

# CONTRACEPTIVE EQUITY: CURING THE SEX DISCRIMINATION IN THE ACA'S MANDATE

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# CONTRACEPTIVE EQUITY: CURING THE SEX DISCRIMINATION IN THE ACA'S MANDATE

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*Birth control is typically viewed as a woman's problem despite the fact that men and women are equally capable of using contraception. The Affordable Care Act's contraceptive mandate (Mandate), which requires insurers to cover all female methods of birth control without cost, promotes this assumption and reinforces contraceptive inequity between the sexes. By excluding men, the Mandate burdens women in four ways: it fails to financially support a quarter to a third of women that rely on male birth control to prevent pregnancy; it incentivizes women to endure the risks and side effects of birth control when safer options exist for men; it encourages unequal investment in new contraceptive options; and it perpetuates harmful sex stereotypes, like that women are responsible for birth control, that women are to blame for unwanted pregnancy, or that men are indifferent as to whether sex leads to pregnancy. The Mandate's facial sex classification constitutes unconstitutional sex discrimination under the Equal Protection Clause and can only be equitably cured by extending the Mandate to cover male forms of birth control alongside female methods. A neutral, universal mandate will remedy the harms discussed above and create incentives for the creation of new methods of male birth control, benefiting men and women alike.*

## INTRODUCTION

The Affordable Care Act's (ACA's) contraceptive mandate (the Mandate) makes an explicit sex classification: only women are entitled to free birth control.<sup>1</sup> This Article argues that the Mandate's exclusion of men was an unconstitutional mistake that perpetuates contraceptive inequity<sup>2</sup> and harms women.

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1. The Mandate arose under the "Woman's Health Amendment," which guaranteed preventative services to women without cost sharing. Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010) (codified as amended at 42 U.S.C. § 300gg-13 (2012)). The agency charged with implementing this provision, the Health Resources and Services Administration, concluded that the Amendment required women to have free access to "the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods." *Women's Preventive Services Guidelines*, HEALTH RESOURCES & SERVS. ADMIN. (Oct. 2017), <https://www.hrsa.gov/womens-guidelines/index.html> (last reviewed Sept. 2018). And "[p]lans aren't required to cover . . . services for male reproductive capacity, like vasectomies." *Birth Control Benefits*, HEALTHCARE.GOV (emphasis omitted), <https://www.healthcare.gov/coverage/birth-control-benefits/> (last visited Oct. 2, 2019).

2. Throughout the Article, I use the term *equity* as distinct from *formal equality*. Formal equality simply requires that both sexes are treated the same (even if both are worse off). Equity requires a level playing field, often by advancing the interests of historically subjugated groups. See *infra* Part IV.

Equal access to male birth control is a women's rights issue for four reasons. First, a quarter to a third of women rely on male forms of birth control to prevent pregnancy.<sup>3</sup> Because all forms of birth control prevent pregnancy *in women*, extending the Mandate to men gives women additional methods to avoid unwanted pregnancy. Second, all forms of female contraception come with serious risks and side effects.<sup>4</sup> Though male options are safer and less invasive, health insurers are not required to cover them,<sup>5</sup> incentivizing women to endure contraceptive burdens that men can more safely assume. Third, the Mandate encourages investment into new female methods of birth control even though male options are few and have remained stagnant since World War II.<sup>6</sup> The lack of male options creates pressure for women to continue bearing contraceptive burdens. Finally, the Mandate perpetuates the expectation that women should take the primary responsibility for preventing pregnancy—and the blame when accidents occur—despite the fact that men and women contribute equally to unplanned pregnancies and are equally capable of using contraception. This Article offers an extended analysis of these propositions, linking them to well-grounded Equal Protection Clause jurisprudence and extending them into a framework for full contraceptive equity that benefits men and women alike.

Courts examine explicit sex classifications, like the Mandate's, under intermediate scrutiny, which requires the government to prove that the classification furthers an important governmental objective that is substantially related to the classification.<sup>7</sup> One way for the government to meet its burden under intermediate scrutiny is to prove that the sex classification was needed to combat a history of sex discrimination.<sup>8</sup>

It is undeniable that women in the United States faced a long history of discrimination in accessing birth control. Not only was contraception illegal nationally until the 1930s—and in certain states until the 1970s—but even after it was legalized, many health insurers refused to cover it (despite covering other pharmaceuticals). Insurers justified excluding birth control by labeling it a “lifestyle drug,” used not to fight disease but to facilitate enjoyment of sex.<sup>9</sup> This lack of contraceptive coverage entered the national spotlight after the commercialization of Viagra, which insurers were quick to cover despite the reality that Viagra was the epitome of a “lifestyle drug.” Scholars argued that Title VII's

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3. See *infra* Figures 1 and 2.

4. These include, for instance, pain, depression, migraines, and an increased risk of stroke, cancer, and heart attack. See *infra* Part III.B.2.

5. See *infra* Part III.B.2.

6. See *infra* Part III.B.3.

7. See *United States v. Virginia*, 518 U.S. 515, 533 (1996).

8. See, e.g., *Califano v. Webster*, 430 U.S. 313, 320 (1977) (per curiam); *Schlesinger v. Ballard*, 419 U.S. 498, 508 (1975).

9. Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 183 (1999).

prohibition of sex discrimination made it illegal for employer-sponsored health plans to generally cover pharmaceuticals but exclude birth control, a product that only women used.<sup>10</sup> The only circuit to consider the issue, however, disagreed, and many health insurers continued to discriminate against women by refusing to cover birth control until the passage of the ACA.<sup>11</sup> In response to this and other instances of sex discrimination in the health care markets, the ACA explicitly prohibited sex discrimination in health care and also enacted the Women's Health Amendment—through which the Mandate was promulgated—to ensure that insurers covered preventative health services for women without cost sharing.

The Women's Health Amendment was passed to rectify a genuine history of discrimination against women: the senators advocating for the bill made this clear.<sup>12</sup> So, too, was the Mandate promulgated with this history in mind.<sup>13</sup> But still, we must ask whether the Mandate's exclusion of men is actually helping women as it imagines or whether it is just another instance in which the government's good intentions have bad implications for the very group it attempts to help.<sup>14</sup> As the Supreme Court has made clear, a sex classification cannot be used to remedy a history of discrimination when it, in effect, perpetuates harmful sex stereotypes and disserves women.<sup>15</sup>

As previewed above, the Mandate's exclusion of men harms women in four ways. First, roughly a quarter to a third of women rely on male birth control to prevent contraception.<sup>16</sup> The Mandate simply is not helping this significant group of women avoid the financial burdens associated with contraceptive use. Given that only women bear the physical consequences of unintended pregnancy, all forms of birth control—whether used by men or women—help women. Young women and women of color rely on male birth control at the highest rates because all methods of female birth control contain an entry barrier: a doctor's appointment. Minors typically lack direct and confidential access to a doctor, and women of color are marginalized in the health care system;

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10. See, e.g., Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 382–83 (1998).

11. See *In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 944–45 (8th Cir. 2007).

12. See *infra* Parts II.A–B.

13. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,869, 39,887 (July 2, 2013), <https://www.federalregister.gov/documents/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act>.

14. In the 1970s, the Supreme Court found numerous laws unconstitutional that provided women an exclusive benefit on the ground that the law's exclusion of men harmed women. See *infra* Part III.A.

15. In *Mississippi University for Women v. Hogan*, 458 U.S. 718, 727–29 (1982), for instance, the Supreme Court held that it was unconstitutional sex discrimination for a state nursing school to deny entry to men even though the state argued that its admissions policy was designed to remedy past discrimination against women in education. The Court held that “[r]ather than compensate for discriminatory barriers faced by women, MUW’s policy of excluding males from admission to the School of Nursing tends to perpetuate the stereotyped view of nursing as an exclusively woman’s job.” *Id.* For more examples, see Part III.A below.

16. See *infra* Figures 1 and 2.

these factors help explain why both groups are more likely to choose over-the-counter condoms to prevent pregnancy than female methods of birth control.<sup>17</sup> As a result, the Mandate's exclusion of male birth control disproportionately affects young women and women of color.

Second, the Mandate incentivizes women, not men, to endure the risks and side effects of birth control. For instance, vasectomy (for men) and tubal ligation (for women) are both permanent, surgical contraceptive methods, but the Mandate financially encourages tubal ligation, even though vasectomy is less invasive, carries fewer risks and side effects, and is more effective.<sup>18</sup> In other words, the government makes it cheaper for women to undergo a riskier, more invasive, and less effective procedure when a safer, easier, and more effective option exists for men. The same reasoning applies to other methods of contraception. Hormonal birth control carries increased risks of a number of serious conditions, and some women experience particularly troubling side effects.<sup>19</sup> Yet women are financially encouraged to endure these burdens instead of relying on available male contraceptives, including the safest contraceptive option: condoms. The government should not be incentivizing women to expose themselves to risks and side effects when safer male products exist.

Third, the Mandate encourages innovation solely for female methods of birth control, as only female methods are guaranteed insurance coverage. While all contraceptive investment is welcome and important, investment in male methods is more urgent. Men only have access to two methods of birth control—condoms and vasectomy—both of which have been on the market since World War II.<sup>20</sup> Women, by contrast, have access to twenty birth control methods, many of which were approved in recent decades.<sup>21</sup> This discrepancy places additional pressure on women to assume the risks and burdens of birth control. It also makes it more difficult for men to share those risks and burdens with their partners. A universal Mandate that promised insurance coverage of male and female options would provide a carrot to incentivize industry investment into new contraception for both sexes.

Finally, the Mandate perpetuates harmful sex stereotypes. The most obvious one is that it is the woman's job—and her's alone—to prevent pregnancy. This stereotype engenders others, including that accidental pregnancies are a

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17. See Joyce C. Abma & Gladys M. Martinez, *Sexual Activity and Contraceptive Use Among Teenagers in the United States, 2011–2015*, 104 NAT. HEALTH STAT. REP. 1, 7–8 (2017), <https://www.cdc.gov/nchs/data/nhsr/nhsr104.pdf>; Cynthia D. Grady et al., *Racial and Ethnic Differences in Contraceptive Use Among Women Who Desire No Future Children, 2006–2010 National Survey of Family Growth*, 92 CONTRACEPTION 62, 67 tbl.3 (2015).

18. See, e.g., Brian T. Nguyen et al., *Putting the Man in Contraceptive Mandate*, 89 CONTRACEPTION 3, 3 (2014).

19. See *infra* Part III.B.2.

20. See *infra* Part III.B.3.

21. NAT'L WOMEN'S LAW CTR., STATE OF BIRTH CONTROL COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 4 (2015), <https://www.nwlc.org/sites/default/files/pdfs/stateofbirthcontrol2015final.pdf> [hereinafter STATE OF BIRTH CONTROL COVERAGE].

woman's fault or that women should also be responsible for additional reproductive and domestic labor that comes down the line. But other stereotypes exist as well: that men are not responsible enough to trust with birth control or that they are unconcerned about whether sex leads to pregnancy. Sex equality law is particularly focused on the relationship between sex classifications and sex stereotypes, regardless of whether those stereotypes may be true. But here, the research demonstrates that each of these stereotypes is either false or based on evolving norms, making them particularly problematic.<sup>22</sup> By offering a reproduction-related benefit to women only, the government is effectively branding birth control as a woman's problem and making it harder for both men and women to exercise autonomy over their reproductive lives. Thanks to the litigation efforts of advocates like Ruth Bader Ginsburg, the Supreme Court has a long history of invalidating government benefits exclusive to women that are based on women's presumed primacy over reproduction and child-rearing.<sup>23</sup>

In light of these concerns, it is unlikely that the government would be able to successfully rebut a constitutional sex discrimination lawsuit, even by arguing that the classification was necessary to rectify a genuine history of sex discrimination. This Article starts with a history of the birth control movement in the United States, from illegalization to the Mandate. Though two huge birth control battles have been won—constitutional protection for birth control and free access for women—the Article argues that the next frontier is universal coverage of contraceptive methods for men and women alike. The Article next explores the sex discrimination argument, noting that even though the Mandate was promulgated to rectify a history of discrimination, it should not pass constitutional muster because the exclusion of men harms women in the four ways discussed above. Finally, the Article suggests that the proper remedy for this constitutional violation is to extend the Mandate to men, notwithstanding the background rule that courts can cure a constitutional defect either through extension or nullification. True contraceptive equity cannot be achieved until the government removes its discriminatory restrictions.

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22. See *infra* Part III.B.4.

23. See *infra* Part III.A.

## I. THE STORY OF BIRTH CONTROL'S LEGALIZATION

*“Birth control is the first important step woman must take toward the goal of her freedom. It is the first step she must take to be man’s equal. It is the first step they must both take toward human emancipation.”*

– Margaret Sanger (1918)<sup>24</sup>

It is hard to overstate modern birth control’s impact on women. For most of human history, women were either pregnant or lactating throughout the decades between marriage and menopause.<sup>25</sup> Without contraception, women can expect to become pregnant twelve to fifteen times in their lives.<sup>26</sup> In 1800, the average American woman had over seven living children—not including the children who were stillborn or who died before their first birthdays.<sup>27</sup> And childbirth was risky. Though precise data from this time period does not exist, infant mortality rates before 1900 are estimated to be as high as 30%–40% in certain parts of the country,<sup>28</sup> and maternal mortality was nearing 1% for each birth.<sup>29</sup> Moreover, the maternal mortality rate tripled for women with eight or more pregnancies.<sup>30</sup> The result was that after marriage, women were held hostage by their own biology. With little sexual autonomy, it was difficult to prevent conception, which led to regular births that put women’s health at risk. At this moment in time, the need for contraception was not yet rooted—as it would become—in a woman’s ability “to participate equally in the economic and social life of the Nation,”<sup>31</sup> but it was rooted in her fundamental health, safety, and financial security.

Though various methods of contraception have existed for millennia, it was not until the vulcanization of rubber in the 1840s that birth control became cheaply made and mass-produced.<sup>32</sup> Rubber was used to create the first modern

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24. Margaret Sanger, *Mortality and Birth Control*, BIRTH CONTROL REVIEW (1918) reproduced at PUBLIC WRITINGS AND SPEECHES OF MARGARET SANGER (2013) (emphasis added), <https://www.nyu.edu/projects/sanger/webedition/app/documents/show.php?sangerDoc=213391.xml> [hereinafter *Mortality and Birth Control*].

25. See PETER C. ENGELMAN, A HISTORY OF THE BIRTH CONTROL MOVEMENT IN AMERICA 1 (2011).

26. Cornelia T.L. Pillard, *Our Other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy*, 56 EMORY L.J. 941, 975 (2007).

27. ENGELMAN, *supra* note 25, at 5.

28. “In 1900 in some U.S. cities, up to 30% of infants died before reaching their first birthday.” Div. of Reprod. Health, Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Healthier Mothers and Babies*, CDC (Oct. 1, 1999), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm>. In 1800, roughly 45% of children died before their fifth birthday worldwide. Max Roser et al., *Child & Infant Mortality*, OUR WORLD IN DATA (2019), <https://ourworldindata.org/child-mortality>.

29. In 1900, roughly 850 women died in childbirth per 100,000 live births. Robert Goldenberg & Elizabeth M. McClure, *Maternal Mortality*, 205 AM. J. OBSTETRICS & GYNECOLOGY 293, 293 (2011), [https://www.ajog.org/article/S0002-9378\(11\)00962-8/pdf](https://www.ajog.org/article/S0002-9378(11)00962-8/pdf).

30. Elizabeth Temkin, *Contraceptive Equity*, 97 AM. J. PUB. HEALTH 1737, 1742 (2007), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2006.098145>.

31. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

32. ENGELMAN, *supra* note 25, at 2–4.

form of birth control—condoms—and by the middle of the century, they were readily available for purchase.<sup>33</sup> Also in this time frame, wealthy women, with the assistance of physicians, began to have access to early IUDs and pessaries,<sup>34</sup> though the IUDs required anesthesia for insertion before the 1950s.<sup>35</sup> And abortion was not uncommon—by 1870, women terminated roughly 20% of all pregnancies.<sup>36</sup> The country was urbanizing, causing families to prefer fewer children as they no longer needed extra hands on the farm and could not afford as many children in the city.<sup>37</sup> This zeitgeist was met with early contraceptive education, including the first publications advocating for birth control.<sup>38</sup> At least partly as a result of the new availability and use of birth control, the nineteenth century witnessed a precipitous drop in American birth rates, from more than seven children per couple in 1800 to only three-and-a-half in 1900.<sup>39</sup>

Birth control first entered the country without regulation and with little thought.<sup>40</sup> The general view at the time was that life did not start until quickening—when the woman first felt her fetus move.<sup>41</sup> Within a few decades after the commercialization of birth control, however, moralists entered the scene, disturbed that women were preventing conception and reducing their family sizes.<sup>42</sup> Anthony Comstock was the leader of the movement; he believed that contraceptives “facilitate[d] immoral conduct” because they “reduce[d] the risk that individuals who engage[d] in premarital sex, extramarital sex, or prostitution [would] suffer the consequences of venereal disease or unwanted pregnancy.”<sup>43</sup> Congress was persuaded and enacted the Comstock Act in 1873.<sup>44</sup> It prohibited any person to send birth control through the mail; it also became illegal to send through the mail any obscene matter, which expressly included any content that discussed birth control, even if the author or recipient was a physician.<sup>45</sup> The U.S. Postal Service was allowed to censure and confiscate any

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33. *Id.* at 4; GEOFFREY R. STONE, *SEX AND THE CONSTITUTION* 189 (2017).

34. LINDA GORDON, *THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA* 34–35 (3d ed. 2002). Poor women largely lacked access to these devices. STONE, *supra* note 33, at 197. Pessaries, diaphragms, and cervical caps all prevent conception in the same way: by creating a barrier to prevent sperm from entering the uterus. *Cervical Caps and Diaphragms*, CASE WESTERN RES. U., <https://case.edu/affil/skuyhistcontraception/online-2012/Cervical-Caps-Diaphragms.html> (last visited Sept. 27, 2019).

35. Temkin, *supra* note 30, at 1743.

36. STONE, *supra* note 33, at 181.

37. ENGELMAN, *supra* note 25, at 5.

38. *See* STONE, *supra* note 33, at 182.

39. ENGELMAN, *supra* note 25, at 5.

40. *See* STONE, *supra* note 33, at 189.

41. *Id.* at 185.

42. *See id.* at 189–90.

43. *Id.* at 190.

44. *Id.*

45. GORDON, *supra* note 34, at 12–13; STONE, *supra* note 33, at 190; Martha J. Bailey, *Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception*, 46 *BROOKINGS PAPERS*

material that was illegal under the Comstock Act.<sup>46</sup> And shortly thereafter, Comstock was appointed the postal inspector of New York, giving him enormous enforcement power.<sup>47</sup> Once the Comstock Act went into effect, most states passed their own Comstock laws, some of which went above and beyond the national law.<sup>48</sup> In Connecticut, for instance, the state completely banned the *use* of contraceptives.<sup>49</sup>

“[T]he [Comstock] laws had teeth.”<sup>50</sup> Comstock, who enforced the law himself, boasted about the number of women who committed suicide as a result of his prosecutions—and many did.<sup>51</sup> Nevertheless, birth control products continued to be used and sold but by less reputable sources.<sup>52</sup> This caused a rather unfortunate outcome: reputable physicians best able to help women covered “while quacks and purveyors of bootleg contraceptives and ‘feminine hygiene’ articles and formulas flourished.”<sup>53</sup> The law also caused a dramatic increase in abortions, many of them unsafe, as some women no longer had access to birth control.<sup>54</sup> It took a movement starting in the early twentieth century to bring the importance of birth control to light.<sup>55</sup> It was led by activist Margaret Sanger, whose legacy is not without taint: despite her pivotal role in the birth control movement, her later interest in eugenics has divided support for her amongst communities of color and others.<sup>56</sup>

Margaret Sanger was born in 1879 in New York.<sup>57</sup> Her mother died young after having eighteen pregnancies in twenty-two years; eleven of her children

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ON ECON. ACTIVITY 341, 344 (2013), [https://www.brookings.edu/wp-content/uploads/2016/07/2013a\\_bailey.pdf](https://www.brookings.edu/wp-content/uploads/2016/07/2013a_bailey.pdf).

46. STONE, *supra* note 33, at 159.

47. *See id.* at 158–59.

48. *Id.* at 190.

49. *Id.*

50. Margaret Sanger, *The Status of Birth Control*, NEW REPUBLIC (Apr. 20, 1938), <https://newrepublic.com/article/100850/the-status-birth-control-1938> [hereinafter *The Status of Birth Control*].

51. *See* ENGELMAN, *supra* note 25, at 17, 24; STONE, *supra* note 33, at 190–92.

52. *See* GORDON, *supra* note 34, at 33–34; STONE, *supra* note 33, at 192–93.

53. *The Status of Birth Control*, *supra* note 50.

54. *See* STONE, *supra* note 33, at 192. “In 1935 the medical inspector for New York City’s Health Department reported being summoned to 5 cases of septic abortion each week . . . .” Temkin, *supra* note 30, at 1740. These women were reported to the authorities after being brought for medical assistance. *Id.*

55. *See* STONE, *supra* note 33, at 203.

56. *See* ANGELA Y. DAVIS, WOMEN, RACE, & CLASS 213–15 (1st ed. 1981); *see also* N.Y. Univ., *Birth Control or Race Control? Sanger and the Negro Project*, MARGARET SANGER PAPERS PROJECT (Fall 2001), [https://www.nyu.edu/projects/sanger/articles/bc\\_or\\_race\\_control.php](https://www.nyu.edu/projects/sanger/articles/bc_or_race_control.php). *See generally* Charles Valenza, *Was Margaret Sanger a Racist?*, 17 FAM. PLANNING PERSPS. 44 (1985) (discussing Sanger’s controversial views relating to race and eugenics). This Article does not attempt to rehash the arguments on Margaret Sanger’s legacy—communities of color, for instance, have argued both sides of the debate. *Compare* DAVIS, *supra*, at 213–15, *with* Anna Holley, *Margaret Sanger and the African American Community*, TRUST BLACK WOMEN (July 2010). Rather, I wanted to highlight the controversy so that readers are aware of Sanger’s controversial past and to mitigate the risk that this Subpart reads as a hero’s tale of Margaret Sanger.

