No. 05-3877

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

TANA CUMMINS,
Appellant,

v.

STATE OF ILLINOIS,
Appellee.

Appeal From the United States District Court
For the Southern District of Illinois
Case No. 4:02-CV-04201
The Honorable Judge J. Phil Gilbert

Brief of *Amici Curiae* Karen J. Antell, M.D., Megan App, M.D., M.P.H., Corinne M. Blum, M.D., Juliet Bradley, M.D., Mariela Cano, M.D., Allison A. Cowett, M.D., M.P.H., Catharine Crockett, M.D., Andrew M. Davis, M.D., M.P.H., Julia E. Eckersley, M.D., Loraine Endres, M.D., Elizabeth Feldman, M.D., Lucy Fox, M.D., Marilynn C. Frederiksen, M.D., Etoi Garrison, M.D., Melissa Gilliam, M.D., M.P.H., Mandy Gittler, M.D., Emily Godfrey, M.D., Cassing Hammond, M.D., Estella F. Hernandez, M.D., M.P.H., Sabrina Holmquist, M.D., Christine K. Jacobs, M.D., Maureen Lee, M.D., E. Steve Lichtenberg, M.D., M.P.H., Marybeth Lore, M.D., Vaishali Mody, M.D., Scott Moses, M.D., Ashlesha Patel, M.D., Murray Pelta, M.D., Iris Romero, M.D., John Henning Schumann, M.D., Sarah-Anne Henning Schumann, M.D., Brian A. Smith, M.D., M.P.H., Nada Stotland, M.D., M.P.H., Lauren Streicher, M.D., Debra Stulberg, M.D., Suzanne Ruth Trupin, M.D., Mark Vajaranant, M.D., Marion Verp, M.D., Tuwanda C. Williamson, M.D. and Bonnie E. Wise, M.D.

In Support of Appellant Tana Cummins
and In Support of Reversal

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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No.: 05-3451

Short Caption: Tana Cummins v. State of Illinois

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(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

The Roger Baldwin Foundation of ACLU, Inc.

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Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). Yes __X___ No _____

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Esther Katz et al. eds, *Margaret Sanger and the Woman Rebel*, in The Papers of Margaret Sanger, http://adh.sc.edu/ms/ms-table.html. 3

FDA, *Birth Control Guide*, http://www.fda.gov/fdac/features/1997/babyguide2.pdf (last modified Dec. 2003) 5, 13, 14

Gold, Rachel Benson, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception,* Guttmacher Rep. on Pub. Pol., Aug. 1998..... 14, 17

Guttmacher Institute, Issues in Brief 2002 Series No. 3, *Women and Societies Benefit when Childbearing is Planned* (2002) 5, 6, 9

Guttmacher Institute, Issues in Brief, *U.S. Policy Can Reduce Cost Barriers to Contraception* (July 1999), www.guttmacher.org/pubs/ib_0799.html..... 11

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Kaiser Family Foundation*, Contraception in the '90s: Which Methods are Most Widely Used? And, Who Uses What?,* Fact Sheet (June 1997), http://www.kff.org/womenshealth/1270-contra90f.cfm..... 5

Kaiser Family Foundation, *Kaiser Family Foundation National Survey on Insurance Coverage of Contraceptives: Questionnaires and Toplines* (July 19, 1998), http://www.kff.org/womenshealth/1404-index.cfm 14

Klerman, Lorraine V. et al., *Family Planning: An Essential Component of Prenatal Care*, 50 J. Am. Med. Women's Assoc. 147 (1995) 6, 7

Koonin, Lisa, *Overview: Contraception in the Healthy Pregnancy Continuum*, in Promoting Healthy Pregnancies: Counseling and Contraception as the First Step 2-3 (Wash. Bus. Group on Health, 2000)..... 7, 8, 12

Kost, Kathryn et al., *The Effects of Pregnancy Planning Status on Birth Outcomes and Infant Care*, 30 Fam. Plan. Persp. 223 (1998)..... 6, 8

