Nos. 19–431, 19–454

IN THE

Supreme Court of the United States

THE LITTLE SISTERS OF THE POOR
SAINTS PETER AND PAUL HOME, PETITIONER

v.

PENNSYLVANIA, ET AL., RESPONDENTS

DONALD J. TRUMP
PRESIDENT OF THE UNITED STATES, ET AL., PETITIONERS

v.

PENNSYLVANIA, ET AL., RESPONDENTS

On Writs of Certiorari to the
United States Court of Appeals for the Third Circuit

BRIEF OF 186 MEMBERS OF THE UNITED STATES CONGRESS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

CASES

STATUTES

REGULATIONS

LEGISLATIVE MATERIALS

OTHER AUTHORITIES

STATEMENT OF INTEREST OF *AMICI CURIAE* [1]

Amici are 186 Members of the United States Congress, including Members who were in Congress when the Patient Protection and Affordable Care Act ("ACA" or "the Act"), Pub. L. No. 111–148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 (2010), and the Religious Freedom Restoration Act of 1993 ("RFRA"), Pub. L. No. 103–141, 107 Stat. 1488, were passed and who supported their passage.[2]

Amici have a substantial and unique interest in explaining Congress's intent, as demonstrated by the ACA's legislative history, to provide access to coverage for contraceptive services with no out-of-pocket costs[3] in order to promote public health and

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[1] *Amici* affirm that no counsel for a party to these proceedings authored this brief in whole or in part, and that no person other than *amici* or their counsel made a monetary contribution to its preparation or submission. Counsel for all parties have submitted blanket consents to the filing of *amicus curiae* briefs in this case.

[2] A complete list of Members of Congress participating as *amici* appears as an Appendix to this brief.

[3] This brief uses "cost-free," "no cost-sharing," and "no out-of-pocket costs" interchangeably to refer to a group health plan and health insurance issuer offering group or individual health insurance coverage for which women pay no co-payments or deductibles, as provided in 42 U.S.C. § 300gg–13.

welfare and equality for women. The ACA's contraceptive coverage requirement provides for coverage of the full range of contraception methods approved by the Food and Drug Administration ("FDA"), as well as patient education and counseling. 42 U.S.C. § 300gg–13; U.S. Dep't of Health and Human Servs., Health Res. & Servs. Admin., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womens-guidelines-2019 (last visited Apr. 3, 2020).

Amici submit this brief to express their strong view that the expansive exemptions (the "Exemptions") to the contraceptive coverage requirement issued by the Department of Health and Human Services ("HHS"), the Department of the Treasury, and the Department of Labor (collectively, the "Departments") are inconsistent with the text of, and Congress's intent for, both the ACA and RFRA, and that neither law authorizes the Exemptions. The contraceptive coverage requirement and the original administrative regulations for accommodating certain employers' religious objections to providing such coverage (the "religious accommodation") appropriately implemented the ACA and RFRA consistent with Congress's goals to advance public health and welfare and promote equality for women, using the least restrictive means of furthering those goals.

SUMMARY OF ARGUMENT

This Court should reject Petitioners' attempt to undermine Congress's intent by creating the Exemptions to the requirement for cost-free contraceptive coverage under the ACA.

First, the ACA's requirement for cost-free coverage of preventive care benefits and services, including contraception, was a critical part of achieving Congress's goal of advancing public health by improving Americans' access to affordable health care and reducing inequalities for women in the health care system. The centrality of this goal is evident from the ACA's text and legislative history and is strongly supported by *amici*. Indeed, the ACA has been successful in achieving Congress's goal of improving women's access to preventive care, including contraceptive coverage. Since the passage of the ACA, women's health care coverage has increased and out-of-pocket expenses for contraceptive services have decreased significantly for millions of women. Congress's goals in enacting the ACA would be severely undermined if the Departments were permitted to carry out the Exemptions.