57. STONE, *supra* note 33, at 194.

survived.<sup>58</sup> Sanger coined the phrase “birth control” in 1914.<sup>59</sup> She was a nurse by training and started advocating for birth control after witnessing too many deaths from improper abortions.<sup>60</sup> Sanger was particularly affected by the requests of working-class women, who begged her for information about how to control their family sizes like the wealthy.<sup>61</sup> Sanger lambasted the “women of the wealthy class” who “so carefully guarded” their knowledge of birth control while “tenaciously withh[olding it] from the working women.”<sup>62</sup> Sanger also attacked the “blood-sucking men with M.D. after their names who perform operations” for wealthy women, while poor women are “left in ignorance” about how to prevent conception.<sup>63</sup> Physicians at the time did significantly mark up the cost of pessaries—the most popular and effective method of female birth control at the time—in part due to the legal risk under the Comstock laws, rendering them too expensive for most women.<sup>64</sup>

Sanger believed that a “woman can never call herself free until she is mistress of her own body”<sup>65</sup> and blamed the Comstock laws for the death of thousands of women:

The Comstock laws not only thwarted efforts to protect mothers from excessive child bearing and children from being born sick, weak, unwanted and unprovided for, but were responsible, directly or indirectly, for the deaths of a million mothers during the six decades in which they were enforced. These deaths occurred among mothers who were the victims of abortions or of bearing children when in unfit physical condition.<sup>66</sup>

Her articles quickly got the attention of Comstock himself, who indicted her.<sup>67</sup> She fled to England but only after defiantly distributing 100,000 copies of *Family Limitation*, a pamphlet she wrote “detail[ing] information that she had gathered about the most effective and available means of contraception.”<sup>68</sup>

58. MICHAEL ELSOHN ROSS, *SHE TAKES A STAND: 16 FEARLESS ACTIVISTS WHO HAVE CHANGED THE WORLD* 4–6 (2015).

59. STONE, *supra* note 33, at 194–95.

60. *Id.* at 195.

61. *Id.* at 194–95.

62. *Morality and Birth Control*, *supra* note 24. She continued:

The women who have this knowledge are the women who have been free to develop, free to enjoy in its best sense, and free to advance the interests of the community. And their men are the ones who motor, who sail yachts, who legislate, who lead and control. The men, women and children of this class do not form any part whatever in the social problems of our times.

*Id.*

63. Margaret Sanger, *The Prevention of Conception*, *THE WOMAN REBEL*, Mar. 8, 1914, reproduced at PUBLIC WRITINGS AND SPEECHES OF MARGARET SANGER (2003), <https://www.nyu.edu/projects/sanger/web/edition/app/documents/show.php?sangerDoc=420038.xml>.

64. See ENGELMAN, *supra* note 25, at 18–19; Bailey, *supra* note 45, at 345.

65. *Morality and Birth Control*, *supra* note 24.

66. *The Status of Birth Control*, *supra* note 50.

67. See STONE, *supra* note 33, at 197.

68. *Id.* Her pamphlet recommended condoms, douching, laxatives, sponges, suppositories, and pessaries (the early equivalent of diaphragms) to prevent conception, the last of which she noted was the most

In her exile, women organized.<sup>69</sup> The National Birth Control League was created, with over 2,000 women attending the first meeting.<sup>70</sup> Contemporaries of Sanger, like Emma Goldman, launched nationwide lecture tours and distributed *Family Limitation*.<sup>71</sup> The charges against Sanger were eventually dropped, and she returned to the United States.<sup>72</sup> She opened birth control clinics throughout New York, including a partnership with the black community to open a clinic in Harlem in the 1920s.<sup>73</sup> The clinics were shut down, and Sanger and her sister were arrested, convicted, and shortly jailed after widely publicized trials—but the attention only helped their cause.<sup>74</sup>

The relentless Comstock could not stop the growing movement, and ten days after personally convicting Sanger's husband for distributing *Family Limitation* in 1915,<sup>75</sup> Comstock died of pneumonia.<sup>76</sup> Though the federal Comstock laws remained on the books for many decades, they had lost much of their resonance with the American people.<sup>77</sup> Between 1895 and 1925, the nation's birth rate dropped again by 30% due to increased use of birth control.<sup>78</sup> By the 1930s, polls indicated that the majority of Americans supported contraception, at least for married couples.<sup>79</sup> But birth control activists had a new foe in the Catholic Church, which had, for the first time, inserted itself into the debate, lobbying to stop Congress and the states from repealing the Comstock laws.<sup>80</sup>

In come the courts. Sanger ordered a package of pessaries from Japan in 1935—delivered to Dr. Hannah Stone—to distribute as contraceptives.<sup>81</sup> The package was confiscated as part of the Tariff Act, which prohibited the import of devices intended for contraception or abortion.<sup>82</sup> The Second Circuit, however, found that the statute must permit the importation of contraceptives to doctors who could be prescribing them to women for medical reasons.<sup>83</sup> This

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effective method. *See generally* MARGARET SANGER, *FAMILY LIMITATION* (1914), <https://archive.lib.msu.edu/DMC/AmRad/familylimitations.pdf> (providing detailed information on the proper use of various forms of contraception).

69. STONE, *supra* note 33, at 197–98.

70. *Id.* at 198.

71. *Id.*

72. *Id.* at 200.

73. Wangui Muigai, *Looking Uptown: Margaret Sanger and the Harlem Branch Birth Control Clinic*, MARGARET SANGER PAPERS PROJECT (Spring 2010), <https://www.nyu.edu/projects/sanger/articles/harlem.php>.

74. STONE, *supra* note 33, at 200–01.

75. *People v. Sanger*, 118 N.E. 637, 637–38 (N.Y. 1918).

76. STONE, *supra* note 33, at 199.

77. *Id.* at 200.

78. *Id.* at 205. The Depression accelerated this trend—between 1930 and 1940, 42% of women in their childbearing years had only one child. *Id.* at 207.

79. *See id.* at 208; Bailey, *supra* note 45, at 345.

80. STONE, *supra* note 33, at 202–05; Mary L. Dudziak, *Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut*, 75 IOWA L. REV. 915, 927–31 (1990).

81. STONE, *supra* note 33, at 208.

82. *United States v. One Package*, 86 F.2d 737, 738 (2d Cir. 1936); STONE, *supra* note 33, at 208.

83. *One Package*, 86 F.2d at 739.

decision was momentous: the government dropped its appeal, and quickly thereafter, the Treasury Department “issued instructions to Customs authorities to admit contraceptive supplies addressed to physicians.”<sup>84</sup> Ultimately, federal prosecutors stopped enforcing any of the Comstock laws.<sup>85</sup> In 1937, the American Medical Association added their voice to the debate, declaring that birth control was “an essential part of medical practice and education.”<sup>86</sup> These victories freed doctors to distribute birth control and educate women about contraception in the twenty-eight states that no longer had their own versions of the Comstock laws.<sup>87</sup>

Less than fifteen years later, Sanger secured funding and a researcher willing to investigate the first contraceptive pill.<sup>88</sup> While the manufacturer was seeking FDA approval, Sanger helped organize the Planned Parenthood Federation in 1957;<sup>89</sup> the FDA approved the first pharmaceutical pill to prevent conception three years later.<sup>90</sup> The pill changed everything—over a million women were using it by 1962.<sup>91</sup> A decade later, that number increased to ten million.<sup>92</sup> It was the most effective form of birth control on the market.<sup>93</sup> The demand was enormous, but women’s access was impeded by the fact that it was still illegal for physicians and pharmacists to distribute it in the twenty-two states where Comstock-era laws were still on the books.<sup>94</sup> The birth control pill, though, marked the death toll of the remaining state Comstock laws: “once the pill was on the market, the old Comstock Law was finally doomed.”<sup>95</sup>

Activists set their sights on dismantling these state laws. Connecticut’s law was particularly stringent; it prohibited physicians from prescribing contraception (even when necessary to protect the health or life of the woman) and couples from using contraception (even when married).<sup>96</sup> To challenge the law, Estelle Griswold and Charles Lee Buxton opened the first Connecticut Planned

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84. *The Status of Birth Control*, *supra* note 50.

85. *See id.*

86. *Id.*; *see also* STONE, *supra* note 33, at 208.

87. *See* STONE, *supra* note 33, at 206; *The Status of Birth Control*, *supra* note 50. The federal Comstock laws, however, were not formally repealed until 1971. STONE, *supra* note 33, at 363.

88. *See* ENGELMAN, *supra* note 25, at 183; STONE, *supra* note 33, at 352 n.\*; Rachel Cooke, *Fifty Years of the Pill*, *GUARDIAN* (June 5, 2010, 7:04 PM), <https://www.theguardian.com/society/2010/jun/06/rachel-cooke-fifty-years-the-pill-oral-contraceptive>.

89. STONE, *supra* note 33, at 353.

90. Cooke, *supra* note 88.

91. STEVEN M. GILLON, *THE AMERICAN PARADOX: A HISTORY OF THE UNITED STATES SINCE 1945*, at 180 (2012).

92. *Id.*

93. *See id.*

94. *See* STONE, *supra* note 33, at 355–56; Bailey, *supra* note 45, at 348; Cooke, *supra* note 88.

95. RICKIE SOLINGER, *PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA 177* (2005).

96. For a comprehensive discussion of Connecticut’s anticontraceptive law prior to *Griswold*, including the many challenges to the law on the basis of maternal health, *see* Dudziak, *supra* note 80, at 921–38.

Parenthood in New Haven in 1961.<sup>97</sup> They were arrested and convicted, after which point they launched a constitutional challenge to the law that eventually landed in the Supreme Court.<sup>98</sup>

In a 7–2 decision published in 1965, the Court held that the intimacies of marriage concern “a right of privacy older than the Bill of Rights—older than our political parties, older than our school system.”<sup>99</sup> Justice Douglas, who authored the majority opinion, found that the law improperly inserted itself “within the zone of privacy created by several fundamental constitutional guarantees” and, therefore, could not stand.<sup>100</sup> *Griswold v. Connecticut* “offered women the most significant constitutional protection since the Nineteenth Amendment gave women the right to vote . . . .”<sup>101</sup> Though it was a landmark case for birth control advocates, over time, feminist scholars have regretted that the Court failed to ground the right to contraception in equal protection, not privacy.<sup>102</sup> They argue that birth control is an equality right because women cannot obtain full citizenship with men until women can fully control their reproductive destinies.<sup>103</sup> Though the ACLU’s amicus brief in *Griswold* advanced this position,<sup>104</sup> the Supreme Court has regretfully never explicitly adopted it.

The *Griswold* decision was not only pivotal but also popular—polling taken shortly after the decision showed that more than 80% of Americans supported birth control, including 78% of Catholics.<sup>105</sup> And within five years of the decision, Congress enacted Title X, a federal program to fund family-planning counseling and services for low-income women who lacked access to contraception due to cost.<sup>106</sup> The initial budget was small—only \$6 million—but was

97. STONE, *supra* note 33, at 356.

98. *Id.*

99. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965).

100. *Id.* at 485.

101. Neil S. Siegel & Reva B. Siegel, *Contraception as a Sex Equality Right*, 124 YALE L.J.F. 349, 349 (2015).

102. *Id.* at 349–50, 357.

103. *See id.* at 349–50.

104. Brief for the American Civil Liberties Union and the Connecticut Civil Liberties Union as Amici Curiae at 15–16, *Griswold v. Connecticut*, 381 U.S. 479 (1965) (No. 496) (“[I]n addition to its economic consequences, the ability to regulate childbearing has been a significant factor in the emancipation of married women. In this respect, effective means of contraception rank equally with the Nineteenth Amendment in enhancing the opportunities of women who wish to work in industry, business, the arts, and the professions.” (citation omitted)); Siegel & Siegel, *supra* note 101, at 355–57.

105. STONE, *supra* note 33, at 362.

106. RACHEL BENSON GOLD, TITLE X: THREE DECADES OF ACCOMPLISHMENT 1 (2001), [https://www.guttmacher.org/sites/default/files/article\\_files/gr040105.pdf](https://www.guttmacher.org/sites/default/files/article_files/gr040105.pdf). The birth control pill was very expensive at the time because the pharmaceutical company that made it had a monopoly. Bailey, *supra* note 45, at 349.

passed with wide bipartisan support.<sup>107</sup> Though a huge step forward, the *Griswold* decision only went so far as to protect contraception for married couples.<sup>108</sup> By this point, the sexual revolution of the 1960s was in full swing, and advocates sought to secure access to birth control outside of marriage.<sup>109</sup> Seventy-three percent of Americans believed that birth control should be available to anyone who wanted it.<sup>110</sup>

Boston University students petitioned a known birth control advocate, physician Bill Baird, to challenge the law in Massachusetts, which made it a felony for anyone (including doctors) to distribute birth control to unmarried persons.<sup>111</sup> After Baird was arrested for distributing a condom and contraceptive foam to a student, he challenged the constitutionality of the law.<sup>112</sup> In 1972, the Supreme Court held that the Massachusetts statute was unconstitutional under the Equal Protection Clause.<sup>113</sup> The Court held that the state cannot treat married and unmarried individuals differently when it comes to contraception.<sup>114</sup> And because the state cannot prohibit married couples from accessing contraception, it, therefore, cannot prohibit such access by unmarried individuals.<sup>115</sup> In so holding, the Court made an important declaration: “If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”<sup>116</sup> Quickly thereafter, in 1973, Congress increased Title X funding to over \$100 million.<sup>117</sup>

The final blow came in 1977, when the Supreme Court struck down a New York statute that prohibited the distribution of contraceptives by anyone other than a licensed pharmacist and to anyone younger than sixteen.<sup>118</sup> The Court, in *Carey v. Population Services*, stated clearly that the “decision . . . whether to bear or beget a child” is a fundamental right and “regulations imposing a burden on it” are subject to strict scrutiny.<sup>119</sup> By the end of the decade, women had succeeded not only in invalidating the laws that criminalized contraception but also

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107. Office of Population Affairs, U.S. Dep’t Health & Human Servs., *Funding History*, HHS.GOV, <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html> (last reviewed Apr. 4, 2019) [hereinafter *Funding History*].

108. STONE, *supra* note 33, at 363.

109. *Id.* at 362, 364–65.

110. By 1959, 73% of Americans thought that “birth control information should be available to anyone who wants it.” Bailey, *supra* note 45, at 346.

111. STONE, *supra* note 33, at 363–64.

112. *Id.* at 365.

113. *Eisenstadt v. Baird*, 405 U.S. 438, 454–55 (1972).

114. *Id.* at 447.

115. *Id.* at 446.

116. *Id.* at 453.

117. *Funding History*, *supra* note 107.

118. *Carey v. Population Servs. Int’l*, 431 U.S. 678, 681–82 (1977).

119. *Id.* at 686.

in securing a constitutional right to it.<sup>120</sup> And with this right came options: businesses invested in contraceptive innovation, creating an array of effective pharmaceuticals and devices for women to choose between.<sup>121</sup> The FDA has now approved twenty unique birth control methods for women, including pills, injections, implants, rings, patches, devices, and surgical options.<sup>122</sup>

Despite all of the innovation for female methods of birth control, male birth control's only innovation since WWII has been to introduce a new version of condoms made from polymers in the 1990s.<sup>123</sup> As early as the 1960s and '70s, feminists have decried the lack of male options, arguing that this scarcity pigeonholed women into assuming the primary responsibility for birth control.<sup>124</sup> Nevertheless, "[t]he 'contraceptive revolution' . . . remained largely restricted to female methods," with only tiny portions of the contraceptive research budget devoted to men.<sup>125</sup> Though this disparity had serious implications for women and men alike, women focused their attention on an even bigger problem: the cost of birth control.

Just because birth control was legal did not mean women could afford it. The constitutional right to contraception extends no further than to be free from governmental intrusion; there is no constitutional right to free or affordable birth control.<sup>126</sup> This proved problematic, as women were routinely discriminated against in the health care markets and contraception was often not covered by health plans.<sup>127</sup> As a result, advocates' attention shifted from litigation to legislative reforms that could extend the right by statute. The next frontier in the struggle for contraception was to seek mandated insurance coverage of birth control. Almost a century after Sanger's movement began, the ACA's Mandate required health insurers to cover contraception cost free.

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120. See STONE, *supra* note 33, at 366–67.

121. See generally NELLY OUDSHOORN, *THE MALE PILL: A BIOGRAPHY OF A TECHNOLOGY IN THE MAKING* 183–85 (2003) (discussing investment in male contraception).

122. STATE OF BIRTH CONTROL COVERAGE, *supra* note 21; Office of Women's Health, U.S. Food & Drug Admin., *Birth Control Chart*, FDA (Feb. 16, 2018), <https://www.fda.gov/consumers/free-publications-women/birth-control-chart>.

123. OUDSHOORN, *supra* note 121, at 6.

124. *Id.* at 6–7.

125. *Id.* at 6.

126. See *Harris v. McRae*, 448 U.S. 297, 316 (1980) (finding that “it simply does not follow that a woman’s freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices . . . . [A]lthough government may not place obstacles in the path of a woman . . . , it need not remove those not of its own creation.”).

127. See *infra* Part II.A.

## II. THE CONTRACEPTIVE MANDATE: ITS CONCEPTION, EVOLUTION, AND EFFECTS

After *Carey*, constitutional law had accomplished all it could to remove the state and federal barriers to contraception. But the cost of birth control continued to challenge women's ability to fully control the number and spacing of their children. Women engaged in a decades-long battle to obtain health insurance that covered birth control. The Mandate was the culmination of these efforts, achieved through legislative reform. The Mandate's current iteration requires insurers to cover at least one version of each of the twenty FDA-approved methods of contraception for women. Like *Griswold*, the Mandate represented a huge step forward for women's equality. But this Article argues that the Mandate does not represent the end of the battle for contraceptive equity. In fact, the Mandate itself is impeding progress toward this goal by excluding men. The next big step toward contraceptive equity will require extending the Mandate's benefits to all, regardless of sex.

### A. *The Fight for Coverage of Birth Control*

In the decade before the passage of the ACA, it had become clear that women were paying much more for health care than men. The individual health care markets in particular were pervaded by sex discrimination, which was not illegal at the time. Over 90% of health plans on the individual market practiced "gender rating," whereby women paid more for their health insurance premiums based solely on their gender.<sup>128</sup> Health care premiums were often between 20% and 50% more for women than men,<sup>129</sup> which meant that women typically paid between \$500 and \$900 more annually on premiums alone.<sup>130</sup> In the majority of plans, nonsmoking women paid more for health care than male smokers.<sup>131</sup> Adding insult to injury, 97% of these plans did not cover maternity services despite the upcharge.<sup>132</sup> Women could also be denied health care coverage altogether for having had a previous "cesarean delivery, a prior pregnancy,

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128. NAT'L WOMEN'S LAW CTR., TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT 7 (2012), [https://www.nwlc.org/sites/default/files/pdfs/nwlc\\_2012\\_turningtofairness\\_report.pdf](https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf). This statistic excludes the thirteen states that had banned gender rating. *Id.* at 8. The discrimination was not limited to the individual market; employer-sponsored health plans were also more expensive if the workforce had more women. *Id.* at 9–10.

129. *Id.* at 20.

130. *Id.* at 22.

131. *Id.* at 8.

132. *Id.* at 7. Even including plans from states that required maternity coverage, only 12% of health plans on the individual market covered maternity services. *Id.* at 11. Regardless, even when insurance covered maternity care, it was not always "comprehensive or affordable." *Id.*

breast or cervical cancer,” or treatment for sexual assault.<sup>133</sup> As a result, before the ACA, more than 19% of women were uninsured.<sup>134</sup>

Coverage of birth control presented a particular problem for women before the ACA. In 1998, with the exception of health maintenance organizations, “two-thirds of private insurance plans exclude[d] coverage for contraceptive pills, even though virtually all private insurance plans include[d] coverage for other prescription drugs.”<sup>135</sup> Three-quarters of those plans also excluded coverage for diaphragms and IUDs.<sup>136</sup> And even when insurers decided to cover some kind of birth control, the vast majority did not cover all of the most common types of birth control and required women to pay co-pays.<sup>137</sup> Largely because of the costs of birth control, “women of childbearing age [were paying] 68% more in out-of-pocket health care costs than . . . men of the same age.”<sup>138</sup>

Tensions over the lack of birth control coverage were inflamed in 1998 with the approval of Viagra. Insurance companies moved “swiftly to pay for the male sex drug Viagra.”<sup>139</sup> Within two months of its approval, the drug was covered for most men, already more than insurers covered most kinds of birth control.<sup>140</sup> The federal government also required states to cover Viagra under Medicaid.<sup>141</sup> This outcome “produc[ed] howls of frustration from many physicians and women’s rights advocates who ha[d] been waging a long, arduous campaign—in legislatures and in the court of public opinion—to coax insurers to cover prescription contraceptives that enable women to enjoy sex without worrying about whether they’ll become pregnant.”<sup>142</sup>

Women were justifiably angry. The rationale for denying coverage for birth control was that it was an elective “lifestyle” drug—used not to treat disease but to facilitate the enjoyment of sex.<sup>143</sup> Of course, this is an incredibly limited

133. NAT’L WOMEN’S LAW CTR., *THE RISK OF REPEAL: HOW ACA REPEAL WILL HURT WOMEN’S HEALTH AND ECONOMIC SECURITY 1* (2016), <https://nwlc.org/wp-content/uploads/2016/12/The-Risk-of-Repeal-FS-5.pdf> [hereinafter *THE RISK OF REPEAL*]. The Pregnancy Discrimination Act, however, ensured that most employer-sponsored health insurance plans covered maternity care. Rachel Benson Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, GUTTMACHER REP. ON PUB. POL. 1, 5 (Aug. 1998), [https://www.guttmacher.org/sites/default/files/article\\_files/gr010405.pdf](https://www.guttmacher.org/sites/default/files/article_files/gr010405.pdf). Before the Pregnancy Discrimination Act, however, health plans often did not cover maternal health services. *Id.*

134. *THE RISK OF REPEAL*, *supra* note 133, at 1.