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

Amici are Karen J. Antell, M.D., Megan App, M.D., M.P.H., Corinne M. Blum, M.D., Juliet Bradley, M.D., Mariela Cano, M.D., Allison A. Cowett, M.D., M.P.H., Catharine Crockett, M.D., Andrew M. Davis, M.D., M.P.H., Julia E. Eckersley, M.D., Loraine Endres, M.D., Elizabeth Feldman, M.D., Lucy Fox, M.D., Marilynn C. Frederiksen, M.D., Etoi Garrison, M.D., Melissa Gilliam, M.D., M.P.H., Mandy Gittler, M.D., Emily Godfrey, M.D., Cassing Hammond, M.D., Estella F. Hernandez, M.D., M.P.H., Sabrina Holmquist, M.D., Christine K. Jacobs, M.D., Maureen Lee, M.D., E. Steve Lichtenberg, M.D., M.P.H., Marybeth Lore, M.D., Vaishali Mody, M.D., Scott Moses, M.D., Ashlesha Patel, M.D., Murray Pelta, M.D., Iris Romero, M.D., John Henning Schumann, M.D., Sarah-Anne Henning Schumann, M.D., Brian A. Smith, M.D., M.P.H., Nada Stotland, M.D., M.P.H., Lauren Streicher, M.D., Debra Stulberg, M.D., Suzanne Ruth Trupin, M.D., Mark Vajaranant, M.D., Marion Verp, M.D., Tuwanda C. Williamson, M.D. and Bonnie E. Wise, M.D.

Amici submit this brief in support of Appellant and urge the Court to reverse the District Court's decision and hold instead that exclusion of prescription contraception drugs and devices from the State of Illinois' health insurance plan constituted sex discrimination in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*.

Amici are physicians licensed in Illinois who specialize in gynecology, obstetrics, and family practice, who regularly prescribe contraception to their patients, both for birth control and non-birth control purposes. *Amici* have substantial experience evaluating the effectiveness of the various methods of contraception, and collectively have counseled thousands of patients through the process of determining the most appropriate method of contraception for their needs. In addition, *amici* have treated pregnant patients suffering from conditions that, exacerbated by

their pregnancies, have put their health and lives at significant risk. *Amici* support contraceptive equity and expanded insurance coverage for contraceptives, without which many women would be unable to afford the drugs and devices that they and their physicians have determined are most appropriate for their health care needs.

All parties have consented to the filing of this brief.

SUMMARY OF ARGUMENT

Throughout history, women and their children have suffered and even died because of the health consequences of pregnancies that were too early, too frequent and too closely spaced. Observing poor women suffering the pain of frequent childbirth and miscarriage, Margaret Sanger, the leading advocate for birth control in the United States in the early 20th Century, became committed to the importance of family limitation as the tool by which working class women could liberate themselves and their families from the health and economic burdens of unintended pregnancy. See Margaret Sanger and the Woman Rebel, in The Papers of Margaret Sanger (Esther Katz et al. eds., 1999), available at http://adh.sc.edu/ms/ms-table.html. She and thousands of women and doctors, risked life and livelihood to make birth control devices available to American women. See generally Planned Parenthood Federation of America, A History of Birth Control Methods (June 2002), at http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/fact-020709-contraception-history.xml.

Access to safe and effective contraception has since become a critical component of basic preventative health care for women. Since 1965, when the Supreme Court first recognized a fundamental right to contraception, see Griswold v. Connecticut, 381 U.S. 479 (1965), maternal and infant mortality rates have dropped by more than two thirds. Planned Parenthood Federation of America, Griswold v. Connecticut – The Impact of Legal Birth Control and the Challenges that Remain (June 2005), at http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/fact-000501-griswolddone.xml. Access to safe and effective contraception gives women control of their fertility, thus improving their physical well-being and empowering them to make educational and

employment choices that have long-term health, economic, and social benefits for them, their families, and their communities. Recognizing these benefits, the federal Centers for Disease Control declared family planning to be one of the 10 most significant U.S. public health achievements of the 20th Century. Centers for Disease Control, Ten Great Public Health Achievements – United States, 1900-1999, 48 Morbidity and Mortality Wkly. Rep. 241, 241 (1999).

Women cannot achieve freedom or equality unless they have the right to decide whether or when to bear children. Without access to, including the ability to pay for, effective contraception, women cannot play a full and equal role in society.

Title VII makes clear that women cannot be treated differently in the workplace because of their reproductive capacity. For this reason, every court – save the district court below – that has evaluated the exclusion of prescription contraception from an otherwise comprehensive health benefit plan has found discrimination in violation of Title VII. This Court should so hold and reverse the decision below.

ARGUMENT

I. CONTRACEPTION IS AN ESSENTIAL COMPONENT OF COMPREHENSIVE HEALTH CARE FOR WOMEN AND IS CRITICAL TO ENABLING WOMEN TO PARTICIPATE FULLY IN SOCIETY.