Second, RFRA did not, and was not intended to, delegate rulemaking authority to administrative agencies to enact broad exemptions to laws of general applicability and thus cannot authorize, much less require, the Exemptions. RFRA was passed to reinstate a long-standing legal test that

Congress believed had effectively balanced individual religious liberty and compelling public interests. That test allowed courts to protect an individual against a law that substantially burdened his or her free exercise of religion. The text and legislative history of RFRA demonstrate that Congress did not intend to grant the Departments authority to apply—or fail to apply—a statute in accord with their own view of its putative effect on religious freedom.

Neither the ACA nor RFRA authorizes or permits the Departments to defeat the government's compelling interest in ensuring that women have access to comprehensive coverage of preventive health care, including contraception.

ARGUMENT

I. The ACA Does Not Authorize the Exemptions, Which Violate the Law's Text, Intent, and Purpose.

Providing for cost-free coverage of preventive benefits and services is necessary to achieve Congress's intent of ensuring access to basic health care for millions of Americans. *See* Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,872 (July 2, 2013).

Congress particularly focused on the importance of women's preventive care, including contraception, recognizing that it was essential to

reform the health care system to "[i]ncrease[] health insurance coverage for women" and "require[] coverage of comprehensive reproductive health services." 155 CONG. REC. 12916 (2009) (statement of Rep. Moran) (noting an increase in women who no longer have money to pay for medical care and that "[t]hese women are literally choosing between a month of birth control and bus fare").

Access to contraception improves health outcomes for women and children by, among other things, allowing "women and couples to avoid an unwanted pregnancy and to space their pregnancies to promote optimal birth outcomes." Hrg. Before H. Comm. on the Judiciary, 112th Cong. 101, Testimony of Linda Rosenstock, Dean of the UCLA School of Public Health and Chair of the IOM Comm. on Preventive Servs. for Women, at 29 (2012). Avoiding unintended pregnancy, which "increases the risk of babies being born preterm or at low birth weight, both of which increase their chance of health and developmental problems," is particularly important because "women with unintended pregnancies are more likely to receive delayed or no prenatal care" and to suffer from other health problems. *Id.* at 28.

There also is strong evidence that access to contraception improves women's social and economic status. *See, e.g.*, Testimony of Guttmacher Inst. Submitted to the Comm. on Preventive Servs. for Women, Inst. of Med. (Jan. 12, 2011) ("[H]aving a reliable form of contraception allowed women to invest in higher education and a career with far less

risk of an unplanned pregnancy.") (citations omitted).

Congress therefore included coverage for women's preventive care services, with no cost-sharing, as part of its comprehensive health care reform, to promote equality in women's access to health care and advance women's health, social, and economic outcomes. *See* 42 U.S.C. § 300gg–13. This coverage includes the full range of FDA-approved contraceptive methods. *See* U.S. Dep't of Health and Human Servs., Health Res. and Servs. Admin., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womens-guidelines-2019 (last visited Apr. 3, 2020).

A. The Legislative History of the ACA Demonstrates That Congress Intended for Women's Preventive Care Benefits, Including Contraceptive Coverage, to Improve Comprehensive Access and Remedy Inequalities in Health Care Coverage for Women.

Congress included cost-free women's preventive services as a core part of the ACA, 42 U.S.C. § 300gg–13(a)(4), to ensure complete coverage for preventive care, improve women's health, further equality for women, and reduce discrimination against women in access to health care. Congress recognized that increasing women's access to a wide range of services would remedy "a situation where many women [were] delaying going to a doctor,

getting their preventive services," 155 CONG. REC. 28842 (2009) (statement of Sen. Boxer), and were being discriminated against by insurers. *See id.* at 28835–36 (statement of Sen. Reid).

Congress therefore added the Women's Health Amendment ("WHA") to the ACA, *see id.* at 29310, which included critically important preventive services specific to women in the ACA's minimum coverage requirement. *See id.* at 28843 (statement of Sen. Gillibrand) ("The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique health care needs of women throughout their lifespan."); *id.* at 29301 (statement of Sen. Harkin) ("By voting for the [WHA], we can make doubly sure that the floor we are establishing in the bill for preventive services that are unique to women also has no copays and no deductibles.").

