Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, and 15-191

In the Supreme Court of the United States

DAVID A. ZUBIK, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE THIRD, FIFTH, TENTH, AND DISTRICT OF COLUMBIA CIRCUITS

SUPPLEMENTAL REPLY BRIEF FOR THE RESPONDENTS

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(Additional Captions Listed on Inside Cover)

PRIESTS FOR LIFE, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ROMAN CATHOLIC ARCHBISHOP OF WASHINGTON, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

EAST TEXAS BAPTIST UNIVERSITY, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

LITTLE SISTERS OF THE POOR HOME FOR THE AGED, DENVER, COLORADO, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

SOUTHERN NAZARENE UNIVERSITY, ET AL., PETITIONERS

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

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SUPPLEMENTAL REPLY BRIEF FOR THE RESPONDENTS

A. RFRA Does Not Support Petitioners' New Insistence On Unworkable Contraceptive-Only Insurance Policies

In a sharp departure, petitioners now acknowledge that they cannot invoke RFRA to prevent the government from requiring that the insurers with which they contract also provide separate contraceptive coverage to their employees. But petitioners assert that it is not enough that insurers provide that coverage entirely outside petitioners' health plans and without their involvement, as the accommodation already requires. Petitioners also insist that the coverage must consist of contraceptive-only insurance policies, not direct payments for contraceptives. And they add that women must take affirmative steps to enroll, and cannot be covered automatically.

RFRA does not give petitioners the right to insist upon those new conditions. The statute simply does not entitle them to dictate the terms of insurers' separate dealings with women. And the particular terms that petitioners now demand would not work—as petitioners know. The Departments specifically considered contraceptive-only policies during rulemaking proceedings, but adopted a different approach after insurers (echoed by at least one petitioner) explained that state insurance laws would make reliance on such policies unworkable. Petitioners' current proposal—which they have never before suggested would be sufficient to meet their RFRA objections—thus provides no basis for finding the accommodation inadequate.

1. RFRA does not entitle petitioners to control insurers' separate dealings with women

When employers with insured plans invoke the accommodation, the insurers must "[e]xpressly exclude"

contraceptive coverage from the employers' policies and "[p]rovide separate payments" for contraceptives. 45 C.F.R. 147.131(c)(2)(i). Those payments occur entirely outside the employers' plans. Gov't Supp. Br. 4-5. The payments are not provided via contraceptive-only policies, which would trigger "state insurance law." 78 Fed. Reg. 39,876 (July 2, 2013). Instead, insurers "must, as a federal regulatory requirement, provide payments for contraceptive services." *Ibid.* Women need not take any action to become eligible for those payments. *Ibid.*

Petitioners assert (Br. 3-12) that separate coverage would satisfy RFRA only if it took the form of "contraceptive-only" insurance policies, and only if women had to take affirmative steps to enroll.[1] But RFRA does not entitle petitioners to insist on those requirements, which concern interactions between third parties in which petitioners have no role. Either way, the same insurers provide separate contraceptive coverage to the affected women. And either way, that coverage occurs outside petitioners' plans and "does not require any involvement of petitioners." Order 1. Whether the coverage consists of state-regulated insurance policies or federally-mandated direct payments, and whether women must take affirmative steps or are automatically eligible, nothing at all is required of petitioners. That must be dispositive. As petitioners have previously acknowledged, RFRA does not permit objectors to "dictate the conduct of the government or of third parties." *Zubik*

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[1] Petitioners also state that insurers must separate employers from payments for and communication about contraceptives. But they concede (Br. 11) that "the current scheme" already does that. Petitioners further argue (Br. 10) that insurers must use "separate insurance card[s]" for contraceptives. But again, the Departments already allow insurers to do so. 80 Fed. Reg. 41,328 (July 14, 2015).

Br. 45-46 (citation omitted); accord *ETBU* Br. 51-52.