For most women, contraception is not merely an option; it is an essential component of their health care and critical to their ability to control their personal and professional lives. The average woman is fertile for approximately three decades of her life – from age 15 to age 44. William D. Mosher et al., Use of Contraception and Use of Family Planning Services in the United States: 1982-2002 3 (Advance Data from Vital & Health Stat. No. 350, Dec. 10, 2004). Without contraception, the average woman could expect to become pregnant twelve to fifteen

times during this period. See Washington Business Group on Health, Family Health in Brief, Promoting Healthy Pregnancies: Counseling and Contraception as the First Step, at 1 (Aug. 2000). Thus, at any given time, approximately two-thirds of American women of reproductive age seek to avoid or delay pregnancy. See American College of Obstetricians and Gynecologists, Guidelines for Women's Health Care 150 (2d ed. 2002) [hereinafter ACOG Guidelines]; see also Kaiser Family Foundation, Contraception in the '90s: Which Methods are Most Widely Used? And, Who Uses What? – Fact Sheet (June 1997), available at http://www.kff.org/womenshealth/1270-contra90f.cfm (reporting that of the women in the United States in their childbearing years, 42 million (or seven out of 10) are sexually active and do not wish to become pregnant). Perhaps, understandably then, virtually all American women (98%) aged 15-44 who have ever had sexual intercourse have used at least one method of contraception. Mosher et al., supra, at 5. [1]

Pregnancies too frequent and too closely spaced – often resulting from the inability to control reproduction – can result in permanent physical health problems for women. See Guttmacher Institute, Issues in Brief 2002 Series No. 3, Women and Societies Benefit when Childbearing is Planned 2 (2002) [hereinafter Women and Societies Benefit]; see also Cynthia J. Berg et al., Pregnancy-Related Mortality in the United States, 1991-1997, 101 Obstet. & Gynec. 289, 291 (2003) (finding that the rate of pregnancy-related mortality was higher among women who had had numerous live births). For all women, pregnancy carries with it health risks. Out of every 100,000 births in the United States, 8.4 women die as a result of pregnancy-related

[1] The FDA has approved for sale more than 15 different non-surgical contraceptive products. See FDA, Birth Control Guide, http://www.fda.gov/fdac/features/1997/babyguide2.pdf (last modified Dec. 2003). Two types of oral contraceptive pills, the contraceptive patch (Ortho Evra), the vaginal contraceptive ring, the shot (Depo-Provera), the diaphragm, and the IUD are available only to women and only by prescription. Male and female condoms and spermicide are available over the counter without prescription. Id. The FDA has not approved any prescription contraceptive drugs or devices for men. Id.

complications. F. Gary Cunningham et al., Williams Obstet. 7 (22d ed. 2005) [hereinafter Williams Obstet.].[2] Pregnancy can also cause significant health problems resulting in long-term disabilities such as uterine rupture, uterine prolapse (a displacement from the normal position), pelvic inflammatory disease (which can lead to permanent sterility) and obstetric fistula. Women and Societies Benefit, supra, at 1. For women with chronic illnesses such as heart disease, diabetes, hypertension and renal disease, dangerous complications can arise during pregnancy. Williams Obstet., supra, at 190-92. Access to a broad range of contraceptive methods can help to alleviate these risks; "[f]or women who should not become pregnant because of medical problems, contraception [can] save[] lives and prevent[] morbidity." James Trussell, The Economic Value of Contraception: A Comparison of 15 Methods, 85 Am. J. Pub. Health 494, 494 (1995).

Unintended pregnancy can also have significant consequences for the newborn children of women who carry these pregnancies to term. Women whose pregnancies are mistimed or unwanted are less likely to breastfeed (47% and 36%, respectively) than those who intended to conceive when they did (60%). Kathryn Kost et al., The Effects of Pregnancy Planning Status on Birth Outcomes and Infant Care, 30 Fam. Plan. Persp. 223, 229 (1998).[3] In addition, the proportion of infants who are premature, low-birth-weight, or small for gestational age is substantially higher if the birth was unwanted (26%) or mistimed (20%) than if it was intended (16%). Id. at 228-29; see also Lorraine V. Klerman, et al., Family Planning: An Essential Component of Prenatal Care, 50 J. Am. Med. Women's Assoc. 147, 151 (1995) (discussing correlation between unintendedness of pregnancies and low birth weight births); The Best

[2] Risks to a pregnant woman's life include embolism, hemorrhage, preeclampsia and eclampsia, infection and cardiomyopathy. Andrea R. MacKay et al., Pregnancy-Related Mortality From Preeclampsia and Eclampsia, 97 Obstet. & Gynec. 533, 545 (2001).