135. Law, *supra* note 10, at 369–70.

136. *See id.* at 370.

137. *See* Gold, *supra* note 133, at 5–6.

138. *Id.* at 5.

139. *See, e.g.*, Amy Goldstein, *Viagra’s Success Fuels Gender Bias Debate*, WASH. POST, May 20, 1998, at A1; Janet Benshoof, *By Covering Viagra, Insurers Show That Men’s Sexual Well-Being’ Is Still More Vital Than Women’s*, CHI. TRIB. (June 7, 1998), [http://articles.chicagotribune.com/1998-06-07/features/9806070369\\_1\\_prescription-contraception-health-insurance-pills-and-other-prescription](http://articles.chicagotribune.com/1998-06-07/features/9806070369_1_prescription-contraception-health-insurance-pills-and-other-prescription).

140. Goldstein, *supra* note 139.

141. Amy Goldstein, *U.S.: Medicaid Must Cover Viagra*, WASH. POST (July 3, 1998); Letter from Sally Richardson, Dir., Dep’t of Health & Human Servs., to State Medicaid Dir. (Nov. 30, 1998), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd103098.pdf>.

142. Goldstein, *supra* note 139.

143. *See* Hayden, *supra* note 9, at 183–84; Temkin, *supra* note 30, at 1737.

view of birth control, which prevents the side effects and risks of pregnancy as much as any preventative drug prevents the side effects and risks of the condition for which it is prescribed. But even assuming this limited view of birth control is correct, women asked, how is Viagra different? Both drugs provided the consumer with the unique ability to control his or her sexuality; the only difference appeared to be the gender of the user.<sup>144</sup> In response to the public's outrage, within six years of Viagra's approval, twenty states enacted laws requiring insurers to cover some kind of prescription contraceptives.<sup>145</sup> A bipartisan federal bill was introduced, but it never passed.<sup>146</sup>

Scholars developed new legal strategies. Sylvia Law first argued that it was sex discrimination under Title VII and the Pregnancy Discrimination Act ("PDA") for employer-sponsored insurance plans to exclude coverage for contraception.<sup>147</sup> She concluded that because the "typical policy provides men coverage for all physician services and prescription drugs and devices, but denies women coverage for medical services and prescribed drugs and devices for reversible contraception[,] [t]hese plans thus discriminate against women."<sup>148</sup> Law's article was published before the Viagra controversy, and others stretched her ideas to include that additional nuance.<sup>149</sup> Lisa Hayden argued, for instance, that "[i]f insurers provide Viagra to men to enhance their sexuality and give them the freedom to control when and where they can have sex, then insurers must provide women the same freedom."<sup>150</sup> Many called for a federal contraceptive mandate.<sup>151</sup>

The Equal Employment Opportunity Commission (EEOC) eventually adopted Law's position in 2000, finding that it was illegal under Title VII and the PDA for employer health plans to generally cover prescription medications but exclude pharmaceutical birth control—a product only used by women.<sup>152</sup> The Commission found that "[b]ecause 100 percent of the people affected by [the insurance company's] policy are members of the same protected group—

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144. Hayden, *supra* note 9, at 181.

145. Cynthia Dailard, *Contraceptive Coverage: A 10-Year Retrospective*, GUTTMACHER REP. PUB. POL. 6, 7 (JUNE 2004), [https://www.guttmacher.org/sites/default/files/article\\_files/gr070206.pdf](https://www.guttmacher.org/sites/default/files/article_files/gr070206.pdf); see also Carey Goldberg, *Insurance for Viagra Spurs Coverage for Birth Control*, N.Y. TIMES (June 30, 1999), <https://www.nytimes.com/1999/06/30/us/insurance-for-viagra-spurs-coverage-for-birth-control.html>.

146. Dailard, *supra* note 145, at 7, 9.

147. Law, *supra* note 10, at 374–79.

148. *Id.* at 373.

149. See, e.g., Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 160–62 (1998); Kathleen A. Bergin, *Contraceptive Coverage Under Student Health Insurance Plans: Title IX as a Remedy for Sex Discrimination*, 54 U. MIAMI L. REV. 157, 162 (2000); Lisa A. Hayden, *supra* note 9, at 181–82, 193; Jennifer N. White, *The Contraception Misconception: Why Prescription Contraceptives Should Be Covered by Employer Insurance Plans*, 31 HOFSTRA L. REV. 271, 274 (2002).

150. Hayden, *supra* note 9, at 198.

151. *Id.* at 195.

152. U.S. Equal Emp. Opportunity Comm'n, DECISION ON COVERAGE OF CONTRACEPTION (2000), <http://www.eeoc.gov/policy/docs/decision-contraception.html>.

here, women—[the insurance company’s] policy need not specifically refer to that group in order to be facially discriminatory.”<sup>153</sup> The Commission recommended that companies “cover the expenses of prescription contraceptives to the same extent, and on the same terms, that they cover the expenses of [other] types of drugs, devices, and preventive care” to avoid violating Title VII.<sup>154</sup> But EEOC decisions are not entitled to *Chevron* deference, and the courts were free to interpret Title VII requirements themselves.<sup>155</sup>

Initially, district courts were mixed on whether to follow the EEOC’s guidance.<sup>156</sup> But in the only case to reach a circuit court, the Eighth Circuit held that it was not discrimination under Title VII or the PDA for employers to exclude birth control coverage in employee prescription health care plans.<sup>157</sup> Though the court acknowledged that “prescription contraception is currently only available for women,” it held that the employer’s policy was not discriminatory because it refused to cover all birth control, including vasectomies.<sup>158</sup> Thus, “the coverage provided to women is not less favorable than that provided to men” and “there is no violation of Title VII.”<sup>159</sup> Judge Bye wrote a powerful dissent, arguing that the court was indulging a fiction by viewing the policy as equal:

When one looks at the medical effect of Union Pacific’s failure to provide insurance coverage for prescription contraception, the inequality of coverage is clear. This failure only medically affects females, as they bear all of the health consequences of unplanned pregnancies. An insurance policy providing comprehensive coverage for preventative medical care, including coverage for preventative prescription drugs used exclusively by males, but fails to cover prescription contraception used exclusively by females, can hardly be called equal. It just isn’t so.<sup>160</sup>

After a decade of controversy, contraceptive coverage at the time the ACA was passed was not very different than it was in 1998. Despite nearly universal

153. *Id.*

154. *Id.*

155. Courts have held that Congress did not delegate authority to the EEOC to interpret Title VII. See *Nat’l R.R. Passenger Corp. v. Morgan*, 536 U.S. 101, 110 n.6 (2002). See generally Theodore W. Wern, *Judicial Deference to EEOC Interpretations of the Civil Rights Act, the ADA, and the ADEA: Is the EEOC a Second Class Agency?*, 60 OHIO ST. L.J. 1533 (1999).

156. Compare *Alexander v. Am. Airlines Inc.*, No. 4:02-CV-0252-A, 2002 WL 731815, at \*1 (N.D. Tex. Apr. 22, 2002) (granting a motion to dismiss regarding a complaint by a female employee alleging sex discrimination based on the employer’s failure to cover birth control), with *Cooley v. DaimlerChrysler Corp.*, 281 F. Supp. 2d 979, 981-82, 988 (E.D. Mo. 2003) (denying a motion to dismiss regarding Title VII claim brought by EEOC against employer who refused to cover birth control in its health plan), and *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1271 (W.D. Wash. 2001) (finding that the employer’s exclusion of contraception from its health plan violated Title VII as amended by the PDA).

157. *In re Union Pac. R.R. Emp’t Practices Litig.*, 479 F.3d 936, 944-45 (8th Cir. 2007).

158. *Id.* at 939, 943.

159. *Id.* at 944-45.

160. *Id.* at 945 (Bye, J., dissenting) (“When a policy excludes coverage for vasectomies, the medical effect of this exclusion is born entirely by women, as the record demonstrates women are the only gender which can become pregnant.”); *id.* at 948 (Bye, J., dissenting) (“Once pregnant, only the woman’s health is affected.”).

usage of birth control among women of reproductive age,<sup>161</sup> there was no federal law requiring insurance companies to cover contraception: “[u]nless a state had a contraceptive coverage mandate, insurers and employers could choose whether or not to provide coverage for contraception.”<sup>162</sup> Only half of the states had such mandates, and the state laws had large loopholes that made the law ineffective for 61% of employees.<sup>163</sup> As a result, only 63% of employers covered at least some prescription contraception in 2010 despite otherwise covering prescription drugs.<sup>164</sup> And as was true a decade earlier, plans that covered birth control often did not cover all methods and required women to pay co-pays.<sup>165</sup> Before the Mandate went into effect, 30%–44% of women’s total out-of-pocket health care costs were spent on contraceptives alone.<sup>166</sup>

From the beginning, discussions surrounding how to reform America’s health care system focused on the need to combat the long history of discrimination that women faced in accessing health care. And the ACA sought to craft a remedy to correct this discrimination and improve health care equity.

### B. *The Mandate’s Creation and Evolution*

After the election of President Barack Obama and the prioritization of health care reform, women quickly jumped at the opportunity to correct sex discrimination in health care. The ACA enacted two provisions particularly aimed at fixing these problems. The first, known as Section 1557, officially made it illegal to discriminate in the health care market, including on the basis

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161. GUTTMACHER INST., *CONTRACEPTIVE USE IN THE UNITED STATES 1* (2018) [hereinafter *CONTRACEPTIVE USE IN THE UNITED STATES*], [https://www.guttmacher.org/sites/default/files/factsheet/fb\\_contr\\_use\\_0.pdf](https://www.guttmacher.org/sites/default/files/factsheet/fb_contr_use_0.pdf) (“More than 99% of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method. . . . 60% of all women of reproductive age are currently using a contraceptive method.”).

162. LAURIE SOBEL ET AL., KAISER FAMILY FOUND., *PRIVATE INSURANCE COVERAGE OF CONTRACEPTION 2* (2016), <http://files.kff.org/attachment/issue-brief-private-insurance-coverage-of-contraception>; Hayden, *supra* note 9, at 192–93.

163. SOBEL ET AL., *supra* note 162, at 2.

164. GARY CLAXTON ET AL., KAISER FAMILY FOUND. & NAT’L RESEARCH & EDUC. TR., *EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 196* (2010), <https://www.kff.org/wp-content/uploads/2013/04/8085.pdf>. However, 85% of large employers covered some prescription contraceptives. *Id.*

165. SOBEL ET AL., *supra* note 162, at 2; Adam Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee?*, 20 GUTTMACHER POL’Y REV. 8, 9 (2017), [https://www.guttmacher.org/sites/default/files/article\\_files/gpr2000816\\_0.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr2000816_0.pdf) (showing that most women paid some out-of-pocket expenses for their birth control before the Mandate).

166. NAT’L WOMEN’S LAW CTR., *THE AFFORDABLE CARE ACT’S BIRTH CONTROL BENEFIT: TOO IMPORTANT TO LOSE 2* (2018) [hereinafter *TOO IMPORTANT TO LOSE*], <https://nwlc-ciw49tixgw5lbb.stackpathdns.com/wp-content/uploads/2018/06/BC-Benefit-Whats-At-Stake-MH.pdf>; Nora Becker & Daniel Polsky, *Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 HEALTH AFF. 1204, 1208 (2015), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0127>.

of sex.<sup>167</sup> This provision ended the practice of gender rating<sup>168</sup> and also ensured that women were not treated differently because of “[p]regnancy, childbirth and related medical conditions.”<sup>169</sup> By defining sex discrimination in such a broad way, Section 1557 can “be understood to stand next to Title VII and Title IX, defining a statutory scheme of antidiscrimination law more robust than constitutional protections alone. Such a definition of sex discrimination provides more protections for women seeking health care, and specifically care related to reproduction.”<sup>170</sup> Section 1557 also granted parties the right to sue private actors.<sup>171</sup>

The second provision was the Women’s Health Amendment (Amendment), which requires health plans to cover, “with respect to women, such additional preventive care and screenings” without “any cost sharing requirements.”<sup>172</sup> The legislative history of the Amendment demonstrates that it was intended to correct health plans’ exclusion of services only women need, like mammograms, maternal health care, and birth control.<sup>173</sup> Female legislators were particularly vocal about the need for this Amendment. Senator Kirsten Gillibrand, for instance, lamented the “fundamental inequity in the current system,” which she described as “dangerous and discriminatory,” and argued that the Amendment was needed to ensure “coverage of preventive services [that] takes into account the unique health care needs of women throughout their lifespan.”<sup>174</sup> Senator Barbara Mikulski similarly noted that “[o]ften those things unique to women have not been included in health care reform. Today we guarantee it and we assure it . . . .”<sup>175</sup> She later said that the Amendment was a response to “punitive practices of insurance companies that charge women more

167. 42 U.S.C. § 18116 (2012); Office for Civil Rights, U.S. Dep’t of Health & Human Servs., *Section 1557: Frequently Asked Questions*, HHS.GOV, <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html> (last reviewed May 18, 2017).

168. Elizabeth B. Deutsch, Note, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act’s Nondiscrimination Mandate*, 124 YALE L.J. 2470, 2493 (2015).

169. Office for Civil Rights, U.S. Dep’t of Health & Human Servs., *Section 1557: Protecting Individuals Against Sex Discrimination*, HHS.GOV, <https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-sex-discrimination/index.html> (last reviewed Aug. 25, 2016). The original rule also prohibited discrimination in health care on the basis of gender identity or abortion, but those provisions have been temporarily enjoined in ongoing litigation. *Id.*

170. Deutsch, *supra* note 168, at 2495.

171. *Id.* at 2493–94.

172. 42 U.S.C. § 300gg-13.

173. 155 CONG. REC. S12,271 (daily ed. Dec. 3, 2009) (statement of Sen. Franken) (“Under [the WHA], the Health Resources and Services Administration will be able to include other important services at no cost, such as . . . family planning.”); 155 CONG. REC. S12,272 (daily ed. Dec. 3, 2009) (statement of Sen. Stabenow) (“Women of childbearing age pay on average 68 percent more for their health care than men do.”); 155 CONG. REC. S12,030 (daily ed. Dec. 1, 2009) (statement of Sen. Dodd) (“I support the effort by Senator Mikulski on her efforts to see to it that women are treated equally, and particularly in preventive care . . . .”); 155 CONG. REC. S12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) (“[Women] pay more for the coverage we seek for the same age and the same coverage as men do . . . .”).

174. 155 CONG. REC. S12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand).

175. 155 CONG. REC. S11,988 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski).

and give [them] less in a benefit.”<sup>176</sup> Though the Amendment did not explicitly require insurance companies to cover birth control, contraception was always intended to be a part of the services it required.<sup>177</sup> The Amendment delegated the determination of what services would fall under its umbrella to the Health Resources and Services Administration (HRSA).<sup>178</sup> In an effort to depoliticize the process, HRSA asked the Institute of Medicine to recommend which preventative services should be freely accessible to women.<sup>179</sup> The report, issued in July 2011, recommended that the Amendment cover “[t]he full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.”<sup>180</sup> The following month, HRSA adopted the recommendations, requiring coverage without cost sharing for all FDA-approved contraception—now known as the contraceptive mandate.<sup>181</sup> Even more importantly, as the Amendment called for, the Mandate required insurers to provide this coverage without any co-pays, even when the woman had not yet met her deductible.<sup>182</sup>

HRSA updated the Mandate in December 2016 to address “advancements in science and gaps identified in the existing guidelines.”<sup>183</sup> These updates made the guidelines more specific. The Mandate now requires coverage of the following:

(1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), (8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including

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176. 155 CONG. REC. S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski).

177. Sarah Lipton-Lubet, *Contraceptive Coverage Under the Affordable Care Act: Dueling Narratives and Their Policy Implications*, 22 AM. U. J. GENDER SOC. POLY & L. 343, 346 (2014) (“Although the exact list was to be determined through an administrative process, contraception was always intended to be on it; senator after senator discussed family planning as one of the expected benefits when arguing in favor of adopting the amendment.”).

178. 42 U.S.C. § 300gg-13(a)(4) (2012).

179. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 1 (July 2011), <https://www.nap.edu/resource/13181/reportbrief.pdf>.

180. *Id.* at 3.

181. *Women’s Preventive Services Guidelines*, HEALTH RESOURCES & SERVS. ADMIN. (Sept. 2018), <https://www.hrsa.gov/womens-guidelines/index.html>.

182. *Birth Control Benefits*, *supra* note 1.

183. *Women’s Preventive Services Guidelines*, *supra* note 1.

the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.<sup>184</sup>

HRSA changed the language in response to reports that insurers were using loopholes to avoid covering all types of contraception.<sup>185</sup> For instance, in 2015, the Kaiser Family Foundation found that many insurance companies were not covering all FDA-approved contraceptive drugs and devices—instead covering one brand of birth control pill, one brand of IUD, etc.<sup>186</sup> The Mandate's added specificity ensured that employers must cover every *type* of FDA-approved birth control without co-pays.

New research was also released in this time frame showing that “access to the full range of contraceptive methods is associated with increased contraceptive use and decreased unintended pregnancy rates.”<sup>187</sup> Providing women with a range of birth control options is paramount; when choosing a birth control method, women must make complicated choices that balance their personal risks, preferences, and experiences with side effects.<sup>188</sup> If an insurer only covers options that do not work for a particular woman, then she will not use the method consistently or at all.<sup>189</sup> The updated Mandate recognized the importance of choice and ensured that women had a plethora of options to facilitate consistent use.

Importantly, however, the Contraceptive Mandate is explicitly a female benefit<sup>190</sup> and does not require health plans to cover male birth control: “Plans aren't required to cover . . . services for male reproductive capacity, like vasectomies.”<sup>191</sup> This exclusion is best understood by examining the purpose of the Mandate, which was intended to correct for past discrimination against women: “The contraceptive coverage requirement helps . . . to equalize the provision of preventive health care services to women and, as a result, help[s] women contribute to society to the same degree as men.”<sup>192</sup> Because women were the sex

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184. *Id.*

185. STATE OF BIRTH CONTROL COVERAGE, *supra* note 122, at 6–7 (noting that insurance companies, for instance, were not covering the ring or the patch because they covered other hormonal contraceptive options or only covered generics).

186. LAURIE SOBEL ET AL., KAISER FAMILY FOUND., COVERAGE OF CONTRACEPTIVE SERVICES: A REVIEW OF HEALTH INSURANCE PLANS IN FIVE STATES 1 (2015), <https://www.kff.org/womens-health-policy/report/coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states/>.

187. WOMEN'S PREVENTIVE SERVS. INITIATIVE, RECOMMENDATIONS FOR PREVENTIVE SERVICES FOR WOMEN: FINAL REPORT TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES & SERVICES ADMINISTRATION 82 (Dec. 2016) [hereinafter RECOMMENDATIONS FOR PREVENTIVE SERVICES FOR WOMEN], [http://www.dfr.oregon.gov/business/reg/health/Documents/WPSI\\_2016FullReport.pdf](http://www.dfr.oregon.gov/business/reg/health/Documents/WPSI_2016FullReport.pdf).

188. *See infra* Part III.B.1.

189. SOBEL ET AL., *supra* note 186, at 8.

190. *Women's Preventive Services Guidelines*, *supra* note 1.

191. *Birth Control Benefits*, *supra* note 1 (emphasis omitted).

192. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,869, 39,887 (July 2, 2013), <https://www.federalregister.gov/documents/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act>.

harmed by the status quo, the Mandate focused on women alone. But while guaranteeing free birth control for women was necessary to cure the sex discrimination women faced in health care, excluding men from the guarantee was not. Not only does the Mandate explicitly discriminate against men but also it appears that no one appreciated the negative consequences that a women-exclusive Mandate would create for women.

### C. *The Mandate's Impact*

The Mandate unequivocally cured much of the discrimination women were experiencing in health care before the ACA.<sup>193</sup> As of 2015, “[o]ver 62.4 million women [had] coverage of birth control and other preventive services without out-of-pocket costs.”<sup>194</sup> Moreover, the average percentage of out-of-pocket spending for women who use IUDs or pharmaceutical birth control “dropped by 20 percentage points after implementation of the ACA mandate,”<sup>195</sup> and the average woman saved \$269 per year on birth control.<sup>196</sup> The percentage of women spending no money out of pocket for the birth control pill rose from 15% to 67% after the Mandate; from 27% to 59% for injectable contraception; from 20% to 74% for the contraceptive ring; and from 45% to 62% for the IUD.<sup>197</sup> Overall, women with commercial insurance spent “70% [less] in mean total out-of-pocket expenses for [FDA-]approved contraceptives.”<sup>198</sup> These benefits made the Mandate very popular, with over 77% of women supporting it in 2017.<sup>199</sup>

There is also some evidence to suggest that the Mandate not only saves women money but also increases birth control use. After the Mandate was promulgated, there was a 5% uptick in filled birth control prescriptions,<sup>200</sup> and “[t]he U.S. abortion rate declined 14% between 2011 and 2014”—the lowest it has ever been.<sup>201</sup> In 2017, the numbers dropped further to 13.5%.<sup>202</sup> Some data

193. Vacheria Cherie Tutson, *The Aftermath of Zubik v. Burwell: The War on Contraception*, 60 HOW. L.J. 325, 326 (2016) (“Expanding access to contraceptives finally granted women full and equal health care coverage, addressing the longstanding gender discrimination in health care.”).