2. Contraceptive-only policies would be unworkable

a. The Departments initially proposed an accommodation that would have relied on "insurance policies providing contraceptive-only coverage" like the ones petitioners now demand. 78 Fed. Reg. 8468 (Feb. 6, 2013); see *id.* at 8462-8463. At the time, petitioners did not suggest that such policies would allay their objections. In fact, several petitioners strenuously opposed the proposal despite its use of "two different insurance policies." *E.g.*, J.A. 511. And the Departments ultimately rejected individual contraceptive-only policies because insurers protested that such policies do not exist in the market and "would not be permitted under state contracting or insurance law" for a host of reasons. Am. Health Ins. Plans Comment 1 (Apr. 8, 2013) (AHIP).[2]

First, "[s]ome states do not recognize, permit, or have the statutory authority to approve single-benefit policies (other than dental or vision)." Groom Law Grp. Comment 2 (Apr. 8, 2013) (Groom); see Kaiser Permanente Comment 2 (Apr. 8, 2013) (Kaiser). Second, cost-free contraceptive policies would not satisfy state laws conditioning policy approval on a "reasonable premium." AHIP 2; see Groom 2. Third, such policies would not be valid contracts because, *inter alia*, "the prospective policyholder [would] not provide consideration." AHIP 9. Fourth, some insurers that sell group coverage could not offer contraceptive-only policies because they do not "offer coverage in the individual market." *Id.* at 12. Fifth, state laws would "prevent issuers licensed to issue group health insurance policies in one state from issuing

[2] All comments cited in this brief are part of the administrative record; internet citations are included in the Table of Authorities.

individual health insurance policies to employees of an eligible organization residing in other states." 78 Fed. Reg. at 39,876; see Groom 12. Insurers also raised practical problems, noting that contraceptive-only policies would "greatly complicate * * * eligibility, state regulatory filing, verification, and renewal." Kaiser 4.[3]

b. To avoid such obstacles, one insurer proposed that insurers instead exclude contraceptives from objecting employers' policies and assume sole responsibility for separately providing coverage, but without issuing contraceptive-only policies. Kaiser 2, 5-6. The Departments adopted that proposal, explaining that it avoided triggering "issuer licensing and product approval requirements under state law" and "minimize[d] cost and administrative complexity for issuers." 78 Fed. Reg. at 39,876. The Departments added that the final accommodation "achieve[d] the same end" as the original proposal because contraceptive coverage is still "expressly excluded" from the employers' insurance policies and group health plans. *Ibid.* That accommodation has been functioning smoothly for insurers around the country, for the many religious organizations that have invoked it, and for the women who are separately receiving the contraceptive coverage to which they are entitled by law.

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[3] Contraceptive-only policies would also raise other legal questions. Federal law generally does not permit single-benefit policies, but makes exceptions for dental and vision benefits and other "excepted benefits" specified by statute or regulation. 42 U.S.C. 300gg-21(c)(1), 300gg-91(c)(2). The Departments initially proposed to treat contraceptive-only policies as a new category of excepted benefit. 78 Fed. Reg. at 8467-8468. But excepted benefits are exempt from most federal insurance laws, including the requirement to cover preventive services without cost-sharing. 42 U.S.C. 300gg-21(c)(1). Insurers thus questioned the Departments' authority to require contraceptive-only policies without cost-sharing. AHIP 13-14.

c. Petitioners now assert—for the first time—that the accommodation must be fundamentally modified to incorporate the very contraceptive-only policies that the Departments specifically rejected. But petitioners are well aware that reliance on such policies would not work. RCAW's own rulemaking comments opposing the Departments' original proposal highlighted the barriers to "'state approval for new individual insurance products'" and noted that, in some cases, "'individual policies covering only one service' would conflict with state law." J.A. 514 (brackets and citation omitted). Without acknowledging those comments, petitioners now declare (Br. 8-9) that state-law obstacles are not "insurmountable" because four States require contraceptive-only policies in certain circumstances. Even if that were true, it would not help women in the other 46 States. And in fact, not one of the statutes petitioners cite actually provides for cost-free contraceptive-only policies.[4]

3. An affirmative enrollment requirement would impose a needless barrier to contraceptive coverage

Petitioners also oppose (Br. 9-10) automatic "enrollment" in contraceptive coverage. An approach relying on contraceptive-only insurance policies would require women to be enrolled in those policies. But under the accommodation, "nothing causes [women] to be automat-