Intentions: Unintended Pregnancy and the Well-Being of Children and Families 70-71 (Sarah S. Brown & Leon Eisenberg eds., 1995) [hereinafter Best Intentions] (discussing correlation between unintendedness of pregnancies and low birth weight births). Research demonstrates that appropriate spacing of pregnancies can reduce these high-risk births. See Bao-Ping Zhu et al., Effect of the Interval Between Pregnancies on Perinatal Outcomes, 340 New Eng. J. Med. 589 (1999) (finding that the optimal pregnancy interval for the lowest risk of low-birth-weight, pre-term birth, and small for gestational age is 18 to 23 months); Klerman, supra, at 148-49 (reviewing studies finding relationship between short pregnancy intervals and low-birth-weight).[4]

Through the effective and consistent use of contraceptive devices, women can plan the number, timing, and spacing of their pregnancies. Such planning allows a woman to take steps before and in the earliest stages of pregnancy to protect her own health and to improve outcomes for her future child. "A planned pregnancy allows a woman to prepare herself for the emotional and physical well-being needed for a healthy pregnancy." Lisa Koonin, Overview: Contraception in the Healthy Pregnancy Continuum, in Promoting Healthy Pregnancies: Counseling and Contraception as the First Step 2-3 (Wash. Bus. Group on Health, 2000). Thus, for example, a woman who is intending to become pregnant may reduce or eliminate harmful behaviors such as smoking and the consumption of alcohol. Id. at 3; see also Klerman, et al., supra, at 149 ("If a pregnancy is intended, there is a greater likelihood of the woman's engaging in health-promoting behaviors such as reducing or abstaining from smoking and drinking and

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[3] Breastfeeding is beneficial for newborns, and is recommended by the American Academy of Pediatrics. Williams Obstet., supra, at 701.

[4] A woman who gives birth within 18 months of her last pregnancy – meaning she conceived within nine months of her last live birth – may suffer from maternal nutritional depletion and postpartum stress during the subsequent pregnancy. These factors increase the risk of an adverse perinatal outcome in the subsequent pregnancy. Zhu, supra, at 593.

avoiding potentially harmful drugs, illegal or legal; gaining adequate weight; and initiating prenatal care early.").

She might also take steps to try to ensure the healthiest pregnancy by, for example, increasing her intake of folic acid,[5] obtaining preconceptual counseling, or seeking specific treatment to address special health needs prior to conception. See Koonin, supra, at 3; Best Intentions, supra, at 76-79; see also Guttmacher Institute, Uneven and Unequal: Insurance Coverage and Reproductive Health Services 2 (1995) (quoting the United States Public Health Service: "Safe and healthful childbearing both contributes to, and is a result of, effective family planning.") Women who plan for pregnancy are also more likely to initiate early prenatal care that can lead to positive outcomes for the pregnant women and her future child. See Kost et al., supra, at 227; Best Intentions, supra, at 66.[6]

Pregnancy planning also allows women to plan for and take advantage of employment and educational opportunities and to avoid the discriminatory treatment they historically were forced to endure because of their reproductive capacity. As the Supreme Court recognized in Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992), "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to

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[5] Folic acid significantly decreases the risk of a fetus developing a neural tube defect. Williams Obstet., supra, at 192, 218. The Public Health Service recommends that all women of childbearing age ingest the recommended daily allowance of folic acid, as it is most effective with respect to fetal development at the very earliest stages of pregnancy. Increasing folic acid intake when the pregnancy is first detected – which, for a woman not expecting a pregnancy, usually occurs one to two weeks after the first missed period – will not be effective in preventing neural tube defects, as the fetus's spinal cord has already formed by this time. Id. at 190.