194. *Id.* (citing ASSISTANT SEC’Y FOR PLANNING AND EVALUATION, U.S. DEP’T OF HEALTH AND HUMAN SERVS., *THE AFFORDABLE CARE ACT IS IMPROVING ACCESS TO PREVENTIVE SERVICES FOR MILLIONS OF AMERICANS* (2015), [http://aspe.hhs.gov/health/reports/2015/Prevention/ib\\_Prevention.pdf](http://aspe.hhs.gov/health/reports/2015/Prevention/ib_Prevention.pdf)).

195. Becker & Polsky, *supra* note 166, at 1204.

196. STATE OF BIRTH CONTROL COVERAGE, *supra* note 122, at 1.

197. Sonfield, *supra* note 165, at 9.

198. RECOMMENDATIONS FOR PREVENTIVE SERVICES FOR WOMEN, *supra* note 187, at 84.

199. TOO IMPORTANT TO LOSE, *supra* note 166, at 1.

200. *Id.*

201. Joerg Dreweke, *U.S. Abortion Rate Reaches Record Low Amidst Looming Onslaught Against Reproductive Health and Rights*, 20 GUTTMACHER POL’Y REV. 15, 15 (2017).

202. RACHEL K. JONES ET AL., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2017, at 7 (2019), [https://www.guttmacher.org/sites/default/files/report\\_pdf/abortion-incidence-service-availability-us-2017.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf).

also suggests that there was a slight increase in long-term but reversible birth control methods, like IUDs, after they became free.<sup>203</sup> This effect was expected: the price of IUDs, which typically have a high upfront cost, was prohibitive for many women before the Mandate. But overall, public-health experts have been disappointed that free access has not led to greater contraceptive use, and it is not yet clear that the unintended pregnancy rate in the United States has significantly dropped since the Mandate.<sup>204</sup>

A few challenges continue to confront women's access to birth control. First and foremost, 10.6 million women remain uninsured as of 2017.<sup>205</sup> For them, the Mandate provides no protection. Low-income women and women of color are more likely to lack insurance and therefore not be protected by the Mandate.<sup>206</sup> Second, the Mandate's religious exemption, which allows religious employers to avoid the Mandate's requirements, has ballooned after recent Supreme Court decisions and the Trump Administration's expansion of it.<sup>207</sup> Though two courts issued preliminary injunctions in January to stop Trump's expansion of the Mandate's religious exemption from going into effect while the merits are litigated,<sup>208</sup> the Trump Administration's estimates that, if effectuated, its rules would remove the contraceptive benefit from 6,400 to 127,000 women (and opponents suggest the numbers would be much higher than the Administration estimates).<sup>209</sup> Third, employers can still continue to use medical

203. EC Heisel et al., *Utilization of Intrauterine Devices (IUDs) Increases Among Women Who Benefited Most from Mandated Coverage of Contraception*, 96 *CONTRACEPTION* 263, 283 (2017); Caroline S. Carlin, Angela R. Fertig & Bryan E. Dowd, *Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women with Employer Coverage*, 35 *HEALTH AFF.* 1608, 1613 (2016).

204. Jonathan M. Bearak & Rachel K. Jones, *Did Contraceptive Use Patterns Change After the Affordable Care Act? A Descriptive Analysis*, 27 *WOMEN'S HEALTH ISSUES* 316, 320 (2017).

205. KAISER FAMILY FOUND., *WOMEN'S HEALTH INSURANCE COVERAGE* 3 (2018), <http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage>.

206. *Id.* at 3–4; Phyra M. McCandless, *The Fallacy of Mandating Contraceptive Equity: Why Laws That Protect Women with Health Insurance Deepen Institutional Discrimination*, 42 *U.S.F. L. REV.* 1115, 1135 (2008) (noting that these laws are dubbed “contraceptive equity laws”).

207. *See, e.g.,* *Burwell v. Hobby Lobby, Inc.*, 573 U.S. 682 (2014); Religious Exemptions and Accommodations for Coverage of Certain Preventive Services, 83 *Fed. Reg.* 57,536 (Nov. 15, 2018), <https://www.federalregister.gov/documents/2018/11/15/2018-24512/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the>; Moral Exemptions and Accommodations for Coverage of Certain Preventive Services, 83 *Fed. Reg.* 57,592 (Nov. 15, 2018), <https://www.federalregister.gov/documents/2018/11/15/2018-24514/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable>; *see also* Corey A. Ciochetti, *Religious Freedom and Closely Held Corporations: The Hobby Lobby Case and Its Ethical Implementations*, 93 *OR. L. REV.* 259, 304 (2014); *Fact Sheet: Final Rules on Religious and Moral Exemptions and Accommodation for Coverage of Certain Preventive Services Under the Affordable Care Act*, HHS.GOV. (Nov. 7, 2018), <https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html>.

208. *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 792 (E.D. Pa. 2019); *California v. Health & Human Servs.*, 351 F. Supp. 3d 1267, 1267 (N.D. Cal. 2019).

209. Maya Behn et al., *The Trump Administration's Final Regulations Limit Insurance Coverage of Contraception*, 29 *WOMEN'S HEALTH ISSUES* 103, 104 (2019), [https://www.whijournal.com/article/S1049-3867\(18\)30751-5/pdf](https://www.whijournal.com/article/S1049-3867(18)30751-5/pdf).

management techniques to control the cost of birth control.<sup>210</sup> This includes, for instance, imposing cost sharing on a preferred brand-name drug when a generic is available, imposing cost sharing on equivalent branded drugs, or requiring consumers to try a lower cost drug before approving coverage of its higher cost equivalent.<sup>211</sup>

Finally, this Article argues that women's access to birth control is also hindered by the fact that male birth control is not covered. A quarter to a third of women rely on male birth control to prevent pregnancy, and the Mandate simply is not helping these women avoid the costs of contraception.<sup>212</sup> But access is only part of the story: full coverage of male birth control is also necessary for contraceptive equity. As explored below, the government simply should not be encouraging women to take the primary role in any domestic, reproductive, or child-rearing activity.

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The Amendment and Mandate are an incredible step forward in the fight for women's access to birth control. They explicitly benefit women who were suffering from the status quo. Nevertheless, they created a facial sex classification that excludes men from a benefit. Though the government might try to justify the sex classification as necessary to remedy a very real history of sex discrimination in accessing contraception, I argue below that the exclusion of male birth control from the Mandate actually harms the very group it was intended to support and is therefore unconstitutional. The best way to help women and men alike is to make birth control free to both sexes.

### III. CONTRACEPTIVE EQUITY AS A SEX EQUALITY RIGHT

By only requiring insurers to cover cost-free birth control for women, the Mandate uses a constitutionally suspicious sex classification. Not all sex classifications are constitutionally invalid,<sup>213</sup> but this Part argues that the government cannot meet its burden under the Equal Protection Clause to justify the Man-

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210. SOBEL ET AL., *supra* note 162, at 3.

211. DEP'T OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XII) 7 (2013), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf>. "However . . . a plan or issuer must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version." *Id.* Nevertheless, many insurers have never established a specific waiver process. SOBEL ET AL., *supra* note 186, at 2, 17. And even if one exists, women may not be aware of this exception and do not realize they can appeal the insurance company's initial decision.

212. *See infra* Part III.B.1.

213. *See* *Nguyen v. INS*, 533 U.S. 53 (2001); *Michael M. v. Superior Court*, 450 U.S. 464 (1981).

date’s exclusion of men. Part III.A explores the relevant equal protection jurisprudence, and Part III.B then details the four reasons the Mandate’s exclusion of men is not in the best interest of women.

*A. The Mandate’s Exclusion of Men Constitutes Illegal Sex Discrimination*

In *United States v. Virginia*, the Supreme Court held that “neither federal nor state government acts compatibly with the equal protection principle when a law or official policy denies to women, simply because they are women”—or men, simply because they are men—rights or government-sponsored benefits.<sup>214</sup> Under this test, when the government creates a facial sex classification, it must demonstrate that the classification “serves ‘important governmental objectives and that the discriminatory means employed’ are ‘substantially related to the achievement of those objectives.’”<sup>215</sup> The justification for the sex-based classification must be “exceedingly persuasive”<sup>216</sup> and, most importantly, cannot be grounded in sex stereotypes.<sup>217</sup> This test is commonly referred to as intermediate scrutiny.

Though facial sex classifications are typically suspect, they can be upheld when necessary “to compensate women ‘for particular economic disabilities [they have] suffered.’”<sup>218</sup> As a result, remedying a “history of discrimination against women has been recognized as . . . an important governmental objective.”<sup>219</sup> Although the strength of this justification may be less clear today,<sup>220</sup> the government could certainly argue that the Mandate’s sex classification sought to remedy a history of discrimination against women. The Mandate’s

214. 518 U.S. 515, 532 (1996) (per curiam).

215. *Id.* at 533 (internal quotation marks omitted) (quoting *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982)).

216. *Id.*

217. David Fontana & Naomi Schoenbaum, *Unsexng Pregnancy*, 119 COLUM. L. REV. 309, 321 (2019) [https://columbialawreview.org/wp-content/uploads/2019/03/Fontana-Schoenbaum-UNSEXING\\_PREGNANCY.pdf](https://columbialawreview.org/wp-content/uploads/2019/03/Fontana-Schoenbaum-UNSEXING_PREGNANCY.pdf) (“Scholars agree, though, that when it comes to sex discrimination cases, the ball game is about stereotypes, not scrutiny.”).

218. *Virginia*, 518 U.S. at 533 (per curiam) (alteration in original) (quoting *Califano v. Webster*, 430 U.S. 313, 320 (1977)).

219. *Webster*, 430 U.S. at 317 (per curiam) (citing *Schlesinger v. Ballard*, 419 U.S. 498 (1975); *Kahn v. Shevin*, 416 U.S. 351 (1974)).

220. In cases dealing with race, the Supreme Court has limited this justification to instances where the government was remedying its own history of discrimination—a history of societal discrimination was not enough. *See, e.g.*, *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 731 (2007) (“The sweep of the mandate claimed by the district is contrary to our rulings that remedying past societal discrimination does not justify race-conscious government action.” (citing *Shaw v. Hunt*, 517 U.S. 899, 909–10 (1996)); *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 485 (1989); *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267, 276 (1986) (“Societal discrimination, without more, is too amorphous a basis for imposing a racially classified remedy.”)). These cases do not limit their holdings to race discrimination and may therefore apply with equal force in the context of sex discrimination. The government’s sex discrimination with regard to birth control ended nearly fifty years ago with the Supreme Court’s declaration that citizens have a fundamental right to birth control.

exclusion of male birth control “was not a decision rooted in some sort of animus against men. Rather, lawmakers’ and advocates’ focus on women’s health issues was in response to their historical neglect.”<sup>221</sup> The legislative history associated with the Women’s Health Amendment establishes that Congress was genuinely motivated to correct this history of discrimination.<sup>222</sup> And the final rule promulgating the Mandate spelled out the government’s remedial purpose:

The government also has a compelling interest in assuring that women have equal access to health care services. Women would be denied the full benefits of preventive care if their unique health care needs were not considered and addressed. For example, prior to the implementation of the preventive services coverage provision, women of childbearing age spent 68 percent more on out-of-pocket health care costs than men, and these costs resulted in women often forgoing preventive care. The IOM found that this disproportionate burden on women imposed financial barriers that prevented women from achieving health outcomes on an equal basis with men. The contraceptive coverage requirement helps remedy this problem by helping to equalize the provision of preventive health care services to women and, as a result, helping women contribute to society to the same degree as men.<sup>223</sup>

Despite the remedial purpose, sex-based classifications cannot be justified to cure historical discrimination “when the classifications in fact penalize[] women.”<sup>224</sup> For instance, in *Mississippi University for Women v. Hogan*, a male applicant to the nursing program at a state women’s college in Mississippi sued for sex discrimination after being denied admission.<sup>225</sup> The State justified the single-sex admission policy on the basis that “it compensate[d] for discrimination against women and, therefore, constitute[d] educational affirmative action.”<sup>226</sup> The Court was not convinced. It noted that a gender-based classification must be “free of fixed notions concerning the roles and abilities of males and females” and not apply “traditional, often inaccurate, assumptions about the proper roles of men and women.”<sup>227</sup> In this case, the Court found that instead of “compensat[ing] for discriminatory barriers faced by women, MUW’s

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221. Adam Sonfield, *Rounding Out the Contraceptive Coverage Guarantee: Why ‘Male’ Contraceptive Methods Matter for Everyone*, 18 GUTTMACHER POL’Y REV. 34, 35 (2015), [https://www.guttmacher.org/sites/default/files/article\\_files/gpr1803415.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr1803415.pdf).

222. See Lipton-Lubet, *supra* note 177, at 346–47 (“The Women’s Health Amendment was designed to address longstanding gender discrimination in health care. . . . The problem here was not just the cost of care but the fundamental inequity of excluding services, unique to women, from insurance coverage.”); legislative history discussion *supra* Part II.B.

223. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,869, 39,887 (July 2, 2013), <https://www.federalregister.gov/documents/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act>.

224. *Webster*, 430 U.S. at 317 (per curiam) (citing *Califano v. Goldfarb*, 430 U.S. 199, 209 n.8 (1977); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 645 (1975)).

225. 458 U.S. 718, 720–21 (1982).

226. *Id.* at 727.

227. *Id.* at 725–26.

policy of excluding males” actually harmed women by “perpetuat[ing] the stereotyped view of nursing as an exclusively woman’s job.”<sup>228</sup> “MUW’s admissions policy lends credibility to the old view that women, not men, should become nurses, and makes the assumption that nursing is a field for women a self-fulfilling prophecy.”<sup>229</sup> In fact, the American Nurses Association argued that discouraging men from the nursing field actually reduced the largely female nurses’ wages, which the Court remarked would further “penalize[] the very class the State purports to benefit.”<sup>230</sup>

In the decade before *Hogan*, the Court had similarly invalidated various laws that provided economic benefits solely to women as perpetuating harmful stereotypes, despite objections that the laws were intended to remedy past discrimination. In *Frontiero v. Richardson*, the Court invalidated a law that granted automatic spousal benefits to the wives of male service members because it presumed that military wives, not husbands, were always dependent on their spouse.<sup>231</sup> The Court noted that many laws aimed at protecting women, “in practical effect, put women, not on a pedestal, but in a cage.”<sup>232</sup> In *Weinberger v. Wiesenfeld*, the Court invalidated part of the Social Security Act that only paid survivorship benefits to female widows, not male widowers, on the assumption that men work and women stay at home.<sup>233</sup> Finally, in *Orr v. Orr*, the Court held that it was illegal for states to only require men, not women, to pay alimony, even though the law was purportedly passed to “compensat[e] women for past discrimination during marriage.”<sup>234</sup> In so holding, the Court determined that the law was premised on the stereotype that only women need financial support after divorce.<sup>235</sup> As a result, “even statutes purportedly designed to compensate for and ameliorate the effects of past discrimination must be carefully tailored,” and when “the State’s compensatory and ameliorative purposes are as well served by a gender-neutral classification as one that gender classifies and therefore carries with it the baggage of sexual stereotypes, the State cannot be permitted to classify on the basis of sex.”<sup>236</sup>

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228. *Id.* at 729.

229. *Id.* at 730 (citing *Stanton v. Stanton*, 421 U.S. 7, 95 (1975)).

230. *Id.* at 730 n.15.

231. 411 U.S. 677, 678, 689–91 (1973).

232. *Id.* at 684.

233. 420 U.S. 636, 644–45 (1975) (“Obviously, the notion that men are more likely than women to be the primary supporters of their spouses and children is not entirely without empirical support. But such a gender-based generalization cannot suffice to justify the denigration of the efforts of women who do work and whose earnings contribute significantly to their families’ support.” (citation omitted)). The Court similarly invalidated Congress’s subsequent attempt to limit survivor benefits only to widowers who could prove dependency (when widows were not required to prove dependency). *See* *Califano v. Goldfarb*, 430 U.S. 199 (1977).

234. 440 U.S. 268, 280 (1979).

235. *Id.* at 283 (“Legislative classifications which distribute benefits and burdens on the basis of gender carry the inherent risk of reinforcing the stereotypes about the ‘proper place’ of women and their need for special protection.”).

236. *Id.*

Unfortunately, well-intentioned legislators often make the same mistake in their attempts to improve women's rights: create a benefit exclusively for women, which ultimately feeds into stereotypes that harm women. "Many of the efforts to create a separate legal status for women stem from a good-faith attempt to advance the interests of women. Nevertheless, the preponderant effect has been to buttress the social and economic subordination of women."<sup>237</sup> "History and experience have taught us that in such a dual system one group is always dominant and the other subordinate."<sup>238</sup> Catherine MacKinnon argued that "[d]ifference is the velvet glove . . . of domination. This is as true when differences are affirmed as when they are denied, when their substance is applauded or when it is disparaged, when women are punished *or when they are protected in their name*."<sup>239</sup> As the *Orr* Court made clear, most female-exclusive benefits, if made sex-neutral instead, could accomplish the same goals without any of the corresponding harms—women would continue to receive the benefits alongside men but are not disadvantaged by stereotypes.<sup>240</sup> In other words, the *sex classification* is not necessary to remedy the history of discrimination because a sex-neutral benefit (especially one that women may disproportionately access or enjoy) would accomplish the same goals. So too with the Mandate.

There are two cases that could be read to buck this established rule, both of which held that genuine biological differences can justify sex classifications in the law. They have both been heavily criticized,<sup>241</sup> but regardless, their holdings should not apply in the case of the Mandate. The first, *Michael M. v. Superior Court*, upheld a statutory rape law that only punished men who had sex with underage women—not women who had sex with underage men.<sup>242</sup> The Court reasoned that because (1) "[o]nly women may become pregnant, and they suffer disproportionately the profound physical, emotional and psychological consequences of sexual activity" and (2) "a gender-neutral statute would frustrate [the state's] interest in effective enforcement,"<sup>243</sup> the State's sex classification furthered the government's objective to prevent illegitimate, teenage pregnancies

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237. Barbara A. Brown et al., *The Equal Rights Amendment: A Constitutional Basis for Equal Rights for Women*, 80 YALE L.J. 871, 873 (1971).

238. *Id.* at 874.

239. CATHERINE MACKINNON, *FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW* 8 (1987) (emphasis added).

240. *Orr*, 440 U.S. at 282.

241. See, e.g., Rachel K. Alexander, Nguyen v. INS: *The Supreme Court Rationalizes Gender-Based Distinctions in Upholding an Equal Protection Challenge*, 35 CREIGHTON L. REV. 789, 856 (2002) (noting that *Nguyen* "harkened back to the days when it did not consider gender a suspect classification."); David H. Gans, *Stereotyping and Difference: Planned Parenthood v. Casey and the Future of Sex Discrimination Law*, 104 YALE L.J. 1875, 1888–89 (1995) (criticizing the *Michael M.* opinion for "reproduc[ing] stereotypical reasoning while denying its presence" and "[denying] all social meaning attached to women's capacity to become pregnant").

242. *Michael M. v. Superior Court*, 450 U.S. 464 (1981).

243. *Id.* at 471, 473. The "effective enforcement" point was argued on the ground that if women were also liable, they would be less likely to report a crime for fear of mutual liability.

and could survive.<sup>244</sup> The second case, *Nguyen v. INS*, upheld a law that required proof of paternity to establish U.S. citizenship when a child is born outside of the United States to an unmarried alien mother and American father.<sup>245</sup> The law did not apply to children born abroad to an unmarried alien father and American mother.<sup>246</sup> The Court held that the biological, reproductive differences between men and women are not stereotypes: women are always present and participating in the birth of a child, demonstrating maternity, while paternity is more difficult to establish because men are not always present at the birth.<sup>247</sup> In light of the Government's important interest in ensuring that only children descending from an American parent become citizens, the Court held that the Government's sex classification was justified and furthered its goal.<sup>248</sup>

In both cases, the Court decided that when biological differences between the sexes justify the government treating the sexes differently, the sex classification is not unconstitutional. It might be natural to assume that because contraception concerns reproduction—in which biological differences appear the most relevant—the Mandate's exclusion of men could be justified under a similar theory. But this assumption is a mistake for the following reason: all people regardless of sex can prevent pregnancy by using contraception. In other words, the biological differences between men and women are irrelevant here. Though only women can become pregnant,<sup>249</sup> any sexual partner can prevent pregnancy. "Sex classifications unjustified by physical differences are impermissible, because there is then no necessary connection between sex and the classification, and thus the classification is an overbroad stereotype."<sup>250</sup>

Furthermore, intermediate scrutiny would require the government to prove that the sex classification is both important and substantially related to the Mandate's goal. "In practice, sex must serve as a 'perfect proxy' for the law's objective."<sup>251</sup> The Mandate's purpose was to ensure that women can control the number and spacing of their children without regard to cost. A sex-neutral Mandate helps the government accomplish its goal of broadening women's access

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244. *Id.* at 472–74.

245. *Nguyen v. INS*, 533 U.S. 53, 59–60 (2001).

246. *Id.*

247. *Id.* at 73 ("To fail to acknowledge even our most basic biological differences—such as the fact that a mother must be present at birth but the father need not be—risks making the guarantee of equal protection superficial, and so disserving it.").

248. *Id.*

249. Scholars are now challenging the assumption that all pregnancy-related benefits can be justified based on biological differences. See Fontana & Schoenbaum, *supra* note 217, at 311 ("While typically only women can bear children, an emerging consensus across a variety of scholarly fields recognizes the nine months of pregnancy as much more than a physical fact. Rather, pregnancy involves a wide range of care-work—such as quitting smoking, taking a childcare class, and choosing a pediatrician—that has more in common with childrearing than childbearing.").