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[4] All four States provide for women to *purchase* contraceptive coverage. Two expressly provide that the coverage is delivered through a "rider" attached to the employer's group policy. N.Y. Ins. Law § 3221(*l*)(16)(B)(i); W. Va. Code Ann. § 33-16E-7(c). The other two do not specify the form of coverage, but also do not appear to contemplate stand-alone contraceptive-only policies. Haw. Rev. Stat. Ann. § 431:10A-116.7(e); Mo. Ann. Stat. § 376.1199(5). As the insurance industry explained, such a policy simply "does not exist in the market." AHIP 1; see *id.* at 12 ("does not currently exist").

ically enrolled in contraceptive coverage" because there is no enrollment at all. 78 Fed. Reg. at 39,878. Insurers notify women of the availability of separate payments for contraceptive services, but no payments are made unless a particular woman "opt[s] to use such services." *Ibid.*

In any event, petitioners' insistence that women take affirmative steps to become eligible for coverage would impose precisely the kind of barrier to the delivery of preventive services that Congress sought to eliminate. Petitioners trivialize the impact of enrollment requirements (Br. 10), but a wealth of evidence shows that "participation dramatically declines when people have to take even small administrative steps to participate" in beneficial programs. Guttmacher Br. 33; see Am. Acad. Pediatrics Br. 15 (study finding that "patients who had to opt in to a free vaccination program were 36% less likely to receive the vaccine" than those "automatically enrolled").

B. RFRA Does Not Grant Petitioners The Right To Exempt Themselves Without Notifying Anyone

Our supplemental brief explained (at 7-11, 14-15) that the accommodation could operate without written notice from employers with insured plans, but that the Court should not mandate the elimination of the existing notice requirement because it is a minimally intrusive process that plays an important role in effectuating the accommodation. Petitioners provide no reason to conclude otherwise. They still have not asserted any religious objection to stating in writing their opposition to contraceptives and eligibility to opt out. But they now assert (Br. 5) that they oppose *any* arrangement that would require them to "take any affirmative step to avoid the threat of penalties" for failing to cover contraceptives.

That is an extraordinary position. The penalties at issue are not features of the accommodation; they are

attached to the concededly valid general requirement that employers and insurers cover contraceptives. RFRA sometimes mandates exemptions to generally applicable laws and their associated penalties. But the accommodation itself furnishes a mechanism for claiming such an exemption. And it would be startling to hold that RFRA entitles a religious objector not only to an exemption, but also to insist on being exempted *without notifying anyone*. Religious exemptions routinely require objectors to opt out by specified means, including by certifying their eligibility. Gov't Supp. Br. 10 & n.3.

Previously, petitioners steadfastly maintained that they were not "'objecting to objecting,' or to the act of 'opting out.'" *ETBU* Reply Br. 3; see, *e.g.*, *Zubik* Br. 1; Oral Arg. Tr. 10. Yet they now are doing just that. Indeed, it appears that even the arrangement posited in this Court's order would not satisfy them: The order assumes that petitioners would take the "affirmative step," Pet. Br. 5, of telling insurers that their refusal to cover contraceptives rests on "religious grounds," Order 2, so that the insurers would know that they could legally exclude contraceptives from petitioners' policies.

The Court should reject petitioners' sweeping position, which would mean that virtually any opt-out mechanism designed to protect religious objectors could itself be subject to strict scrutiny. It would be particularly inappropriate to hold that RFRA entitles objectors to opt out without notice here, where the rights and duties of third parties are at stake. Petitioners seek an exemption not only for themselves, but also for their insurers. And that exemption would affect the statutory rights of tens of thousands of employees and beneficiaries. Written instruments are routine and important in a wide variety of legal, com-

mercial, and regulatory contexts in which such rights and obligations are created or altered.[5]

C. Petitioners' New Proposals For Women Covered By Self-Insured Plans Are Profoundly Flawed

1. Petitioners agree (Br. 16-17) that, as the Court's order appeared to anticipate, the arrangement posited in the order could not work for women covered by self-insured plans. Petitioners also do not identify any way for those women to get contraceptive coverage through the TPAs that administer their other health coverage unless the government designates those TPAs as "plan administrators" under ERISA. Gov't Supp. Br. 15-17. Instead, petitioners propose (Br. 20-23) that the affected women should have to enroll in the same "contraceptive-only" policies that they advocate in the insured-plan context. But as we have explained, state laws would make those policies unworkable. See pp. 3-5, *supra*.