[6] Early and regular prenatal care reduces the risk of maternal death and adverse birth outcomes. Williams Obstet., supra, at 190-98, 203-04. Regularly scheduled prenatal visits involve assessment of gestational age, regular monitoring of fetal heart rate, size, activity, and amount of amniotic fluid, and testing of maternal blood pressure, weight and symptoms, with the goal of detecting risk factors as early as possible. Id. at 211-12. The physician will also conduct a number of laboratory tests to detect infections, gestational diabetes, or genetic diseases. Id. at 212-13. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics recommend that prenatal care begin before conception, or as soon as there is a reasonable likelihood of pregnancy. Id. at 204.

control their reproductive lives." See also U.S. Dep't of Health and Human Servs., Healthy People 2010: Understanding and Improving Health 9-5 (2000) ("Socially, the costs of unintended pregnancy can be measured in . . . reduced educational attainment and employment opportunity . . . ."). A woman who cannot control the timing of her pregnancies is less likely to make long-term human capital investments – such as attending secondary or graduate school or entering a trade apprenticeship. See, e.g., Women and Societies Benefit, supra, at 4 ("[I]n many developing countries, the increase in women's education over the last two decades is believed to be strongly associated with women's increased ability to postpone childbearing and have smaller families."); Sandra L. Hofferth et al., The Effects of Early Childbearing On Schooling over Time, 33 Fam. Plan. Persp. 259, 264 (2001) (finding that women who delayed their first child birth until age 30 completed more years of schooling on average than women who had given birth at an earlier age).

In this same vein, the career paths of women who are unable to control their fertility suffer from the interruptions of unintended, unplanned pregnancy. Moreover, as Congress recognized when it passed the Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (1978) [hereinafter PDA], there is a risk that employers may resist assigning female employees responsibility for long-term projects or clients if there is the chance that their work will be interrupted by a maternity leave. See H.R. Rep. 95-948, at 3 (1978), as reprinted in 1978 U.S.C.C.A.N. 4749, 4751. As Congress concluded, "the assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs." Id.; see also Sheehan v. Donlen Corp., 173 F.3d 1039, 1045 (7th Cir. 1999) ("Discrimination on the basis of pregnancy is part of discrimination against women, and one of the stereotypes involved

is that women are less desirable employees because they are liable to become pregnant."); cf. Nevada Dep't of Human Resources v. Hibbs, 538 U.S. 721, 731 n.5 (2003) (labeling the assumption that "women's family duties trump those of the workplace" as a "gender stereotype" that has "historically produced discrimination in the hiring and promotion of women"); Back v. Hastings on Hudson Union Free School Dist., 365 F.3d 107, 120 (2d Cir. 2004) (concluding that employer's comments that employee "cannot 'be a good mother' and have a job that requires long hours" were gender-based stereotypes); Maldonado v. U.S. Bank and Mfrs. Bank, 186 F.3d 759, 768 (7th Cir. 1999) (employer violated Title VII by firing pregnant employee "because it 'anticipated' that she would be unable to fulfill its job expectations" after she gave birth; "[t]his is the exact sort of employment action that the PDA was designed to prevent"). The "adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the 'marketplace and the world of ideas.'" Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (quoting Stanton v. Stanton, 421 U.S. 7, 14-15 (1975)).

II. UNINTENDED PREGNANCY REMAINS A PROBLEM THAT CAN ONLY BE ADDRESSED THROUGH ACCESS TO A BROAD RANGE OF CONTRACEPTION, INCLUDING PRESCRIPTION CONTRACEPTION.

Sexually active women can reduce their risk of unintended pregnancy through accurate and consistent use of contraception. U.S. Dep't of Health and Human Servs., Healthy People 2010: Understanding and Improving Health, supra, at 9-3; Best Intentions, supra, at 2. Because of the significant health benefits of pregnancy planning, the nation's leading medical and public health organizations – including the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, the American Public Health Association, the Association of Reproductive Health Professionals and the

American Medical Women's Association – support increased access to contraception as a critical component of women's health care.[7]

Between 1987 and 1994, the rate of unintended pregnancy in the United States fell 16%. Stanley K. Henshaw, Unintended Pregnancy in the United States, 30 Fam. Plan. Persp. 24, 29 (1998). "A likely explanation for the decline in unintended pregnancy is an increase in widespread and effective contraceptive use." Id. During this time, overall use of contraception increased, and two new highly effective methods of contraception – implanted and injected – were introduced. Id.