250. *Id.* at 322.

251. *Id.* at 359.

to all forms of contraception, including contraception used by men.<sup>252</sup> In other words, even if the government attempted to defend the Mandate's sex classification on the biological difference that only women can become pregnant and therefore deserve more government assistance in avoiding pregnancy, the government could never show that the sex classification is substantially related to that goal. Providing men access to free birth control also accomplishes the Mandate's goal of helping women avoid unwanted pregnancy. The government therefore would fail to meet the narrow tailoring required by intermediate scrutiny.

Finally, it is worth noting that both *Michael M.* and *Nguyen* were decided by only five justices over a strong, four-justice dissent.<sup>253</sup> The *Michael M.* dissent argued that the true purpose of the statutory rape law—passed in 1850—was to protect women's chastity (perpetuating a harmful sex stereotype that only women must be chaste) and that the State failed to produce any data showing that the sex classification was necessary to achieve the purported goal of reducing teenage pregnancy.<sup>254</sup> Scholars have also criticized the majority opinion for failing to “examine[] the statute's significance to women,” particularly from an antisubordination perspective.<sup>255</sup> The *Nguyen* dissent similarly argued that the law perpetuated harmful sex stereotypes—that mothers will care for their biological children while fathers will disappear—and that a neutral law could equally accomplish the Government's goals.<sup>256</sup> Scholars have criticized the *Nguyen* majority for applying rational basis review under the guise of intermediate scrutiny.<sup>257</sup> Thus, this line of cases inspires deep skepticism from both scholars and judges, which could discourage the Court from extending it further.

The Supreme Court's equal protection precedent underscores that the state can only justify a facial sex classification to remedy historical discrimination if it does not perpetuate harmful sex stereotypes or effectively harm the group it intends to benefit. Part III.B describes the myriad ways women are disadvantaged by the Mandate's refusal to cover male birth control. Though it is clear that the Amendment and Mandate were created to combat a legitimate history of sex discrimination in access to contraception, it is equally clear that the exclusion of men from the Mandate harms women. As a result, the sex classifica-

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252. As argued in Part IV below, roughly a quarter to a third of women rely on male forms of birth control to avoid conception. See *infra* Part III.B.3.

253. *Nguyen*, 533 U.S. at 74; *Michael M. v. Superior Court*, 450 U.S. 464, 488, 496 (1981).

254. *Michael M.*, 450 U.S. at 493–95.

255. Ruth Colker, *Anti-Subordination Above All: Sex, Race, and Equal Protection*, 61 N.Y.U. L. REV. 1003, 1044 (1986).

256. *Nguyen*, 533 U.S. at 85, 92 (O'Connor, J., dissenting).

257. See, e.g., Alexander, *supra* note 241, at 855; Erin Chlopak, Comment, *Mandatory Motherhood and Frustrated Fatherhood: The Supreme Court's Preservation of Gender Discrimination in American Citizenship Law*, 51 AM. U. L. REV. 967, 997 (2002); Norman T. Deutsch, *Nguyen v. INS and the Application of Intermediate Scrutiny to Gender Classifications: Theory, Practice, and Reality*, 30 PEPP. L. REV. 185, 267 (2003).

tion does not further the goal of the law. The best remedy for this equal protection violation would be to require universal access to cost-free birth control, which would ensure women receive all the Mandate's benefits without any of the harms.

*B. The Mandate's Exclusion of Men Harms Women*

The Mandate was a huge win for women. For many, it represented the end of a long battle to ensure that women could control the number and spacing of their children. Because the movements advancing birth control have always been led by women on behalf of women, it is unsurprising that the Mandate crystallizes the right to birth control as a woman's right. But as argued below, coverage of male birth control is, in fact, a women's rights issue. Only women experience the physical effects of unwanted pregnancy, and as a result, failing to cover male birth control harms the women who become pregnant because they or their partners lacked access to male birth control. Furthermore, the Mandate incentivizes women, not men, to endure the risks, side effects, and burdens of contraception. It also stymies innovation for male birth control, frustrating the possibility of true contraceptive equity. Finally—and most importantly from a constitutional law perspective—the Mandate codifies the unfortunate stereotypes that birth control is a woman's problem, that women are to blame for unintended pregnancies, and that men are not concerned about unwanted pregnancies or responsible enough to be trusted with birth control.

Of course, men also stand to benefit from free access to male birth control—they too should be able to control the number and spacing of their children without regard to cost. They too would benefit from more contraceptive options and greater autonomy over their reproductive destinies. This Part focuses on the benefits to women, however, to preclude an argument that the history of sex discrimination against women in accessing contraception justifies the Mandate's exclusion of men. This Part fundamentally argues that limiting the Mandate to women harms the very group the law was designed to assist and therefore cannot be justified on the grounds that it remedies past discrimination.<sup>258</sup> Nevertheless, this is not a zero-sum game, and men stand to benefit as much as women from universal access to free birth control.

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258. This Article examines these arguments solely in the context of birth control (and the Mandate), not with regard to preventative health services (and the Amendment) generally. As a result, I am not addressing whether the entirety of the Women's Health Amendment is unconstitutional.

1. *The Physical Consequences of Uncovered Male Birth Control Fall on Women, Many of Whom Prefer Male Contraception*

“Women, and only women, bear all of the *physical* burdens of unwanted pregnancy.”<sup>259</sup> Access to any kind of birth control affects women, who alone become pregnant when contraception is unavailable. This is true regardless of whether the uncovered birth control is made for women or men.<sup>260</sup> Thus, excluding men from the Mandate disproportionately harms women, who bear the exclusive physical consequences of any unintended pregnancy.

Figure 1<sup>261</sup>

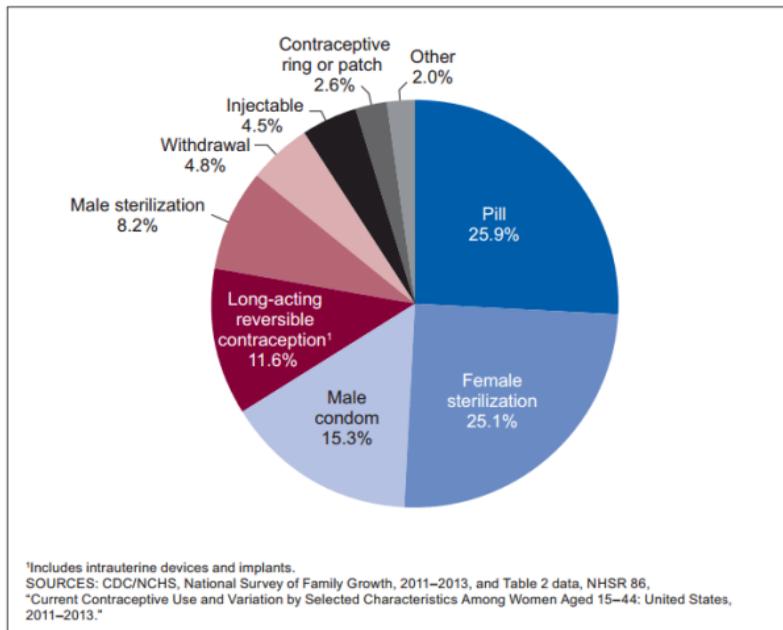


Figure 1. Percent distribution of women aged 15–44 who are currently using contraception, by type of contraceptive method used: United States, 2011–2013

259. Law, *supra* note 10, at 375.

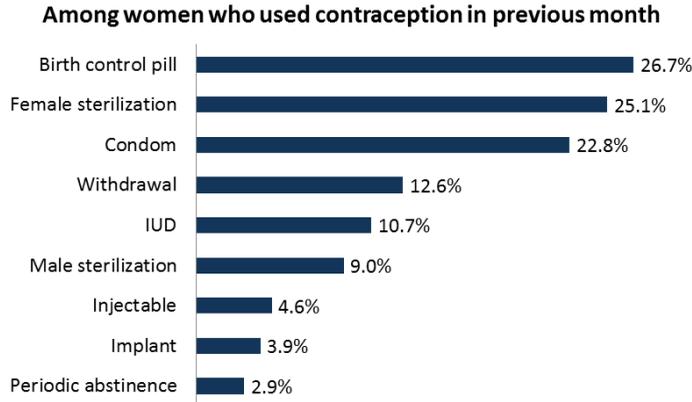
260. *In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 945 (8th Cir. 2007) (Bye, J., dissenting) (“When a policy excludes coverage for vasectomies, the medical effect of this exclusion is born entirely by women.”).

261. Kimberly Daniels et al., *Current Contraceptive Use and Variation by Selected Characteristics Among Women Aged 15–44: United States, 2011–2013*, 86 NAT'L HEALTH STAT. REP. 1, 4 (2015), <https://www.cdc.gov/nchs/data/nhsr/nhsr086.pdf>.

Figure 2<sup>262</sup>

Figure 1

### Contraceptive methods used by women ages 15-44, 2011-2013



Note: 61.7% of women ages 15-44 used contraception in previous 30 days. More than one method may be used by a woman., but these data only reflect most effective method used.

Source: CDC. (2015). *Health, United States, 2014: Table 9.*



Roughly a quarter to a third of women rely on male forms of birth control to prevent pregnancy.<sup>263</sup> Fifteen to twenty-two percent of women rely on condoms, while eight to nine percent rely on their partner's vasectomy.<sup>264</sup> To put that figure in context, at least as many women rely on male forms of birth control as rely on the birth control pill.<sup>265</sup> Partners in monogamous relationships typically discuss how to prevent unwanted pregnancy collectively and choose a form of birth control together.<sup>266</sup> Research has shown that male birth control is “not necessarily ‘male-controlled’ contraception” but rather “involves both sexual partners[, where] women play an active role in decision[-]making.”<sup>267</sup> There are many reasons why couples might prefer male birth control: the female partner might experience side effects or risks with hormonal birth control that range from annoying to debilitating, the couple might decide that equity demands each partner to take a turn with contraception, or the male partner might prefer the control and assurances associated with being the contraceptive

262. SOBEL ET AL., *supra* note 162, at 1.

263. *See supra* Figures 1 and 2.

264. *Id.*

265. *Id.*

266. *Condom Use from a Female Perspective: Clue's Study with KI-CURT*, CLUE (Apr. 11, 2018), <https://hello.clue.com/articles/sex/condom-survey>.

267. *Id.*

user.<sup>268</sup> Vasectomies, for instance, are the safest, least invasive, and most effective form of permanent birth control, which might be particularly appealing for couples who are finished having (or never want) children.<sup>269</sup>

For casual sexual relationships, the individuals might prefer male birth control for its immediate accessibility and the prevention of sexually transmitted diseases. Condoms are the only contraceptive that can prevent both pregnancy and STDs.<sup>270</sup> They are also the only form of birth control available over the counter and on immediate demand other than emergency contraception, which is not intended for regular use. Female birth control requires a doctor's appointment: diaphragms need to be fitted, pharmaceuticals require a prescription, and of course, surgical options involve a hospital procedure.<sup>271</sup> This physician barrier is especially problematic for adolescents and young women who often do not control their own doctors' appointments and might be embarrassed to talk about sex with an adult, especially if a parent is present.<sup>272</sup> These reasons are why the majority of female adolescents rely on condoms for birth control<sup>273</sup> and 75% of women use condoms for contraception the first time they have sex.<sup>274</sup>

The physician barrier associated with female contraception may also play a role in the racial disparities in contraceptive use: minority women—who have the least access to the health care system—are almost twice as likely to use condoms as white women.<sup>275</sup> One survey reported that 21% of black women and 17% of Hispanic women rely on condoms, compared to 11% of white women.<sup>276</sup> This trend is likely the result of two factors. First, the health care system marginalizes minority women, making it even more difficult for these

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268. See OUDSHOORN, *supra* note 121, at 183–85 (describing a desire to share contraceptive burdens); Sonfield, *supra* note 221, at 36 (discussing that just as some women “favor contraceptive methods that they can control,” so, too, do some men); Sonfield, *supra* note 165, at 9.

269. See *supra* Part III.B.1.

270. *Preventing STDs & Pregnancy*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/teens/preventing-pregnancy-stds> (“Condoms are the only type of birth control that helps prevent pregnancy and STDs at the same time.”) (last visited Nov. 12, 2019).

271. See generally Sharon Cohen Landau, et al., *Birth Control Within Reach: A National Survey on Women's Attitudes Toward and Interest in Pharmacy Access to Hormonal Contraception*, 74 *CONTRACEPTION* 463 (2006), [https://www.contraceptionjournal.org/article/S0010-7824\(06\)00311-8/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(06)00311-8/fulltext).

272. See COMMITTEE ON ADOLESCENTS, AM. ACAD. OF PEDIATRICS, *CONTRACEPTION AND ADOLESCENTS* 1137 (2007), <http://pediatrics.aappublications.org/content/pediatrics/120/5/1135.full.pdf> (“The primary reason that adolescents may hesitate or delay obtaining family planning or contraceptive services is concern about lack of confidentiality.”).

273. Abma & Martinez, *supra* note 17, at 7; *CONTRACEPTIVE USE IN THE UNITED STATES*, *supra* note 161, at 7.

274. Abma & Martinez, *supra* note 17, at 1.

275. Cynthia D. Grady et al., *Racial and Ethnic Differences in Contraceptive Use Among Women Who Desire No Future Children, 2006–2010 National Survey of Family Growth*, 92 *CONTRACEPTION* 62, 67 tbl.3 (2015).

276. *Id.*

women to obtain physician assistance with their birth control decision.<sup>277</sup> Second, black women have a particularly traumatic historical experience with birth control: “During the 1960s and 1970s, thousands of poor black women were coercively sterilized under federally funded programs. Women were threatened with termination of welfare benefits or denial of medical care if they didn’t ‘consent’ to the procedure.”<sup>278</sup> It is therefore not surprising that “many black[] [women see] the pill as just another tool in the white man’s efforts to curtail the black population” and instead choose to rely on condoms.<sup>279</sup>

In addition to the physician barrier, most methods of female birth control—those that involve hormones or surgery—are not immediately effective after they are initiated.<sup>280</sup> Hormonal forms of birth control, including the pill, patch, IUD, and injections, typically require a wait period before unprotected sex is recommended, unless timed with a woman’s period.<sup>281</sup> And physicians typically recommend at least a week after tubal ligation before having sex.<sup>282</sup> Of course, this does not take into account the wait time to get an appointment with your doctor or schedule surgery.<sup>283</sup> Taken together, female birth control is clearly a planned intervention that works best for women who engage in regular sexual activity. But sex is not always planned or with a regular partner. Condoms are the only form of birth control that work instantaneously, do not require a doctor’s visit, and can be purchased at almost any pharmacy, gas station, or grocery store. Women who have unplanned sex need access to unplanned birth control.

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277. Karla Kossler et al., *Perceived Racial, Socioeconomic and Gender Discrimination and Its Impact on Contraceptive Choice*, 84 *CONTRACEPTION* 273, 273–75 (2011), [https://www.contraceptionjournal.org/article/S0010-7824\(11\)00005-9/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(11)00005-9/fulltext); see also Lisa S. Callegari et al., *Racial/Ethnic Differences in Contraceptive Preferences, Beliefs, and Self-Efficacy Among Women Veterans*, 216 *AM. J. OBSTETRICS & GYNECOLOGY* 504.e1, e7 (2017) (“Because hormonal methods require a prescription or insertion and removal by a provider, mistrust of family-planning providers may be another factor underlying minority women’s preferences for nonhormonal methods that can be obtained without providers.”).

278. Dorothy Roberts, *Forum: Black Women and the Pill*, 32 *GUTTMACHER INST.* (Mar. 1, 2000), <https://www.guttmacher.org/journals/psrh/2000/03/forum-black-women-and-pill>.

279. *Id.* (emphasis omitted); Callegari et al., *supra* note 277, at e3 (“Other studies have found that, compared with whites, minority women have greater concerns about hormonal method safety and side effects and higher mistrust of family planning providers.”).

280. Unless hormonal contraception is started when the woman is menstruating, hormonal forms of birth control are generally not effective for at least two to seven days. *How Long Does It Take for Birth Control to Work? Pills, IUD, and More*, *HEALTHLINE*, <https://www.healthline.com/health/birth-control/how-long-does-birth-control-take-to-work#shot> (last visited Oct. 25, 2019).

281. *Id.*

282. *What Can I Expect If I Get a Tubal Ligation?*, *PLANNED PARENTHOOD*, <https://www.plannedparenthood.org/learn/birth-control/sterilization/what-can-i-expect-if-i-get-tubal-ligation> (last visited Oct. 25, 2019).

283. Landau et al., *supra* note 271, at 463 (“Appointment delay is a significant obstacle even for women who have access to care: a national survey found that a new patient waits for more than 2 weeks for an obstetrics–gynecology appointment.”).

The Mandate recognizes that it is not acceptable for women to simply have access to *a* form of birth control; they must have access to options. The availability of options ensures successful use:

One basic truth for reproductive health advocates when talking about the [Mandate] is that contraceptive methods are not interchangeable. . . . [P]eople need unfettered access to not just any method of contraception, but to the one most suitable for their individual needs and circumstances at any given time in their reproductive lives.<sup>284</sup>

Choice is paramount to birth control's efficacy—women who dislike their birth control “are particularly likely to use it inconsistently or incorrectly, or to experience gaps in use.”<sup>285</sup> Improper or inconsistent use, of course, leads to unintended pregnancy.<sup>286</sup> The Mandate was updated in 2016 in recognition that “access to the full range of contraceptive methods is associated with increased contraceptive use and decreased unintended pregnancy rates.”<sup>287</sup> The revised version required insurers to cover every method of FDA-approved female birth control so that women can decide, based on their own needs, which method is best for them.<sup>288</sup> But for many women, the method that works best for them is designed for men. A woman's choice is therefore not fully empowered until she can just as easily and cheaply decide to rely on male birth control for contraception as female birth control.

Until male methods of birth control are added to the Mandate, the cost of birth control may continue to be a barrier for women who rely on male birth control. While condoms are relatively inexpensive compared to most forms of birth control—they typically cost less than \$1 per condom if purchased in bulk<sup>289</sup>—they “can cost substantial amounts over a year, not to mention over the 30 years that a woman typically spends trying to avoid pregnancy.”<sup>290</sup> This low cost might nevertheless be prohibitive for the primary group of women who rely on them: adolescents. Vasectomies, on the other hand, are expensive. A vasectomy can cost between \$350 and \$1,000<sup>291</sup> but on average costs \$708.<sup>292</sup> Seventy-five percent of insurance companies cover the procedure for men—but with cost sharing.<sup>293</sup> Thus, if the man has not met his deductible, he could be responsible for the full amount, even if the procedure is covered; when his

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284. Sonfield, *supra* note 221.

285. Sonfield, *supra* note 165.

286. *Id.*

287. RECOMMENDATIONS FOR PREVENTIVE SERVICES FOR WOMEN, *supra* note 187.

288. *See supra* Part III.B.1.

289. *How Do I Get Condoms?*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/birth-control/condom/how-do-i-get-condoms> (last visited Oct. 25, 2019).

290. CONTRACEPTIVE USE IN THE UNITED STATES, *supra* note 161, at 4.

291. KAISER FAMILY FOUND., STERILIZATION AS A FAMILY PLANNING METHOD 3 (2018), <https://www.kff.org/womens-health-policy/fact-sheet/sterilization-as-a-family-planning-method/>.

292. Nguyen et al., *supra* note 18, at 4.

293. *Id.*

deductible has already been met, he will typically pay a percentage of the cost as a co-pay.<sup>294</sup> A vasectomy with a 30% co-pay would still cost more than \$200 based on the average price.<sup>295</sup>

The Mandate was promulgated to ensure that women can control the number and spacing of their children regardless of their financial circumstances. The Mandate is therefore not doing its job for the substantial number of women (25%–33%) who rely on male birth control.<sup>296</sup> The harms fall disproportionately on young and minority women. If male birth control options were covered under the Mandate, insurers would be required to pay for condoms<sup>297</sup> and vasectomies without cost sharing, just like all forms of female birth control. Because all kinds of birth control—whether for men or women—are used to prevent pregnancy *in women*, the government should ensure access to both. If the Mandate aims to help women avoid unintentional pregnancy, it does not matter who uses the contraception. Creating an inclusive Mandate that covers male and female birth control does not take anything away from women; rather, it gives women more options.

## 2. *The Mandate Incentivizes Women to Bear All the Side Effects and Risks of Birth Control*

Like all pharmaceuticals, devices, and surgeries, birth control has inherent risks and side effects. The Mandate incentivizes women, not men, to endure those risks and side effects by making it cheaper for women to use birth control.<sup>298</sup> This is particularly problematic for surgical options: vasectomies are more effective, less invasive, and less risky than tubal ligation, but the Mandate ensures that tubal ligation is more affordable.<sup>299</sup> The same can be said of hormonal contraception and condoms. Though the methods are quite different,

294. *Id.*

295. *Id.*

296. *See supra* Figures 1 and 2.

