the States and the tens of thousands of women nationwide who could lose statutorily guaranteed contraceptive coverage under the District Court's permanent injunction. As described above in Part II, if Nevada is not permitted to intervene to defend those interests, many residents of Nevada and the *Amici* States may lose their cost-free contraceptive coverage and be forced to seek out alternative insurance coverage or state-subsidized programs that provide reduced-cost or free contraception. Some will be forced to turn to cheaper, more readily available, and less reliable methods of contraception; others may become pregnant unintentionally as a result of losing access to their reliable long-acting method of contraception; and still others may suffer the adverse health and economic consequences that can come with unintended pregnancies. *See supra* at 12-20.

Nevada has thus easily "satisfied its 'minimal' burden to establish that its interest is not adequately represented" by the federal government. *Wal-Mart Stores*, 834 F.3d at 569 (quoting *Edwards v. City of Houston*, 78 F.3d 983, 1005 (5th Cir. 1996)); *see also Brumfield*, 749 F.3d at 341-42 (Rule 24's test "is a flexible one," requiring "a practical analysis of the facts and circumstances of each case," and must be "liberally construed" in favor of intervention (quotation omitted)).

CONCLUSION

For the foregoing reasons as well as those argued by Nevada in its brief, the *Amici* States urge this Court to reverse the order below denying Nevada's motion to intervene, vacate the order granting summary judgment to the plaintiffs, and remand the case to the District Court with instructions to enter judgment for the defendants, including intervenor-defendant Nevada.

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and 32(a)(6) because it has been prepared in a 14-point proportionally spaced serif font.

2. I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because it contains 5,373 words, excluding the parts of the brief exempted under Rule 32(f). The brief also meets the type-volume limitation if the table and its footnotes in the Addendum are included; including the Addendum, the brief contains 5,982 words.

/s/ Elizabeth N. Dewar
Elizabeth N. Dewar

Date: December 20, 2019

CERTIFICATE OF SERVICE

I hereby certify that on December 20, 2019, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Elizabeth N. Dewar
Elizabeth N. Dewar

Date: December 20, 2019

ADDENDUM

Number of Women with Employer-Sponsored Insurance Who Are Income-Eligible for State-Funded Contraceptive Coverage[1]

State	Insured, Income-Eligible Women Ages 15-45[2]	Percent of Enrollees Covered Under a Self-Funded Plan[3]	Insured, Income-Eligible Women Ages 15-45 in Self-Funded Plans[4]
California	1,415,247	41.6%	588,743
Colorado	221,076	57.2%	126,455
Connecticut	151,198	59.3%	89,660
Delaware	45,491	68.3%	31,070
District of Columbia	27,375	49.8%	11,641
Hawaii	88,650	37.6%	33,332
Illinois	612,778	63.3%	387,888
Maine	45,678	57.7%	26,356
Maryland	277,509	49.6%	137,644
Massachusetts	365,762	56.6%	207,021
Michigan	519,728	61.4%	319,113
Minnesota	183,765	[no state mandate]	183,765
Nevada	78,575	47.5%	37,323
New Jersey	380,913	55.1%	209,883
New Mexico	84,771	69.1%	58,577
New York	811,392	53.9%	437,340
North Carolina	380,983	62.5%	298,579
Oregon	188,570	53.7%	101,262
Pennsylvania	580,295	[no state mandate]	580,295
Rhode Island	54,512	47.9%	26,111
Vermont	23,575	60.2%	14,192
Virginia	318,424	[no state mandate]	318,424
Washington	317,669	57.4%	182,342
Total	**7,173,936**	**-**	**4,407,016**

[1] The Table above includes data for the *Amici* States and Nevada. The numbers provided are derived from the Interactive Public Use Microdata Series ("IPUMS"), which provides detailed data from the U.S. Census Bureau's American Community Survey (2015), the State Health Access Data Assistance Center, and the Agency for Healthcare Research and Quality. *See* S. Ruggles et al., IPUMS USA: Version 9.0 Dataset (2019), https://doi.org/10.18128/D010.V9.0. Each person is assigned to a household health insurance unit ("HIU"). The incomes of all members of the same HIU are summed and divided by the FPL for the relevant household size to generate the income of the HIU as a percentage of the FPL. For Column 2, the number reflects women who: (a) are between the ages of 15 and 45; (b) have employer/union provided health insurance; and (c) have HIU income under the relevant percent of the FPL to qualify for that State's program. That initial estimate is further refined (Column 4) based on the percentage of enrollees in self-insured employer plans in each State (Column 3), provided that the State has a contraceptive equity law. We recognize that other data sources and methodologies may achieve different results. Whatever the precise calculations, however, the ultimate conclusion—that millions of women with employer-sponsored insurance are income-eligible for state-funded programs—remains accurate.

[2] For each State on the list, the following is the FPL eligibility threshold for a broadly applicable program that is at least partially state funded: California, 200%; Colorado, 250%; Connecticut, 263%; Delaware, 250%; District of Columbia, 215%; Hawaii, 250%; Illinois, 250%; Maine, 209%; Maryland, 250%; Massachusetts, 300%; Michigan, 250%; Minnesota, 200%; Nevada, 138%; New Jersey, 250%; New Mexico, 250%; New York, 223%; North Carolina, 200%; Oregon, 250%; Pennsylvania, 220%; Rhode Island, 250%; Vermont, 200%; Virginia, 200%; and Washington, 260%. States may have programs that have higher FPL eligibility thresholds, including programs that are available to a narrower class of residents, for example the Children's Health Insurance Program ("CHIP") which extends eligibility above 300% FPL for women under the age of 19 in many States. *See* Kaiser Family Foundation, *Fact Sheet: Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults*, (2018), http://files.kff.org/attachment/Fact-Sheet-Where-are-States-Today-Medicaid-and-CHIP-Eligibility-Levels-for-Children-Pregnant-Women-and-Adults.

[3] The percentage of self-insured plans is taken from U.S. Dep't of Health & Human Services, Medical Expenditure Panel Survey, *Percent of Private-Sector Enrollees That Are Enrolled in Self-Insured Plans at Establishments That Offer Health Insurance by Firm Size and State: United States, 2016* (2019) https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2016/tiib2b1.pdf.

[4] Unlike the other listed States, Minnesota, Pennsylvania, and Virginia do not have contraceptive equity laws that generally require state-regulated plans to cover all FDA-approved forms of contraception. *See supra* at note 1. Accordingly, income-eligible women in both self-funded and state-regulated plans may be affected and are included in the Table's last column.