Even setting aside that fatal flaw, requiring women to obtain most of their health coverage through a TPA but their contraceptive coverage through an unrelated insurer would undermine the compelling interest in ensuring that women receive full and equal health coverage. Women would have "to take steps to learn about, and to sign up for," new contraceptive-only plans. 78 Fed. Reg. at 39,888.[6] And even if they did so, they would "be lim-

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[5] Petitioners also assert (Br. 5-6) that they should not be deemed to "comply" with the contraceptive-coverage requirement. But they have never explained how being *deemed* by the government to comply with a requirement burdens the religious exercise of objectors entitled to opt out of *actual* compliance—as petitioners indisputably are.

[6] Petitioners assert (Br. 21) that the government could enroll women using information from "IRS filings." But that information is protected by criminal confidentiality requirements barring any use or disclosure not authorized under the Internal Revenue Code.

ited by th[e] stand-alone plan's provider network," which may not include their regular doctors. Health Policy Experts Br. 13. Women would thus have to see unfamiliar providers "to be prescribed (or even discuss) contraception." Guttmacher Br. 36-37. And that would be true even when (as often occurs) contraceptives are integrally related to a woman's other medical care. Gov't Br. 56-57, 77-78 & n.31; ACOG Br. 24-27.

Requiring women to surmount those obstacles to get preventive care would frustrate the central purpose of the Affordable Care Act's preventive-services provision. And requiring women *alone* to do so would thwart the fundamental goal of the Women's Health Amendment, which sought to redress longstanding gender disparities in health coverage. Gov't Br. 7-8, 73-76.[7]

2. Petitioners seek to minimize these harms to women by speculating (Br. 12) that their female employees are unlikely to use contraceptives because, under Title VII, petitioners *could* hire only coreligionists. But most petitioners do not *actually* limit their hiring by religion.

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26 U.S.C. 6103, 7213A. Petitioners also suggest (Br. 22) that the government could require doctors to help women enroll. But there is no authority for imposing such a federal mandate on private physicians, which would in any event be extremely cumbersome.

[7] Petitioners assert (Br. 14 n.2) that our focus on "seamless" access to contraceptive coverage "collapses the separate compelling interest and least restrictive means analyses" and that it "emerged late in this litigation." They are wrong on both counts. The interest at stake is "the Government's compelling interest in providing insurance coverage that is necessary to protect the health of female employees" on the same terms as their male counterparts. *Burwell* v. *Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2785-2786 (2014) (Kennedy, J., concurring). From the outset, the Departments have emphasized that achieving that compelling interest requires ensuring that women seeking contraceptive coverage "face minimal logistical and administrative obstacles." 78 Fed. Reg. at 39,888.

Gov't Br. 59; see, *e.g.*, J.A. 981. Neither do many of the other institutions challenging the accommodation, which include the University of Notre Dame and a major hospital system. Moreover, even employers that hire only coreligionists also cover beneficiaries of different faiths, and studies indicate that large majorities of women of all religions have relied on contraceptive services. Gov't Br. 59; Guttmacher Br. 6-7 & n.8.[8] There is thus no justification for denying petitioners' employees and their beneficiaries the ability to decide for themselves whether to use those services, with the benefit of the full health coverage to which they are entitled by law.

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The accommodation serves the government's compelling interest in ensuring that women receive complete, equal health coverage while imposing the minimum possible burden on religious exercise. Every one of petitioners' putative alternatives—old and new—would undermine that interest and harm tens of thousands of women. The Court has never before held that RFRA mandates a religious exemption that would impose such harms. It should not do so here.

Respectfully submitted.

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[8] Experience with the accommodation confirms this point. HHS informs this Office that in 2014, TPAs spent approximately $21 million to provide contraceptive coverage for women enrolled in self-insured plans covering roughly 624,000 people. That expenditure for women covered by objecting religious organizations is consistent with (or greater than) the range of actuarial estimates of the cost of providing contraceptive coverage generally. See HHS, *The Cost of Covering Contraceptives Through Health Insurance* (Feb. 10, 2012).