297. Some might wonder how, logistically, it would work to require insurers to cover over-the-counter contraceptives like condoms. First, insurers are already required to pay for over-the-counter emergency contraception. *Women's Preventive Services Guidelines*, *supra* note 1. Second, the FDA just approved the first app to prevent pregnancy, and insurers will theoretically need to find ways to reimburse women who purchase it. Kate Sheridan, *Will Insurers Have to Cover the Controversial Contraception App Natural Cycles Under Obamacare's Mandate?*, STAT (Sept. 18, 2018), [https://www.statnews.com/2018/09/18/obamacare-natural-cycles-contraception-app-insurance/?wpisrc=nl\\_health202&wpm=1](https://www.statnews.com/2018/09/18/obamacare-natural-cycles-contraception-app-insurance/?wpisrc=nl_health202&wpm=1). The agency will also face its first over-the-counter drug application for hormonal contraception in the next few years. *See, e.g.*, Emily Crockett, *The First Steps Toward Over-The-Counter Birth Control in the US Are Finally Underway*, VOX (Dec. 30, 2016), <https://www.vox.com/2016/12/30/14120874/birth-control-over-the-counter-fda-ibis-hra-pharma>. As a result, health insurers must already create the logistical mechanisms to cover (or reimburse) contraception that does not result from a traditional health care encounter. It should be easy for condoms to be covered in the same way.

298. Shari Motro, *The Price of Pleasure*, 104 NW. U. L. REV. 917, 934 (2010) (“[E]ffective contraception . . . come[s] at great costs, costs that are paid almost entirely by women.”).

299. Nguyen et al., *supra* note 18; *see supra* Part III.B.1.

the Mandate financially encourages women to endure the known risks and side effects of hormonal birth control over condoms, which are less risky.

Every kind of female birth control comes with risks to the user. Nearly 45% of women rely on hormonal methods of birth control: roughly 26% rely on the birth control pill, 4.5% rely on hormonal injections, 2.6% rely on hormonal rings or patches,<sup>300</sup> and 11% rely on IUDs or other implants, most of which also contain hormones.<sup>301</sup>

Though the discovery of hormonal contraception was revolutionary for women, the innovation is not without complications:

[The] harmful side effects [of hormonal birth control] are incontrovertible. Documented risks include strokes, heart attacks, migraine headaches, cancer, diabetes, asthma, breast pains, vaginal dryness and infections, and loss of sexual desire. According to some studies, newer “third generation” pills developed in the 1980s to reduce earlier pills’ minor side effects like acne or facial hair actually double the risk of blood clots—which can result in a stroke, deep vein thrombosis, or pulmonary embolism.<sup>302</sup>

Though the most serious risks of birth control are generally uncommon in healthy, young women, the risks may be unacceptably high for women over the age of thirty-five who smoke or have certain health conditions, like high blood pressure, hypertension, migraines with aura, venous thromboembolism, or diabetes.<sup>303</sup> Doctors recommend that these women avoid estrogen-based contraceptives entirely.<sup>304</sup> Given that 17.6% of women between the ages of thirty-five and forty-four have hypertension and 12.2% of adult women smoke, a significant portion of women are not medically eligible for hormonal birth control.<sup>305</sup> These women are left to rely on surgical contraception, female barrier methods

300. Daniels et al., *supra* note 261, at 10 tbl.2; SOBEL ET AL., *supra* note 162, at fig.1.

301. Daniels et al., *supra* note 261, at 10 tbl.2; SOBEL ET AL., *supra* note 162, at fig.1.

302. Motro, *supra* note 298, at 934; *see also, e.g.*, Omosalewa O. Lalude, *Risk of Cardiovascular Events with Hormonal Contraception: Insights from the Danish Cohort Study*, 15 CURRENT CARDIOLOGY REP. 373, 374 (2013) (“OC pills have long been associated with risk of venous thromboembolism (VT), i.e., deep vein thrombosis (DVT) and pulmonary embolism (PE); and arterial thrombosis (AT), i.e., thrombotic stroke (TS) and myocardial infarction (MI) . . . . Concern for these risks was heightened in 1995 with reports of increased risk of VT with 3rd generation progestins . . .”).

303. Rachel A. Bonnema et al., *Contraception Choices in Women with Underlying Medical Conditions*, 82 AM. FAMILY PHYSICIAN 621, 625 (2010); *Prescribing Contraceptives for Women over 35 Years of Age*, 68 AM. FAMILY PHYSICIAN 547, 547 tbl.1 (2003).

304. *Prescribing Contraceptives for Women over 35 Years of Age*, *supra* note 303.

305. AM. HEART ASS’N, STATISTICAL FACT SHEET 2013 UPDATE: HIGH BLOOD PRESSURE 1 (2013), [https://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm\\_319587.pdf](https://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_319587.pdf); *Current Cigarette Smoking Among Adults in the United States*, CTRS. FOR DISEASE CONTROL AND PREVENTION, [https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/adult\\_data/cig\\_smoking/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm).

like diaphragms, non-hormonal IUDs, or male birth control. Hormonal contraceptives may also be less effective in obese women, who might be encouraged to rely on other forms of birth control.<sup>306</sup>

Moreover, young, healthy women who are not medically disqualified from use often experience side effects like depression, libido loss, prolonged bleeding, migraines, weight gain, or acne that make hormonal birth control undesirable.<sup>307</sup> Side effects are the predominate reason hormonal birth control has such high discontinuation rates.<sup>308</sup> In one study, 50% of women discontinued hormonal contraceptives within a year of starting; one-third stopped because of physical side effects, and one-third stopped because of emotional side effects.<sup>309</sup> Changes in mood after starting hormonal birth control are particularly common and difficult for women.<sup>310</sup> One study reports that 50% of women who have taken hormonal birth control experienced at least one mood effect.<sup>311</sup> Reduced libido is another common side effect: 38% of women experienced a sexual side effect on hormonal contraception,<sup>312</sup> and 8% of women who discontinued birth control did so because of sexual side effects.<sup>313</sup> In another study, 30% of contraceptive users experienced an increase in headaches, 27% experienced a negative effect in mood, 33% experienced weight gain, and 35% experienced reduced libido after six months on hormonal contraception.<sup>314</sup> Many women reasonably decide that hormonal birth control is not worth the sacrifices to their physical, mental, or sexual health. (Of course, almost all forms of female birth control contain hormones; only the copper IUD, surgery, and diaphragms are hormone-free.)

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306. Victoria L. Holt et al., *Body Weight and Risk of Oral Contraceptive Failure*, 99 *OBSTETRICS & GYNECOLOGY* 820, 820 (2002).

307. SARAH CASTLE & IAN ASKEW, POPULATION COUNCIL, *CONTRACEPTIVE DISCONTINUATION: REASONS, CHALLENGES, AND SOLUTIONS* 6–8 (2015), [http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/02/FP2020\\_ContraceptiveDiscontinuation\\_SinglePage\\_Revise\\_02.15.16.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/02/FP2020_ContraceptiveDiscontinuation_SinglePage_Revise_02.15.16.pdf); Franca Fruzzetti et al., *Discontinuation of Modern Hormonal Contraceptives: An Italian Survey*, 21 *EUROPEAN J. CONTRACEPTION & REPROD. HEALTH* 449, 451 fig.3 (2016).

308. Thirty to fifty percent of women stopped using the pill within a year, the majority of whom stopped because of side effects. See Stephanie A. Sanders et al., *A Prospective Study of the Effects of Oral Contraceptives on Sexuality and Well-Being and Their Relationship to Discontinuation*, 64 *CONTRACEPTION* 51, 53–54 (2001); A. Zibners et al., *Comparison of Continuation Rates for Hormonal Contraception Among Adolescents*, 12 *J. PEDIATRIC & ADOLESCENT GYNECOLOGY* 90, 92–94 (1999); *Discontinuation of Contraceptive Methods*, *CTRS. FOR DISEASE CONTROL AND PREVENTION* (July 7, 2017), [https://www.cdc.gov/nchs/nsfg/key\\_statistics/d.htm#discontinuationcont](https://www.cdc.gov/nchs/nsfg/key_statistics/d.htm#discontinuationcont).

309. Sanders et al., *supra* note 308, at 53–54.

310. Ghodrattollah Shakerinejad et al., *Factors Predicting Mood Changes in Oral Contraceptive Pill Users*, 10 *REPROD. HEALTH*, 2013, at 3–4.

311. Ellen R. Wiebe et al., *Characteristics of Women Who Experience Mood and Sexual Side Effects with Use of Hormonal Contraception*, 33 *J. OBSTETRICS & GYNECOLOGY CANADA* 1234, 1236 (2011).

312. *Id.*

313. Sanders et al., *supra* note 308, at 53–54.

314. Carolyn L. Westhoff et al., *Oral Contraceptive Discontinuation: Do Side Effects Matter?*, 196 *AM. J. OBSTETRICS & GYNECOLOGY* 412.e1, 412.e5 tbl.2 (2007).

Surgical options for female birth control also come with serious risks and side effects. A quarter of women rely on surgical birth control to prevent pregnancy.<sup>315</sup> There are two types of tubal ligation, both of which require the patient to undergo general anesthesia.<sup>316</sup> The physician must cut through the woman's abdomen, and though tubal ligation is generally safe and well tolerated, women are subject to all the pain and risks of surgery, including bleeding, infection, damage to other organs, and complications with the anesthesia.<sup>317</sup> Patients frequently feel cramping, pain at the incision site, shoulder pain, dizziness, fatigue, and bloating.<sup>318</sup> As discussed below, vasectomies are a less risky, less invasive, and more effective form of surgical birth control for monogamous partners.

Contraceptive implants and devices, like IUDs, carry their own risks and side effects. IUDs are notorious for their painful insertion, particularly for women who have not had children—most nulliparous women rate the pain between a four and an eight, where a zero is no pain and a ten is the most extreme pain imaginable.<sup>319</sup> Fourteen percent designate the pain as severe.<sup>320</sup> Though clinicians have searched for ways to mitigate the pain, their success has been limited.<sup>321</sup> Women also experience pain, backaches, cramping, and bleeding after the insertion.<sup>322</sup> Women who choose the copper IUD can also expect to experience heavier periods and worse menstrual cramps.<sup>323</sup> Occasionally, IUD insertion can cause an infection or a perforated uterus, which can lead to infertility, severe pain, and other health complications.<sup>324</sup>

Of course, for most women, the incredible benefit of birth control—preventing pregnancy—outweighs its side effects and risks. But this Article questions whether the government should incentivize women to endure the risks when men are equally capable of preventing pregnancy.<sup>325</sup> After all, when men

315. See *supra* Figures 1 and 2.

316. STERILIZATION AS A FAMILY PLANNING METHOD, *supra* note 291, at 2.

317. *Id.*; *Tubal Ligation*, JOHNS HOPKINS MED., [https://www.hopkinsmedicine.org/healthlibrary/test\\_procedures/gynecology/tubal\\_ligation\\_135,2](https://www.hopkinsmedicine.org/healthlibrary/test_procedures/gynecology/tubal_ligation_135,2) (last visited Sept. 10, 2019).

318. Mayo Clinic Staff, *Tubal Ligation*, MAYO CLINIC (Mar. 29, 2018), <https://www.mayoclinic.org/tests-procedures/tubal-ligation/about/pac-20388360>.

319. Andrea Brockmeyer et al., *Experience of IUD/IUS Insertions and Clinical Performance in Nulliparous Women - A Pilot Study*, 13 EUR. J. CONTRACEPTION & REPROD. HEALTH CARE 248, 250 (2008).

320. *Id.*

321. See, e.g., Paula H. Bednarek et al., *Prophylactic Ibuprofen Does Not Improve Pain with IUD Insertion: A Randomized Trial*, 91 CONTRACEPTION 193, 194–95 (2015); K. Gemzell-Danielsson et al., *Management of Pain Associated with the Insertion of Intrauterine Contraceptives*, 19 HUM. REPROD. UPDATE 419, 419 (2013); Laureen M. Lopez et al., *Interventions for Pain with Intrauterine Device Insertion*, COCHRANE LIBR., July 29, 2015, <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007373.pub3/epdf/full>.

322. *What Are the Disadvantages of IUDs?*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/birth-control/iud/what-are-the-disadvantages-of-iuds> (last visited Sept. 10, 2019).

323. *Id.*

324. *How Safe Is the IUD?*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/birth-control/iud/how-safe-is-the-iud> (last visited Sept. 10, 2019).

325. Motro, *supra* note 298, at 934–35 (“Women who are aware of [birth control’s] risks presumably feel the pill’s benefits outweigh its potential harms, but in this tradeoff most of the downsides fall on the woman . . .”).

take responsibility for birth control, women experience the benefits without any personal costs. And, frequently, the risks to men are less than the risks to women.

The perfect way to demonstrate the Mandate's problematic implications for women is to juxtapose vasectomy and tubal ligation. Both methods are permanent forms of birth control and both require surgery. But vasectomy is safer, less invasive, and more effective than tubal ligation. For instance, "[a]bdominal access for tubal ligation carries 20 times the risk of major complications compared to vasectomy" and "[p]ostoperative complications, such as bleeding and infection, are also more common among tubal ligations than vasectomies (1.2% vs. 0.043%)."<sup>326</sup> A vasectomy is a quick procedure that is performed while the man is awake under local anesthesia; patients are free to go home as soon as the procedure concludes.<sup>327</sup> Tubal ligation, however, is a more involved procedure because it typically requires general anesthesia; thus, the patient must get an IV, might be placed on a ventilator, and will take a few hours to awaken after surgery.<sup>328</sup> The additional costs associated with an anesthesiologist's fee and an operating room render a tubal ligation three to four times more expensive to perform than a vasectomy. However, with the Mandate, most consumers no longer pay for the extra cost.<sup>329</sup>

Though tubal ligation is one of the most effective forms of birth control—with a failure rate of only five pregnancies per 1,000 women—it becomes less effective over time.<sup>330</sup> Ten years after the procedure, the failure rate more than triples to eighteen to thirty-seven pregnancies per one thousand women.<sup>331</sup> By comparison, a vasectomy is consistently the most reliable form of birth control, with a failure rate of one pregnancy per one thousand women—dramatically lower than even the most effective tubal ligation.<sup>332</sup> Plus, when tubal ligation does fail to prevent pregnancy, it “carries a 33% risk of ectopic pregnancy,” for which the pregnant woman will experience “significant risk of morbidity and mortality.”<sup>333</sup>

Despite the fact that a vasectomy is safer, less invasive, less expensive, and more effective, it is used much less frequently. Only 8% of women rely on a

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326. Nguyen et al., *supra* note 18 (footnotes omitted); Nancy W. Hendrix et al., *Sterilization and Its Consequences*, 54 *OBSTETRICAL & GYNECOLOGICAL SURV.* 766, 766 (1999) (“Compared with a vasectomy, [tubal ligation] is 20 times more likely to have major complications, 10 to 37 times more likely to fail, and cost three times as much.”).

327. Mayo Clinic Staff, *Vasectomy*, MAYO CLINIC (Feb. 14, 2019), <https://www.mayoclinic.org/tests-procedures/vasectomy/about/pac-20384580>.

328. See Nguyen et al., *supra* note 18.

329. *Id.* at 4.

330. STERILIZATION AS A FAMILY PLANNING METHOD, *supra* note 291, at 2.

331. *Id.*

332. *Id.* at 3.

333. Nguyen et al., *supra* note 18.

partner's vasectomy, compared to the 25% who rely on their own tubal ligation.<sup>334</sup> The Mandate “may widen this disparity by comparatively increasing cost barriers and decreasing social expectations for men.”<sup>335</sup> The Mandate ensures tubal ligation will be cheaper than a vasectomy, creating a government-sponsored incentive for women to undergo a riskier, less effective procedure. As a result, the Mandate’s “incentive [towards tubal ligation over vasectomy] is a disservice to women.”<sup>336</sup>

These incentives operate equally with condoms. Though the contraceptive methods are dissimilar, it is now cheaper for a woman to use hormonal contraception—with its risks and side effects—than condoms, which carry no risks or side effects for the male user other than reduced sexual pleasure and the possibility of an allergic reaction to latex. The decision of which partner should use birth control at a given time should be made by the sexual partners without the government expressing a preference—especially one that disadvantages one sex without any rational basis. The government simply should not place a finger on the scale of this personal decision.

### 3. *The Mandate's Exclusion of Men Impedes Innovation of Male Contraception*

The Mandate's exclusion of men also affects innovation: pharmaceutical companies are more likely to invest in the discovery of additional methods of female birth control, which are guaranteed insurance coverage under the Mandate, than in new methods of male birth control, which are not. This is true despite the fact that there has not been a new form of male birth control since the vasectomy became popular during WWII<sup>337</sup> and that scientists have been projecting the imminence of “[a] male pill” since the 1990s.<sup>338</sup> Increasing the number of male birth control options is vital to true contraceptive equity, as women often feel pressure to assume responsibility for birth control if the male partner dislikes condoms and wants children in the future. The incentive imbalance inherent in the Mandate exacerbates the already unequal investment in birth control methods based on sex.<sup>339</sup> Universalizing the Mandate would encourage research and development of male contraceptive drugs and devices. Moreover, assuming that pharmaceutical male birth control does finally enter the market despite the lack of government incentives, the Mandate creates an additional excuse for men to avoid it—expense—even if it causes fewer side effects in them than female birth control causes in their partners.

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334. See *supra* Figures 1 and 2.

335. Nguyen et al., *supra* note 18, at 3.

336. Sonfield, *supra* note 221, at 36.

337. J.H. Leavesley, *Brief History of Vasectomy*, 1 FAM. PLAN. INFO. SERV. 2, 2 (1980).

338. OUDSHOORN, *supra* note 121, at 7.

339. See generally *id.* at 6.

Women are expected to bear the burdens of birth control, in part, because there are so few options for men:

[C]ontraception involves self-sacrifice because it is, in many cases, a forced responsibility. Women are often saddled with full contraceptive responsibility because there is a significant disparity in both the number and quality of available contraceptives: all contraceptives target women's bodies except condoms and vasectomies; [and] no male contraceptives are both long-acting and reversible . . . .<sup>340</sup>

But this reality would change if new male options were to enter the market. Law influences innovation, and innovation influences equity. For instance, the invention of female hormonal birth control dramatically changed women's lives and has undoubtedly played a role in the advancement of women in higher education and in the workplace.<sup>341</sup> With new contraceptive options for men, women's lives would similarly improve—this time because the burdens of contraception could be more easily shared.

Pharmaceutical companies would be more willing to invest in contraceptive innovations for men if the resulting FDA-approved product was guaranteed insurance coverage under the Mandate. And manufacturers clearly need an incentive. Research and funding to develop new male contraceptives began in the late 1960s.<sup>342</sup> In 1972, the journal *Contraception* published the first study suggesting the efficacy of hormone-based male birth control.<sup>343</sup> In the 1970s, scientists predicted a new male contraceptive option by 1984; by the late 1990s, newspapers proclaimed the possibility of the “male pill” by the year 2000 or within five years.<sup>344</sup> “If you doubt that there has been sex discrimination in the development of the pill, try to answer this question: Why isn't there a pill for men?”<sup>345</sup> The answer is essentially that scientists attempting to create hormonal birth control for men have faced incredible challenges and backlash at every step of the process, including outsized reactions to any side effects,<sup>346</sup> a lack of interest among doctors and the pharmaceutical industry,<sup>347</sup> and a hyper-focus on male

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340. Lisa Campo-Engelstein, *Gender Norms and Contraceptive Trust*, 23 ALB. L.J. SCI. & TECH. 581, 588 (2013) (footnotes omitted).

341. See Pamela Verma Liao, *Half a Century of the Oral Contraceptive Pill*, 58 CANADIAN FAM. PHYSICIAN e757, e758 (2012); Louise Tyrer, *Introduction of the Pill and Its Impact*, 59 CONTRACEPTION 11S, 13S (1999), [https://www.contraceptionjournal.org/article/S0010-7824\(98\)00131-0/pdf](https://www.contraceptionjournal.org/article/S0010-7824(98)00131-0/pdf); Tim Harford, *The Tiny Pill Which Gave Birth to an Economic Revolution*, BBC (May 22, 2017), <https://www.bbc.com/news/business-39641856>.

342. OUDSHOORN, *supra* note 121, at 6–7.

343. P.R.K. Reddy & J.M. Rao, *Reversible Antifertility Action of Testosterone Propionate in Human Males*, 5 CONTRACEPTION 295 (1972).

344. OUDSHOORN, *supra* note 121, at 7.

345. *Id.* at 19 (quoting BARBARA SEAMAN, *THE DOCTOR'S CASE AGAINST THE PILL* (1969)); *id.* at 44–45.

346. *Id.* at 231–32.

347. *Id.* at 84–85, 231.

sexual virility.<sup>348</sup> In this case, gender stereotypes and technology are inexorably intertwined and influence one another: “[I]f the advocates of new contraceptives for men fail to revise cultural preconceptions, it is very likely that the technology will fail altogether.”<sup>349</sup>

Nevertheless, there are a few different types of male birth control currently in clinical trials: a topical gel, an oral pharmaceutical, and two kinds of injections. An extension of the Mandate would be very valuable for ensuring that a new male birth control product finally enters the market after nearly fifty years of research and decades of proof that it is effective.<sup>350</sup>

The first product under investigation, called Nestorone-Testosterone, requires a man to apply a gel to his arms every day.<sup>351</sup> The gel contains enough progestin to lower the sperm count while also replacing testosterone in the user so that he does not experience the side effects of low testosterone.<sup>352</sup> This technology is currently in a Phase IIb clinical trial involving 420 couples from five countries and is scheduled to conclude by 2021.<sup>353</sup> A daily pharmaceutical pill called Dimethandrolone Undecanoate (DMAU), which utilizes a similar hormone combination in men, has just started a Phase IIa clinical trial.<sup>354</sup> Researchers at UCLA are also testing an injectable version of DMAU in men, which is similar to the injectable hormone contraceptive Depovera for women.<sup>355</sup> Finally, a technology called RISUG is finishing up Phase III clinical trials in India.<sup>356</sup> It involves injecting a gel into a man’s vas deferens, which blocks sperm from escaping.<sup>357</sup> The procedure is reportedly reversible with another shot that diffuses the gel.<sup>358</sup> A similar product in the United States, Vasalgel, is only in the animal testing stage and will not be able to seek FDA approval for many

348. *Id.* at 106–09. “This concern reflects a cultural preoccupation with norms of masculinity tha[t] can best be summarized as ‘no tinkering with male sexuality.’” *Id.* at 232.