However, access to effective contraception still remains a problem for many women in the United States.[8] As a result, even though rates of unintended pregnancy have declined, the United States continues to have one of the highest unintended pregnancy rates among developed nations. See ACOG Guidelines, supra, at 150. The Centers for Disease Control estimate that in 1995, 49 percent of all pregnancies in the United States, and 31 percent of pregnancies resulting in live births, were unintended. Centers for Disease Control, Pregnancy Risk Assessment Monitoring System (PRAMS): PRAMS and Unintended Pregnancy, available at

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[7] See American College of Obstetricians and Gynecologists, Preserve Reproductive Health Care: Ask Your Senator to Support S20, the Safe Motherhood Initiative, at http://www.acog.org/departments/dept_notice.cfm?recno=11&bulletin=3310 (last visited Mar. 30, 2006); American Medical Association, H-180.958 Coverage of Prescription Contraceptives by Insurance, at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-180.958.HTM (last visited Mar. 30, 2006); American Academy of Family Physicians, AAFP Policies on Health Issues: Health Plans para. 23 (2003), at http://www.aafp.org/x6856.xml; American Public Health Association, Fact Sheet, Prescription Contraceptive Equity (Dec. 1998), at http://www.apha.org/legislative/factsheets/fs2.htm; Association of Reproductive Health Professionals, ARHP Position Statements: Contraceptive Access, at http://www.arhp.org/aboutarhp/positionstatements.cfm?ID=30#11 (last modified Aug. 25 2005); American Medical Women's Association, AMWA's Position Paper on Reproductive Health (Feb. 2004), at http://www.amwa-doc.org/index.cfm?objectId=2441A11E-D567-0B25-59A74BA228491FD0.

[8] One reason is that contraception is more expensive in the United States than in other developed nations, where prescriptions are easily affordable under universal health insurance systems. See Guttmacher Institute, Issues in Brief, U.S. Policy Can Reduce Cost Barriers to Contraception (July 1999), available at www.guttmacher.org/pubs/ib_0799.html.

http://www.cdc.gov/PRAMS/UP.htm (last modified Mar. 28, 2006) [hereinafter CDC, PRAMS]; Henshaw, supra, at 26. In Illinois in 1999, approximately 46.5 percent of all live births resulted from either mistimed or unwanted pregnancies. CDC, PRAMS, supra.[9]

Because contraceptive methods vary in effectiveness and because not all contraceptives will be appropriate for all women, providing access to many forms of contraception, including a full range of prescription contraceptives, will lead to optimal contraceptive use. Koonin, supra, at 3. "Successful prevention of unplanned pregnancies relies not only on access to available market products, but also on the products' acceptability and couples' willingness and ability to use them effectively." Jill L. Schwartz & Henry L. Gabelnik, Current Contraceptive Research, 34 Persp. on Sexual and Reprod. Health 310, 310 (2002); see also Erickson, 141 F. Supp. 2d at 1273 ("[T]he availability of affordable and effective contraceptives is of great importance to the health of women and children because it can help to prevent a litany of physical, emotional, economic, and social consequences.") (citing Sylvia A. Law, Sex Discrimination and Insurance for Contraception, 73 Wash. L. Rev. 363, 364-68 (1998)).

Choosing a contraceptive method is a personal and private matter that requires a woman to balance her sexual needs, her health, her reproductive goals, and the needs, health, and goals of her partner. The decision also involves determining which contraceptive method will be most effective for a particular woman's lifestyle. Schwartz & Gabelnik, supra, at 310. The variance in the effectiveness, convenience and cost of different contraceptive drugs and devices is an important part of a woman's choice of contraceptive method. Absent access to the method that works best for her, a woman's risk of unintended pregnancy increases.[10]

[9] Approximately half of all unintended pregnancies in the United States end in abortion. Henshaw, supra, at 26.

[10] In addition, some prescription hormonal contraceptives provide significant non-contraceptive health benefits that women may take into consideration when choosing, with their healthcare provider, the

Prescription methods of contraception generally provide a significantly higher rate of effectiveness than over-the-counter methods. With perfect use, prescription hormonal methods – such as the pill,[11] the patch,[12] and the shot[13] – have failure rates of only 1-2 percent. ACOG Guidelines, supra, at 158; FDA, supra, at 3-5. The intrauterine device (IUD), a device inserted into the uterus by a physician or other health professional, fails less than one percent of the time. ACOG Guidelines, supra, at 158. By contrast, the failure rate for the over-the-counter male condom with perfect use is three percent and 14 percent with typical use. Id.[14] Over-the-counter spermicides, when used without an additional prescription barrier method, are even less effective, with reported failure rates of between six percent (perfect use) and 26 percent (typical use). Id. The diaphragm, which is available only by prescription, has a failure rate of approximately six percent. Id.