349. *Id.* at 114.

350. *Id.* at 102; Christina Wang et al., *Male Hormonal Contraception: Where Are We Now?*, 5 CURRENT OBSTETRICS & GYNECOLOGY REP. 38, 40–42 (2016).

351. Niloufar Ilani et al., *A New Combination of Testosterone and Nestorone Transdermal Gels for Male Hormonal Contraception*, 97 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3476, 3477 (2012).

352. *Id.* at 3479.

353. *Study of Daily Application of Nestorone® (NES) and Testosterone (T) Combination Gel for Male Contraception*, CLINICALTRIALS.GOV, <https://clinicaltrials.gov/ct2/show/NCT03452111> (last updated Nov. 7, 2018).

354. *Study of Spermatogenesis Suppression with DMAU Alone or with LNG Versus Placebo Alone in Normal Men*, CLINICALTRIALS.GOV, <https://clinicaltrials.gov/ct2/show/NCT03455075> (last updated Aug. 12, 2019).

355. *Injectable DMAU for Male Contraception in Healthy Male Volunteers*, CLINICALTRIALS.GOV, <https://clinicaltrials.gov/ct2/show/NCT02927210> (last updated Aug. 12, 2019).

356. CENT. DRUG STANDARD CONTROL ORG., MINUTES OF IND COMMITTEE MEETING HELD ON 29.08.2018 AT ICMR (HQ) 6–7 (2019), <https://cdsco.gov.in/opencms/resources/UploadCDSCOWeb/2018/UploadCommitteeFiles/Minutes%20of%20IND%20Committee%20Meeting%20dated%2029.08.2018converted.pdf>.

357. Julia Belluz, *The 3 Most Promising New Methods of Male Birth Control, Explained*, VOX, <https://www.vox.com/2018/4/4/17170262/male-birth-control-explained> (last updated Apr. 1, 2019).

358. *Id.*

years.<sup>359</sup> Though other innovations are also being tested, they are only in the early stages of development.<sup>360</sup>

While these innovations are exciting and promising, many of them may not pan out. For instance, in 2016, a Phase II clinical trial of an injectable male contraceptive called Norethisterone Enanthate was terminated early due to a high rate of adverse side effects, even though the drug was remarkably effective at preventing pregnancy among the 320 men from seven countries enrolled in the trial.<sup>361</sup> The vast majority of these adverse events (91%), however, were mild, including acne in 45% of users, increased libido in 38% of users, and emotional disorders in 17% of users.<sup>362</sup> Sound familiar? The side effects men experienced were many of the same ones that women regularly endure with birth control. Nevertheless, the side effects were deemed too harsh to justify the continued operation of the study, despite the fact that 75% of the study participants “reported being at least satisfied with the method and willing to use this method if available.”<sup>363</sup> It is unclear whether new studies will test the drug in men given the adverse side effects, but so far, no new clinical trials of this injectable appear to be running.

The justification for cancelling the study was twofold: first, the incidence of some adverse effects, like acne, were higher for men in this study than for women generally taking hormonal contraception; moreover, the emotional disorders were severe in a few men.<sup>364</sup> Second, some argue that men should not be asked to endure any side effects when taking birth control because they are not the ones who could get pregnant: “When women use a contraceptive, they’re balancing the risks of the drug against the risks of getting pregnant. . . . But these are healthy men—they’re not going to suffer any risks if they get somebody else pregnant.”<sup>365</sup> But, of course, men suffer if they unintentionally father a child, and for any particular couple, the male partner might not experience any side effects of birth control while the female partner’s side effects are severe: “This gendered individual risk model tends to minimize the health risks for women and enlarge the risks for men.”<sup>366</sup> Perhaps if the government stops signaling that women, not men, are expected to endure the risks

359. See Angela Colagross-Schouten et al., *The Contraceptive Efficacy of Intravas Injection of Vasalgel™ for Adult Male Rhesus Monkeys*, 27 BASIC & CLINICAL ANDROLOGY, 2017, at 2.

360. See, e.g., *Contraceptives in Active Development*, MALE CONTRACEPTIVE INITIATIVE, <https://www.malecontraceptive.org/male-contraception-research/prospective-male-contraceptive-options/> (last updated Mar. 2018).

361. Hermann M. Behre et al., *Efficacy and Safety of an Injectable Combination Hormonal Contraceptive for Men*, 101 J. CLINICAL ENDOCRINOLOGY & METABOLISM 4779, 4779–80, 4783 (2016).

362. *Id.* at 4783, 4786.

363. *Id.* at 4787.

364. *Male Birth Control Study Killed After Men Report Side Effects*, NPR (Nov. 3, 2016), <https://www.npr.org/sections/health-shots/2016/11/03/500549503/male-birth-control-study-killed-after-men-complain-about-side-effects>. For instance, one man reportedly attempted suicide. *Id.*

365. OUDSHOORN, *supra* note 121, at 109; *Male Birth Control Study*, *supra* note 364.

366. OUDSHOORN, *supra* note 121, at 109.

and side effects of birth control, manufacturers will follow suit and continue investing in male birth control products, even though they have side effects.

If the Mandate were expanded to cover all contraceptives regardless of the user's sex, these technologies would be more likely to enter the market. The incentive of guaranteed coverage is needed in light of the history of many successful clinical trials of male birth control never advancing to the point of marketability and of pharmaceutical companies largely shunning such innovations.<sup>367</sup> Pharmaceutical investment requires manufacturers to make business decisions after each phase of development, balancing expectations for payment and presumed demand against the costs of clinical trials. Guaranteed coverage would provide a significant carrot that could help overcome the history of sex discrimination in birth control innovation. Further, assuming one of these drugs eventually enters the market—and male and female pharmaceutical birth control options exist, each of which carry their own side effects—the government should not create an incentive for women to endure the risks over men. This would create the same problem that currently exists with vasectomies and tubal ligations.

Encouraging innovation for male birth control, if effective, would also reduce the rate of unintended pregnancy.<sup>368</sup> After extensive modeling, researchers concluded that a new male birth control option would reduce unintended pregnancy rates by 3.5% to 5.2%, depending on which innovation first reaches the market.<sup>369</sup> Reducing unintended pregnancy is a laudable goal that helps men and women alike. Thus, there is also a good policy reason to support innovation in male birth control by expanding the Mandate.

#### 4. *The Mandate Codifies Harmful Sex Stereotypes*

The first three harms of the Mandate's exclusion of men relate to tangible burdens. But when courts evaluate a sex classification in the law, the most important consideration is whether the classification is based on, and promotes, sex stereotypes: "Scholars agree . . . that when it comes to sex discrimination cases, the ball game is about stereotypes, not scrutiny."<sup>370</sup> The Supreme Court has repeatedly held that the government cannot codify sex stereotypes into the

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367. *Id.* at 84–85, 231; Katherine Ellen Foley, *There's a Scrotal Injection that Works as Reversible Male Birth Control, but Drug Companies Won't Fund It*, QUARTZ (Apr. 11, 2017), <https://qz.com/955439/male-birth-control-options-like-vasalgel-arent-getting-pharmaceutical-company-funding/>.

368. Emily Dorman et al., *Modeling the Impact of Novel Male Contraceptive Methods on Reductions in Unintended Pregnancies in Nigeria, South Africa, and the United States*, 97 CONTRACEPTION 62, 66 (2018).

369. *Id.*

370. Fontana & Schoenbaum, *supra* note 217, at 13; see also Mary Anne Case, "The Very Stereotype the Law Condemns": *Constitutional Sex Discrimination Law as a Quest for Perfect Praxies*, 85 CORNELL L. REV. 1447, 1449 (1999); Cary Franklin, *The Anti-Stereotyping Principle in Constitutional Sex Discrimination Law*, 85 N.Y.U. L. REV. 83, 138 n.296 (2010).

law,<sup>371</sup> but the Mandate does just that. And worse, most of the stereotypes the Mandate perpetuates are demonstrably false, although courts have long held that even those sex stereotypes that accurately reflect reality cannot be legally consecrated.<sup>372</sup>

The most harmful stereotype the Mandate promotes is that birth control is a woman's exclusive domain. This expectation has existed for generations: "Despite all of the advances, birth control remains, as it was in Margaret Sanger's time, 'a woman's problem.'"<sup>373</sup> Excluding men from the Mandate "sends a message reinforcing the all-too-common cultural attitude that contraception is solely a woman's responsibility."<sup>374</sup> Despite safer options existing for men, the expectation is that women should be the ones to endure the physical side effects and risks to prevent pregnancy. The contraceptive Mandate "reflect[s] the nation's current view of family planning as a 'woman's issue,'" instead of a "'human issue,' for which the involvement of men will increase safety and overall savings, as well as ethically balance the weight of the reproductive burden."<sup>375</sup> Despite global recognition as early as 1994 that "[s]pecial efforts should be made to emphasi[z]e men's shared responsibility and promote their active involvement in responsible parenthood . . . including family planning,"<sup>376</sup> the Mandate absolves men entirely of their equal responsibility for pregnancy prevention.

Contraception is, moreover, the first point in a long chain of reproductive and domestic labor where women are asked to assume the lion's share of work. The Mandate ensures that from the very beginning of a woman's reproductive life, she understands that she is in charge of reproduction and what flows from it. Starting in the 1970s, sex equality law systematically dismantled codified sex stereotypes that presumed women would be the primary caregivers of their children.<sup>377</sup> But when the law asks women to assume reproductive responsibilities before children are born, it also influences how those caregiving roles later develop.<sup>378</sup> Professors David Fontana and Naomi Schoenbaum first used this line of reasoning, one point down the chain, to argue that the law should not identify

371. Case, *supra* note 371, at 1449–50; Fontana & Schoenbaum, *supra* note 217, at 13–14.

372. *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 139 n.11 (1994) ("[G]ender classifications that rest on impermissible stereotypes violate the Equal Protection Clause, even when some statistical support can be conjured up for the generalization."); *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1692–93 (2017) ("Overbroad generalizations of that order, the Court has come to comprehend, have a constraining impact, descriptive though they may be of the way many people still order their lives."); Fontana & Schoenbaum, *supra* note 217, at 314–15.

373. Motro, *supra* note 298, at 935 (citing MARGARET SANGER, *WOMAN AND THE NEW RACE* 100 (1920)).

374. Sonfield, *supra* note 221, at 36.

375. Nguyen et al., *supra* note 18, at 4.

376. Gareth Terry & Virginia Braun, *It's Kind of Me Taking Responsibility for These Things': Men, Vasectomy, and 'Contraceptive Economics'*, 21 *FEMINISM & PSYCHOL.* 477, 478 (2011).

377. Fontana & Schoenbaum, *supra* note 217, at 317–21.

378. *See id.* at 343 ("The failure to unsex pregnancy therefore undermines legal efforts to unsex parenting.").

women as solely responsible for pregnancy.<sup>379</sup> They argued that when the law excludes men from certain pregnancy-related benefits or protections, it assumes women will perform caregiving roles before birth that set domestic expectations extending into parenthood.<sup>380</sup> The same is true for contraception. By framing women as responsible for preventing pregnancy, the Mandate sets the tone for reproductive and domestic labor that comes down the line, suggesting that women should also bear the primary responsibility for any pregnancies or children that later result.

The Mandate's exclusion of men also shoulders women with the blame of unwanted pregnancies: if it was her responsibility to use contraception, it is her fault if she gets pregnant.<sup>381</sup> We see this assumption built into abortion laws, which often create exceptions for rape and incest. These exceptions are premised on the notion that unless the woman is sexually abused, she could have stopped the pregnancy and should be responsible for the child that results.<sup>382</sup> As we shift towards viewing contraception as a human responsibility, accidental pregnancies can be seen as they are: mutual mistakes equally shared by the sexual partners.<sup>383</sup>

The default assumption that birth control is a woman's problem instead sends quite the opposite message to men: "Absolving themselves of contraceptive responsibility increases men's freedoms: to have sex worry-free, to avoid bodily invasion, and to have enhanced sexual access to women."<sup>384</sup> Moreover, the Mandate perpetuates the "cultural preoccupation with norms of masculinity tha[t] can best be summarized as 'no tinkering with male sexuality.'"<sup>385</sup> These norms were a huge obstacle in previous attempts to bring a male contraceptive pill to the market.<sup>386</sup> Though men frequently benefit from this stereotype, they can also be harmed. The societal attitude that birth control is a woman's responsibility leaves men feeling disempowered to prevent pregnancy.<sup>387</sup> For instance, in a study of twenty men who experienced an unintentional pregnancy with a sexual partner, most had assumed their partner was responsible for contraception, not realizing that neither party was using birth control.<sup>388</sup> Equalizing

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379. *Id.* at 343, 345–48.

380. *Id.*

381. See Campo-Engelstein, *supra* note 340, at 589.

382. Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97, 137 (2010) ("[T]he notion that women are culpable if they become pregnant unless through rape or incest is a thread that runs through contraception, abortion, and childbirth-related cases.").

383. Of course, the physical effects are still felt only by women.

384. See Campo-Engelstein, *supra* note 340, at 589.

385. OUDSHOORN, *supra* note 121, at 232.

386. *Id.* at 106–09.

387. Scott D. Johnson & Lindy B. Williams, *Deference, Denial, and Exclusion: Men Talk About Contraception and Unintended Pregnancy*, 4 INT. J. MEN'S HEALTH 223, 230–31 (2005).

388. *Id.* at 237 ("Heavy reliance on deference of responsibility and on assumptions that contraception was being used by their partners created situations in which no contraception was used . . .").

the Mandate sends a clear message that both men and women are empowered and responsible for pregnancy prevention. As scholars have long lamented, “sex-role allocation[s] . . . simply disable[] Americans of either sex from restructuring” their assigned roles “to share the burdens and benefits of social existence more equitably.”<sup>389</sup>

Thus, the Mandate operates as a self-fulfilling prophecy: by assigning the responsibility for contraception to women, men settle deeper into the back seat and women assume even more responsibility (and more burden). The Mandate’s incentives for innovation also perpetuate these stereotypes. It is the lack of male options, discussed above, that has contributed to the stereotype that birth control is a woman’s responsibility: “[T]he predominance of modern contraceptive drugs for women has disciplined both men and women to delegate the responsibility for contraception largely to women. In the latter half of the twentieth century, contraceptive use thus came to be excluded from hegemonic masculinity.”<sup>390</sup> The Mandate will therefore likely widen the gap between available male and female contraceptive options by encouraging manufacturers to invest further in female methods that are guaranteed insurance coverage—this will, in turn, reinforce the stereotype that birth control is a woman’s responsibility. The Supreme Court has been particularly wary of sex classifications that cause similar self-fulfilling prophecies.<sup>391</sup>

The Mandate perpetuates other stereotypes as well, such as that men are not concerned about preventing pregnancy: “This culturally inscribed orthodoxy portrays men as *sexually* driven and uninterested in issues of fertility and reproduction, with these areas not considered primary to the formulation of masculine identities.”<sup>392</sup> This stereotype has affected incentives for the development of new male birth control options.<sup>393</sup> Investors assumed that if a product entered the market, men would not be interested in using it.<sup>394</sup> In fact, in 1970, the perceived lack of male interest was discussed as an obstacle to development of a male contraceptive drug: “This leads to the third difficulty—namely, the male’s generally lesser interest in, and greater reservations about,

389. Leo Kanowitz, “Benign” Sex Discrimination: Its Troubles and Their Cure, 31 HASTINGS L.J. 1379, 1402 (1980).

390. OUDSHOORN, *supra* note 121, at 172.

391. See *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1693 (2017); *Nevada Dep’t of Human Res. v. Hibbs*, 538 U.S. 721, 736 (2003) (“These mutually reinforcing stereotypes created a self-fulfilling cycle of discrimination that forced women to continue to assume the role of primary family caregiver, and fostered employers’ stereotypical views about women’s commitment to work and their value as employees. Those perceptions, in turn, Congress reasoned, lead to subtle discrimination that may be difficult to detect on a case-by-case basis.”); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 729–30 (1982) (“MUW’s admissions policy lends credibility to the old view that women, not men, should become nurses, and makes the assumption that nursing is a field for women a self-fulfilling prophecy.”).

392. Terry & Braun, *supra* note 376, at 478; see also Campo-Engelstein, *supra* note 340, at 603 (“[T]here is a social perception that men are not committed to pregnancy prevention, or at least not even close to the degree women are, which make them seem less likely to be trusted to act in a self-sacrificing manner.”).

393. OUDSHOORN, *supra* note 121, at 172.

394. *Id.* at 39.

procedures that are aimed at decreasing his fertility. If the agent were to be administered orally, men would probably be even less reliable about taking a tablet regularly than women . . . .”<sup>395</sup>

Long ago, when paternity was unprovable and men were not financially responsible for their children outside of marriage, they may have been cavalier about the consequences associated with unintended pregnancy. But today’s landscape is entirely different. Men are financially responsible for caring for their children,<sup>396</sup> and paternity is now easy to prove.<sup>397</sup> As a result, men have a lot more skin in the game when it comes to unintended pregnancy, even though they do not bear the physical burdens of pregnancy, abortion, or breastfeeding. Moreover, the assumption that men are less burdened by parenthood is premised on the sex stereotype that the woman will be the primary caregiver.<sup>398</sup> If men were expected to assume equal or greater responsibility over parenting, they would presumably have equal or greater concerns over an unintended and undesired pregnancy.<sup>399</sup>

Research suggests that men care more about family planning than society acknowledges: “Although many assume men are not interested in or supportive of family planning and contraceptive usage, most recent research shows that this is untrue.”<sup>400</sup> In fact, “[m]ost men perceive a couple’s decision-making regarding sexual behavior and contraception as an egalitarian process,” with 78% of men currently in a heterosexual relationship viewing decisions about contraception as “a shared responsibility.”<sup>401</sup> Men are also interested in having more options for themselves. For instance, in a cross-national study of more than 9,000 men, 55% reported their willingness to use a form of hormonal birth control if it existed, with only 21% unwilling.<sup>402</sup> In a study of Australians, 75%

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395. *Id.* at 174 (quoting CARL DJERASSI, *BIRTH CONTROL AFTER 1984*, at 948 (1970)).

396. See generally Leslie Joan Harris, *The Basis for Legal Parentage and the Clash Between Custody and Child Support*, 42 IND. L. REV. 611, 620 (2009) (describing the Temporary Assistance for Needy Families program’s requirement that states seek to establish the paternity of children born to unmarried mothers for purposes of imposing child support obligations on the men).

397. *Id.* (“Reasonably cheap, accurate genetic testing has become the norm for resolving parentage disputes that arise when child support is at stake.”).

398. Lisa Campo-Engelstein, *Contraceptive Justice: Why We Need a Male Pill*, 14 AM. MED. ASS’N J. ETHICS 146, 148 (2012).

399. *Id.* It is worth noting that, unlike for birth control, these sex stereotypes about parenting have been rooted out of the law, though they remain in society at large. Fontana & Schoenbaum, *supra* note 217, at 315–20.

400. Keith A. Frey et al., *The Clinical Content of Preconception Care: Preconception Care for Men*, 199 AM. J. OBSTETRICS & GYNECOLOGY S389, S389 (2008).

401. William R. Grady et al., *Men’s Perceptions of Their Roles and Responsibilities Regarding Sex, Contraception and Childrearing*, 28 FAM. PLAN. PERSP. 221, 224 (1996), [https://www.guttmacher.org/sites/default/files/article\\_files/2822196.pdf](https://www.guttmacher.org/sites/default/files/article_files/2822196.pdf).

402. Klaas Heinemann et al., *Attitudes Toward Male Fertility Control: Results of a Multinational Survey on Four Continents*, 20 HUM. REPROD. 549, 552–53 (2005).

of men indicated they would be willing to try hormonal contraception.<sup>403</sup> “Notwithstanding this empirical evidence, however, the master narrative that men do not value . . . preventing pregnancy as much as women do persists. This cultural trope is usually presented as fact without much or any empirical backing in the literature . . . .”<sup>404</sup>

Even if it were true that men are uninterested in contraception for their own sakes, they are often motivated to remove some of the contraceptive burdens from their partners. In past clinical trials of male birth control occurring between 1987 and 1994, male participants expressed an interest in the product for the sake of equality or to save their partners from the side effects of birth control. For instance, participants reported the following motivations of participating in a trial:

- “It’s about time fellas start taking responsibility for this kind of thing.”<sup>405</sup>
- “I think men have been allowed to be lazy about this.”<sup>406</sup>
- “A man should have 50 percent of the responsibility.”<sup>407</sup>
- “[I joined because] my wife gets depressed when she takes the Pill . . . .”<sup>408</sup>
- “[O]nce [my wife has] taken the risk for a few years, I’ll take the risk.”<sup>409</sup>

In fact, “[t]he dominant image articulated by male trial participants . . . was their interest in sharing responsibility for contraception with their partners.”<sup>410</sup> In another study of men who received vasectomies, the same motivations were described.<sup>411</sup> The researchers concluded that “[t]he choice to have a vasectomy, for many of the men in this study seems to be tied to this sort of identity: egalitarian, responsible and caring.”<sup>412</sup>

It, therefore, seems pretty clear that the stereotype of the disinterested, uncaring male partner is not reflective of the current reality. It may be that men feel a little too proud of themselves when they assume an equal role in contraception, implying that their conduct is unusual and praiseworthy, not simply their fair share.<sup>413</sup> But this is not disinterest. And sadly, “[e]ven when individual men might show some interest in being ‘equally’ involved in the reproductive

403. Gareth C. Weston et al., *Will Australian Men Use Male Hormonal Contraception? A Survey of a Postpartum Population*, 176 *MED. J. AUSTRAL.* 208, 209 (2002).

404. Campo-Engelstein, *supra* note 340, at 617.

405. OUDSHOORN, *supra* note 121, at 183.

406. *Id.*

407. *Id.*

408. *Id.*

409. *Id.* at 184.

410. *Id.*

411. Terry & Braun, *supra* note 376, at 482–84.

412. *Id.* at 484.

413. *Id.* at 485 (“While the language of responsible partnership could be constructed as helping to shape less traditional, more egalitarian masculinities, the inscription of minor ‘heroism’ into the accounts disrupts this.”).

share, many of the social structures that shape, constrain and enable greater reproductive health [like the Mandate] are focused almost exclusively on women.”<sup>414</sup> Ensuring equal access to contraception regardless of sex will help encourage men to take more responsibility and combat this false narrative, which nevertheless continues to pervade the national consciousness to the detriment of all.<sup>415</sup> A universal Mandate would also combat the image that men who use contraception are going above and beyond as opposed to taking their fair share of the burdens.<sup>416</sup>

Finally, the Mandate perpetuates the stereotype that only women are responsible enough to effectively use birth control.<sup>417</sup> This is partly due to a conflation of contraceptive responsibility with responsibility in domestic life:

[T]he parallel between contraception and other types of domestic and reproductive work is seen in the one scientist’s summation of women’s responses to a potential male contraceptive pill: “Not infrequently, the American woman’s response was along the line of, ‘Are you kidding? I can’t even trust him to take out the garbage!’”<sup>418</sup>

Because men are seen as incompetent at domestic chores, they are also perceived to be irresponsible with other forms of “women’s work,” like responsibility for contraception.<sup>419</sup> Women have also been guilty of perpetuating the stereotype that “men cannot be trusted,” which “reflects and reinforces” a “singular and immutable” version of traditional masculinity that may be harming both sexes.<sup>420</sup>

It should go without saying that men are equally capable of consistently using birth control, and when society labels men as incompetent, it assures that

414. *Id.* at 478.

415. For instance, a Healthline article published in 2017 attempted to answer the question of whether men would be interested in a birth control pill using only stereotypes:

“In order to understand the likelihood of whether or not men will use contraceptives, you have to understand that probably the most unfair aspect of human evolution is that women evolved in a way that makes sex a much higher cost,” Dr. Wendy Walsh, a relationship expert, told Healthline. “Because of their unique biology, women are much more susceptible to contracting an STI, much more susceptible to bonding and falling in love with a jerk because women’s bodies emit oxytocin, the bonding hormone, during orgasm. And, of course, women are much more likely to contract an 18-year case of parenthood because our culture is not one where men are doing the bulk of the child care.”

Dan Gray, *Will Men Ever Embrace Male Birth Control?*, HEALTHLINE (Feb. 22, 2017), <https://www.healthline.com/health-news/male-birth-control>.

416. Terry & Braun, *supra* note 376, at 492 (“This privileging of any male involvement over and above the (typically) much longer, quieter and more mundane ‘involvement’ of women is an example of the ongoing imbalances of gender being perpetuated by structures that claim they are breaking them down.”); *id.* at 485 (“[V]asectomy as [an] act of minor heroism” has the “potential to perpetuate male privilege within contraceptive economies.”).

417. See Campo-Engelstein, *supra* note 340, at 603–04.

418. *Id.* at 615; see also Terry & Braun, *supra* note 376, at 480–81.

419. Campo-Engelstein, *supra* note 340, at 615–16.

420. OUDSHOORN, *supra* note 121, at 238.

women will continue to bear the brunt of all domestic responsibilities.<sup>421</sup> Moreover, in particular relationships, the man might be more trustworthy with a consistent pharmaceutical regimen than his partner. Just as some women may not trust their male partners to use contraception accurately,<sup>422</sup> some men may not trust their female partners to consistently adhere to birth control. But, overwhelmingly, it appears that women do trust their partners to take male birth control. In a study of nearly 2,000 women, only 2% said they would not trust their partners to correctly take a male birth control pill.<sup>423</sup> This led the researchers to conclude that despite “the widespread belief that women would not want a ‘male pill’ because they would not trust their partners to use it reliably, our study suggests that a hormonal method for men would be extremely popular and that many women, regardless of culture, would trust their partners to use it.”<sup>424</sup> One researcher explained that even if women do not trust men generally with contraception, most would trust their partners.<sup>425</sup>

The Mandate perpetuates harmful, and often false, sex stereotypes that ensure contraception remains a woman’s responsibility when both sexes crave contraceptive equity. As seen in Part III.A, the Supreme Court’s equal protection jurisprudence harshly judges sex classifications that produce this result. A sex-neutral Mandate would allow all the benefits of the current Mandate without the baggage of sex-stereotyping birth control.

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The constitutional requirement of equal protection prohibits the government from explicitly treating men and women differently. Though there are exceptions when such sex distinctions are allowed, the Court is unlikely to uphold a facially discriminatory law when it promotes sex stereotypes and hurts the group it aims to help—which is the exact effect of the Mandate’s sex classification. As a result, the Mandate should be found unconstitutional. There is no hope for true contraceptive equity while the government encourages women to assume the primary contraceptive role and holds men back from taking more responsibility. Though only women can become pregnant, both men and women can equally prevent pregnancy.

Nevertheless, inherent in the equal protection canon is a more challenging dilemma. When a court is confronted with an equal protection violation, it does

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421. See Susan Frelich Appleton, *The Forgotten Family Law of Eisenstadt v. Baird*, 28 YALE J.L. & FEMINISM 1, 38 (2016).

422. See generally Sonfield, *supra* note 221, at 36 (“Many women do favor contraceptive methods that they can control and possibly even conceal from their partners, and some experience attempts by partners to interfere with their contraceptive use.”).

423. A.F. Glasier et al., *Would Women Trust Their Partners to Use a Male Pill?*, 15 HUM. REPROD. 646, 646 (2000).

424. *Id.* at 649.

425. Campo-Engelstein, *supra* note 340, at 618.

not necessarily require the government to apply the benefit across genders.<sup>426</sup> Rather, the court can also remove the benefit in its entirety or simply order the government to cure the defect however it sees fit.<sup>427</sup> In the following Part, I argue that the only appropriate remedy for this particular constitutional defect is the extension of the Mandate to men.

#### IV. THE PROPER REMEDY TO THE MANDATE'S SEX DISCRIMINATION IS EXTENDING THE MANDATE TO MEN

Once a court concludes the Equal Protection Clause cannot tolerate the Mandate's sex classification, it must decide the appropriate remedy: strike the Mandate in its entirety (denying women the benefit that men lack), apply the Mandate universally (awarding men the benefit that women receive), or grant the government discretion to decide.<sup>428</sup> These possibilities—often referred to as “leveling up” or “leveling down”—are both permissible outcomes under the Equal Protection Clause.<sup>429</sup> These radically different remedies create a “double bind” for women: either “continue to endure unlawful discrimination” or “challenge the inequality and risk worsening the situation” for everyone.<sup>430</sup> My fear in writing this Article is that in attempting to expand the Mandate and promote contraceptive equity, I am describing a challenge that could end with the Mandate's dissolution.

There are three reasons why I think the leveling down risk is low enough to justify pushing for equity in this case. First, the Mandate invokes two lines of cases that would recommend upholding the Mandate for all sexes notwithstanding the general acceptability of leveling down. Second, most scholars would find formal equality insufficient when it perpetuates harms suffered by a historically subjugated group. This Part pulls in their contributions to suggest that courts should expand, not nullify, the Mandate. Finally, the popularity of the Mandate offers some insulation against any court action, as Congress would likely legislate a universal Mandate regardless of the judicial outcome. In fact, just this year, the National Health Law Program drafted model “Contraceptive

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426. Deborah L. Brake, *When Equality Leaves Everyone Worse Off: The Problem of Leveling Down in Equality Law*, 46 WM. & MARY L. REV. 513, 515 (2004).

427. *See id.*

428. *See, e.g., Califano v. Westcott*, 443 U.S. 76, 89 (1979) (“[A] court may either declare [the statute] a nullity and order that its benefits not extend to the class that the legislature intended to benefit, or it may extend the coverage of the statute to include those who are aggrieved by the exclusion.” (second alternation in original) (quoting *Welsh v. United States*, 398 U.S. 333, 361 (1970))).

429. Brake, *supra* note 426, at 515; *see also* GEOFFREY R. STONE ET AL., CONSTITUTIONAL LAW 480 (4th ed. 2001). For instance, in *Orr v. Orr*, discussed above, the Court noted that “[i]n every equal protection attack upon a statute challenged as under-inclusive, the State may satisfy the Constitution's commands either by extending benefits to the previously disfavored class or by denying benefits to both parties.” 440 U.S. 268, 272 (1979).

430. Brake, *supra* note 426, at 516.

Equity” legislation for states interested in creating universal access.<sup>431</sup> The federal government could adopt its own version of this law if the Mandate is threatened. Alternatively, the HRSA could promulgate a rule that expands the Mandate to men without the involvement of Congress.<sup>432</sup>

First and foremost, there are two instances in which the Supreme Court has expressed a preference for leveling up: (1) when equity and congressional intent favor the benefit’s extension, especially in sex discrimination cases, and (2) when it would be illegal to remove the benefit.<sup>433</sup> In particular, the Supreme Court has routinely ordered universal application of a sex-specific benefit to cure sex discrimination.<sup>434</sup> For instance, in *Califano v. Westcott*, which challenged a federal law that provided benefits to families with unemployed fathers but not unemployed mothers, the majority supported extending the benefit to unemployed mothers.<sup>435</sup> It noted that past precedent “suggested that extension, rather than nullification, is the proper course” in equal protection challenges to “underinclusive federal benefits statutes.”<sup>436</sup> The Court was sensitive to the fact that nullification in this case would harm the 300,000 beneficiaries and would not effectuate the congressional intent to minimize the burdens of unemployed fathers who receive the benefits.<sup>437</sup>

Over the next five years, the Court clarified that congressional intent should govern the issue but still maintained that “ordinarily ‘extension, rather than nullification, is the proper course.’”<sup>438</sup> In 2017, the Court reaffirmed this standard,

431. LIZ MCCAMAN, NAT’L HEALTH LAW PROGRAM, MODEL CONTRACEPTIVE EQUITY ACT: LEGISLATIVE LANGUAGE AND ISSUE BRIEF 7 (2019), <https://9kqpw4dcaw91s37kozms5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/Model-ActForWebsiteNationalHealthLawProgram-Jan.31.Final.pdf> (noting that “federal law also fails to recognize the important role that men play in preventing unintended pregnancy”).

432. The HRSA could likely correct this constitutional deficiency itself without judicial intervention through rulemaking. Though the Women’s Health Amendment, under which the Mandate was promulgated, only delegates authority to the agency to identify preventative health services *for women*, 42 U.S.C. § 300gg-13 (2012), the agency could easily defend the addition of male birth control on the grounds that it *is* a preventative service for women. See Part III.B. Like female birth control, male birth control helps women avoid pregnancy. This justification should constitute a reasonable interpretation of the Amendment, entitled to the judicial branch’s deference if proper notice and comment procedures are followed. See *generally* *Chevron v. Nat. Res. Def. Council*, 467 U.S. 837 (1984).

433. *Brake, supra* note 426, at 544–45, 555–56.

434. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1699 (2017) (stating this generality in the context of a sex discrimination case and citing several examples in that context); *Califano v. Goldfarb*, 430 U.S. 199, 202–04, 213–17 (1977) (plurality opinion) (extending survivors’ benefits after striking down a sex classification); *Frontiero v. Richardson*, 411 U.S. 677, 678–79, 691 n.25 (1973) (plurality opinion) (extending military spousal benefits after striking down a sex classification). *But see Morales-Santana*, 137 S. Ct. at 1700 (“Although extension of benefits is customary in federal benefit cases, all indicators in this case point in the opposite direction.” (citation omitted)).

435. *Califano v. Westcott*, 443 U.S. 76, 89–90 (1979).

436. *Id.* “[T]he remaining four Justices would have enjoined the program until Congress amended the statute to cure the violation and to select its preferred remedial course.” *Brake, supra* note 426, at 549 (citing *Califano*, 443 U.S. at 93–94).

437. *Califano*, 443 U.S. at 90.

438. *Heckler v. Mathews*, 465 U.S. 728, 739 n.5 (1984) (citing *Califano*, 443 U.S. at 89); see also *Welsh v. United States*, 398 U.S. 333, 355–56 (1970) (Harlan, J., concurring) (concluding that courts should consider

noting in particular that extension has been the preferred remedy for gender-discrimination claims.<sup>439</sup> This approach makes sense given the history of sex-discrimination cases, which often challenged laws that provided women caregiving benefits under the assumption that only women were caregivers.<sup>440</sup> Such cases underscored that women were far better off when they were supported in caregiving by extending the benefit, not left to fend for themselves.<sup>441</sup> Extending caregiving benefits to men promoted sex equality significantly more than denying the benefits for women. Thus, when equity and congressional intent favor extension, leveling up is the preferred remedy supported by extensive case law.

Equity and congressional intent surely support extension to remedy the Mandate. Millions of women rely on the Mandate and would be harmed by its discontinuation,<sup>442</sup> and nullification would cause mass disruption in the insurance markets as insurers change their contraceptive coverage determinations. Furthermore, it might lead to an increase in unintended pregnancies and abortions, which have gone down since the Mandate.<sup>443</sup> And, like with caregiving benefits, sex equality is promoted by including men in the Mandate by encouraging men to support women and not abandon women to the insurance markets that failed them for decades. In terms of congressional intent, the Congress that passed the ACA would have surely intended extension compared to nullification. For instance, the ACA does not include a severability clause,<sup>444</sup> the inclusion of which the Court has previously considered as expressing a preference for nullification.<sup>445</sup> It is hard to imagine that the Congress that passed the ACA would prefer removing the benefit from millions of women, whom it was explicitly trying to help, instead of extending the benefit to men, which would only further help its intended beneficiary.

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whether “it more nearly accords with Congress’ wishes to eliminate its policy altogether or extend it in order to render what Congress plainly did intend, constitutional?”).

439. *Morales-Santana*, 137 S. Ct. at 1698–1700, 1698 n.22. The Court, however, found this case exceptional, bucking convention and leveling down: “Although extension of benefits is customary in federal benefit cases, all indicators in this case point in the opposite direction. Put to the choice, Congress, we believe, would have abrogated § 1409(c)’s exception, preferring preservation of the general rule.” *Id.* at 1700 (citation and footnotes omitted).

440. See Part III.A.

441. See Fontana & Schoenbaum, *supra* note 217, at 366 (describing Professor Martha Fineman’s book, *The Autonomy Myth*, which argued that “those with caregiving responsibilities—disproportionately women—do not achieve freedom by being left alone but are far more free—and thus far more equal—when they are supported”).

442. See Part III.B.

443. Dreweke, *supra* note 201, at 15.

444. Katie Keith, *State Lawsuit Claims That Individual Mandate Penalty Repeal Should Topple Entire ACA*, HEALTH AFF. (Feb. 28, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180228.852626/full/>.

445. *Heckler v. Matthews*, 465 U.S. 728, 739 n.5 (“In this case, Congress has, through the severability clause, clearly expressed its preference for nullification, rather than extension, of the pension offset exception in the event it is found invalid.”).

Another line of cases outside of the equal protection context suggests that when courts are legally prohibited from nullifying a benefit, equity demands leveling up.<sup>446</sup> At a minimum, the Equal Protection Clause requires formal equality. If nullification is not an option, extension is the only available remedy. One could argue that nullifying the Mandate could violate the Constitution and federal law. For instance, the plaintiffs in the Mandate's religious exemption litigation argue that both Section 1557 of the ACA and the Equal Protection Clause require coverage of birth control.<sup>447</sup> Why? For the same reasons that *Sylvia Law* concluded it was illegal under Title VII for employers to not cover birth control: it would be illegal sex discrimination to limit access to a health intervention only used by women when the ACA otherwise requires comprehensive health care for both sexes.<sup>448</sup> The courts have yet to rule on the merits of those cases, but even if a court is not entirely convinced by these arguments, the statutory interpretation canon of constitutional avoidance (though more recently disfavored) might encourage courts to cure the defect by leveling up to avoid the constitutional question.<sup>449</sup> Thus, if nullifying the Mandate would be illegal or unconstitutional, this line of cases also suggests that extending the Mandate would be preferable to nullifying it.

Second, scholars have long challenged whether formal equality, which is satisfied by leveling down, should be sufficient under the Equal Protection Clause. Ruth Colker, for instance, used the antidisubordination doctrine to argue that an equal protection analysis should focus on the advancement of subjugated groups and not simply equal treatment, which might disproportionately disadvantage the subjugated group.<sup>450</sup> To Colker, "both facially differentiating

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446. Brake, *supra* note 426, at 553–56. For example, if a statute prioritizes religious objections over nonreligious objections in violation of the Establishment Clause but removing the benefit to religious objectors would violate the Constitution's prohibition against bills of attainder, then the only remedy is to provide equal benefits to nonreligious objectors. *Id.*

447. The California attorney general and his state partners argue that "[t]he [Trump Administration's] Rules' express authorization of employers' exempting themselves from providing full and equal coverage to their female employees directly violates Section 1557." States' Notice of Motion and Motion for Preliminary Injunction, with Memorandum of Points and Authorities at 12, *California v. Health & Human Servs.*, 351 F. Supp. 3d 1267 (N.D. Cal. 2019) (No. 17-cv-05783-HSG); *see also* Complaint for Declaratory and Injunctive Relief at ¶ 146, *Pennsylvania v. Trump*, 351 F. Supp. 3d 791 (E.D. Pa. 2019) (No. 17-4540), 2017 WL 4547321 ("Because the Exemption Rules allow employers to refuse previously-mandated preventive medical services for women only, they violate the Constitution's guarantee of equal protection under the law.").

448. *See, e.g.*, Plaintiff's Opposition to Defendant's Motion to Dismiss at 13, *Pennsylvania v. Trump*, 351 F. Supp. 3d 791 (E.D. Pa. 2019) (No. 17-4540), 2017 WL 10620329 ("The Defendants similarly claim the Rules do not violate the principle of equal protection because they 'do not draw a sex-based distinction' and men 'receive no better treatment' than women. But when contraceptive coverage is denied for women, it is women (not men) who bear the risk of unplanned pregnancies. That is why contraceptive coverage was mandated in the first place under the *Women's Health Amendment*." (citation omitted)).

449. *See, e.g.*, *Zobrest v. Catalina Foothills Sch. Dist.*, 509 U.S. 1, 7 (1993) ("It is a familiar principle of our jurisprudence that federal courts will not pass on the constitutionality of an Act of Congress if a construction of the Act is fairly possible by which the constitutional question can be avoided." (citing *United States v. Locke*, 471 U.S. 84, 92 (1985))).

450. Colker, *supra* note 255, at 1003.

and facially neutral policies are invidious only if they perpetuate racial or sexual hierarchy.”<sup>451</sup> Deborah Brake similarly argues that equality should require more than equal treatment—it should require equal concern.<sup>452</sup> She argues that leveling down should be prohibited when it “exacerbate[s] the injuries of discrimination” and therefore fails to express equal concern for the historically disadvantaged group.<sup>453</sup> Under both theories, nullification of the Mandate—even if it satisfies formal equality—is unacceptable because it would perpetuate harms suffered by women and further impede progress toward sex equality.

Finally, even if a court were to strike the Mandate in its entirety or give the government discretion to cure the defect as it sees fit, the Mandate’s popularity would create strong political pressure for Congress to universalize the Mandate. In one poll, more than “77% of women and 64% of men . . . support[ed] . . . no-cost contraceptive coverage.”<sup>454</sup> In another, 67% of Americans overall supported the Mandate, with only 30% opposing it.<sup>455</sup> With at least two-thirds of Americans supporting the Mandate already, it’s unlikely—though not inconceivable—that if Congress were given the discretion to level up or down, it would choose to level up. And if a court remedies the defect itself by leveling down, Congress would face pressure to re-create the Mandate, applying it to all sexes. Though not fail proof, it mitigates some of the leveling-down risk in litigation.

Taken together, there are doctrinal, normative, and practical justifications to level up and extend the Mandate. In tandem, they justify the pursuit of contraceptive equity through litigation under the Equal Protection Clause.

## CONCLUSION

This Article advocates for contraceptive equity through an expansion of the ACA’s contraceptive Mandate. Though the Mandate focused on female birth control in response to a women-led movement to remedy a long history of sex discrimination in access to contraception, the Mandate’s exclusion of men harms women. The Mandate incentivizes women to endure the risks and side effects of birth control, even when safer male options exist, and encourages pharmaceutical companies to continue investing in new methods of female birth control despite the dearth of male options. The Mandate also perpetuates harmful sex stereotypes against both sexes—stereotypes that need to change if contraceptive equity is ever to become a reality. Finally, a significant number of

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451. *Id.* at 1007–08.

452. Brake, *supra* note 426, at 561–62.

453. *Id.* at 560, 570–71.

454. LAURIE SOBEL ET AL., KAISER FAMILY FOUND., THE FUTURE OF CONTRACEPTIVE COVERAGE 1 (2017), <http://files.kff.org/attachment/Issue-Brief-The-Future-of-Contraceptive-Coverage>.

455. Daniel Cox & Molly Fisch-Friedman, *Most Americans Support Mandate for Employer-Covered Contraception*, PRRI (Oct. 6, 2017), <https://www.prii.org/spotlight/employer-contraceptive-mandate/>.

women rely on male birth control to prevent unwanted pregnancy, and these women cannot obtain free access to their chosen birth control method under the Mandate. These harms combined make it unlikely the Mandate could survive an equal protection challenge. Though courts typically allow either extension or removal of the benefit to cure a discriminatory statute, the equal protection doctrine in this case should support extension.