When choosing their preferred method of contraception, women take effectiveness into account, but also consider the level of convenience associated with each drug or device. If the method is well suited to a woman's lifestyle, she is more likely to use the method chosen consistently and appropriately. Thus, convenience can affect the rate of effectiveness.

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method that is best for them. For example, the combined oral contraceptive pill is effective in controlling menstrual cycle irregularities and in reducing premenstrual symptoms. Long-term use can help increase bone density, reduce menstrual blood loss and anemia, reduce the risk of ectopic pregnancy, improve dysmenorrhea from endometriosis, decrease the risk of endometrial and ovarian cancer, reduce some benign breast diseases, inhibit hirsutism progression, reduce acne, prevent atherogenesis, decrease incidence and severity of acute salpingitis, and improve rheumatoid arthritis. See ACOG Guidelines, supra, at 157; Williams Obstet., supra, at 731.

[11] Oral contraceptive pills are daily-dose pills that contain doses of the hormones estrogen and progestin (in the combined pill) or progestin alone (in the progestin-only pill).

[12] The patch, also known as Ortho Evra, is a thin plastic patch worn on the skin containing the same hormones found in the combined oral contraceptive pill.

[13] The shot, marketed as Depo-Provera, is a quarterly injection of the hormone progestin.

[14] "Perfect use" refers to rates that occur when use of the drug is consistent and accurate. "Typical use" reflects a combination of actual method failure and user failure. See Best Intentions, supra, at 101. For most contraceptive drugs or devices, typical use failure rates are substantially higher than perfect use failure rates, and particularly so for coitus-dependent methods such as the condom, spermicide, and

Barrier methods can be less convenient than hormonal methods. The male condom must be put on each time before intercourse begins; the diaphragm and spermicide must also be inserted before each act of intercourse. By contrast, hormonal methods are ingested, worn or injected on a regular schedule without regard to when intercourse might occur. The IUD is similar – once inserted, it can remain in place for up to a year or 10 years, depending on the type of device used. FDA, supra, at 6. Realistically, as the inconvenience associated with a particular method of contraception increases, the risk that a woman will use the device or drug imperfectly or inconsistently also increases, thereby increasing her risk of unintended pregnancy. See Best Intentions, supra, at 171 ("[W]omen who rely on coitus-dependent methods [such as barrier methods] have been found to be more likely to forget to use or fail to use their method, more likely to discontinue their method in favor of no method at all, and more likely to switch methods altogether.").

Another important factor for women – especially women without health insurance or whose health insurance plans do not cover prescription contraception – is the cost associated with each method. See Kaiser Family Foundation, Kaiser Family Foundation National Survey on Insurance Coverage of Contraceptives: Questionnaires and Toplines (July 19, 1998), available at http://www.kff.org/womenshealth/1404-index.cfm (reporting that 68 percent of women believe that cost is an important factor in choosing a method of contraception not covered by insurance); see also Rachel Benson Gold, The Need for and Cost of Mandating Private Insurance Coverage of Contraception, Guttmacher Rep. on Pub. Pol., Aug. 1998, at 5 ("In the absence of comprehensive coverage [of contraceptives], many women may 'choose' a method covered by their plan rather than one that might be more appropriate to their medical or life

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diaphragm. Id. "Methods of contraception that are nearly impervious to user shortcomings [such as the implant and the shot] are most effective in day-to-day life." Id.

circumstances."); Best Intentions, supra, at 144 (discussing effect of pricing on choice of method of contraception). Contraceptive costs vary greatly, with prescription methods – which tend to be more effective and more convenient – costing significantly more than non-prescription or over-the-counter methods. A monthly prescription for the oral contraceptive pill costs between $15 and $35. Planned Parenthood Federation of America, You and the Pill, http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-contraception-pill.xml (last modified Mar. 2006). The cost of the patch, which must be replaced monthly, is between $30 and $40. Planned Parenthood Federation of America, Is the Patch Right for You?, http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-patch-orthoevra.xml (last modified Sept. 2005). The estimated cost of the quarterly Depo-Provera shot is $30-$70. Planned Parenthood Federation of America, Is the Shot Right for You?, http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-depo - provera.xml (last modified Apr. 2005). The cost of the exam, insertion, and follow-up for IUD insertion is between $175 and $500. By contrast, male condoms cost approximately $0.50 each. Planned Parenthood Federation of American, The Condom, http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-condom.xml (last modified Apr. 2004). In addition to male condoms, the only other FDA-approved methods of artificial contraception sold over-the-counter are the female condom and spermicide.

Because not every method of contraception is appropriate for every woman, it is essential that women have access to a range of contraceptive choices. But access means more than an appointment with a physician who can recommend and prescribe a contraceptive drug or device

or a pharmacy nearby that will fill the prescription provided by the physician. Access also includes the ability to pay for whatever drug or device is recommended. Given the limited number of kinds of artificial contraception sold over-the-counter and the relative expense of prescription contraceptives, a health insurance plan that excludes coverage for all prescription contraception radically narrows a covered woman's choices.

III. EXCLUSION OF COVERAGE FOR CONTRACEPTIVE MEDICATION FROM A COMPREHENSIVE INSURANCE PLAN DISCRIMINATES UNLAWFULLY AGAINST WOMEN.

The State of Illinois' exclusion of prescription contraceptives – medication and devices that are integral to comprehensive healthcare for women and that are used only by women – offends Title VII's call for equality in the workplace. Title VII makes it unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's … sex." 42 U.S.C. § 2000e-2(a)(1) (2005). The PDA, an amendment to the definition section of Title VII, clarified that discrimination on the basis of sex includes discrimination "based on pregnancy, child birth or related medical conditions." See id. § 2000e(k); see also H.R. Rep. 95-948, at 1 (1978), as reprinted in 1978 U.S.C.C.A.N. 4749, 4751. Fringe benefits such as employee health insurance are "terms, conditions, or privileges of employment," and therefore, may be the basis for a claim of employment discrimination. Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 682 (1983).

As the Supreme Court has made clear, women cannot be penalized in their employment for qualities relating to their reproductive capacity. See U.A.W. v. Johnson Controls, Inc., 499 U.S. 187, 197-98 (1991) (banning women from certain jobs because of their reproductive capacity constituted unlawful discrimination in violation of Title VII). Title VII simply does not

permit an employer to treat an employee differently because of the employee's sex. City of Los Angeles, Dept. of Water & Power v. Manhart, 435 U.S. 702 (1978); see also Erickson, 141 F. Supp. 2d at 1271 ("[T]he law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception.").

The State's health plan discriminated against women on its face. It excluded from coverage prescription drugs and devices used only by women – to avoid a condition experienced only by women. In so doing, the State made it difficult for many women to access prescription contraception – contraception that is the most effective, often the most convenient and in many cases the most expensive. Thus, for example, some women were undoubtedly forced to settle for a method of contraception poorly suited to their medical and personal needs simply because it cost less.[15] As a result of the State's discrimination in insurance coverage, these women were denied the ability to confidently control their reproduction. As discussed above, this lack of control can carry with it significant risks to a woman's health and to her career and educational advancement.

The State's discriminatory practices perpetuated the very stereotypes that this and other courts have rejected as inimical to the goals of Title VII and to women's equal participation "in the economic and social life of the Nation." Casey, 505 U.S. at 856; see also Sheehan v. Donlen, 173 F.3d at 1045 ("Discrimination on the basis of pregnancy is part of discrimination against

[15] See Gold, supra at 5 ("In the absence of comprehensive coverage [of contraceptives], many women may 'choose' a method covered by their plan rather than one that might be more appropriate to their medical or life circumstances.").

women, and one of the stereotypes involved is that women are less desirable employees because they are liable to become pregnant."); Erickson, 141 F. Supp. 2d at 1274 (recognizing that the assumption that women would get pregnant and leave the workforce "relegated women to the role of marginal, temporary workers who had no need to participate in seniority programs, no hope of promotion, and no claim the full panoply of employment benefits"). This Court cannot now affirm the State's discriminatory practices – a decision that could have an enormous impact not only on plaintiffs but on thousands of women throughout this Circuit and across the country.

CONCLUSION

For the reasons stated herein and in the brief of Appellants, *amici* respectfully request that this Court reverse the decision below and remand with instructions to enter judgment for the plaintiffs.

Dated: April 3, 2006

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned counsel hereby certifies that the foregoing *amicus* brief complies with the volume limitations of Rule 32(a)(7)(B) and Rule 29(d) in that the brief contains 5,305 words, as measured by the word-processing system used to prepare the brief.

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