1. Congress sought to improve women's health as part of the ACA's comprehensive preventive care coverage.

In crafting the ACA, Congress took a comprehensive, multi-tiered approach to improving access to health care for women. The ACA ensured a minimum level of coverage for millions of Americans who previously had no access to health insurance or whose existing coverage was of poor quality.

Moreover, Congress provided for essential health benefits such as maternity and newborn care, prescription drug coverage, emergency services, and rehabilitative services, as well as coverage without cost-sharing for preventive services, including screening for cancer and diabetes, breastfeeding support and counseling, and folic acid supplements. The goal was to fill the gaps in women's existing preventive care by expanding access to services "such as cervical cancer screenings, osteoporosis screenings[,] . . . pregnancy and post-partum screenings[,] . . . and annual checkups for women." 155 CONG. REC. 29306 (2009) (statement of Sen. Stabenow); *see also What Women Want: Equal Benefits for Equal Premiums, Hearing of the S. Comm. on Health, Educ., Labor, and Pensions*, 111th Cong. 36 (Oct. 15, 2009) (hereinafter "Equal Benefits Hearing") (statement of Marcia D. Greenberger, Co-President, National Women's Law Center) ("[T]he vast majority of individual market health insurance policies do not cover maternity care at all."). Congress therefore required that "all health plans cover comprehensive women's preventive care and screenings . . . at little or no cost to women." 155 CONG. REC. 28841 (2009) (statement of Sen. Boxer).

Congress intended for cost-free preventive care to further the goal of improving access to health care for women. *See* 156 CONG. REC. 3836 (2010) (statement of Rep. Lee) ("So I stand today to be able to say to all of the moms and nurturers who happen to be women that we have listened to your call. We have actually recognized that it is important to

provide for preventative care."). Congress recognized that accessible and affordable preventive care was critical to improving public health and lowering health care costs. *See* 155 CONG. REC. 28843 (2009) (statement of Sen. Gillibrand) ("[T]oo many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost."); *id.* at 28844 (statement of Sen. Hagan) ("When these women had to choose between feeding their children, paying the rent, and meeting other financial obligations, they skipped important preventive screenings and took a chance with their personal health."); *see also* 78 Fed. Reg. at 39,872 ("Individuals are more likely to use preventive services if they do not have to satisfy cost-sharing requirements.").

2. Congress intended for contraceptive care to be a part of the WHA.

The WHA was specifically intended to improve women's health care by providing coverage without cost-sharing of the full range of preventive services for women, including "family planning" services. 155 CONG. REC. 28841 (2009) (statement of Sen. Boxer) ("I am proud to support the Mikulski-Harkin-Boxer amendment to improve preventive health coverage for women. The Mikulski amendment addresses this critical issue by requiring that all health plans cover comprehensive women's

preventive care and screenings—and cover these recommended services at little or no cost to women. These health care services include annual mammograms for women at age 40, pregnancy and postpartum depression screenings, screenings for domestic violence, annual women's health screenings, and family planning services."); *see also, e.g.*, *id.* at 29768 (statement of Sen. Durbin) ("Today, there are 17 million women of reproductive age in America who are uninsured. This bill will expand health insurance coverage to the vast majority of them, which . . . will reduce unintended pregnancies . . . ."); 156 CONG. REC. 4172 (2010) (statement of Rep. Kaptur) ("This legislation will help millions of women . . . by enhancing broad coverage options for women's and children's health.").

The legislative record demonstrates the importance that Congress attached to the provision of preventive services to address women's unique medical needs when it considered and passed the WHA—with clear expressions of its intent to cover contraception. *See* 155 CONG. REC. 28843 (2009) (statement of Sen. Gillibrand) ("With Senator Mikulski's amendment, even more preventive screening will be covered, including . . . family planning."); *id.* at 29070 (statement of Sen. Feinstein) ("[The amendment] will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women's health screenings."); *id.* at

28841 (statement of Sen. Boxer) ("The Mikulski amendment addresses this critical issue by requiring that all health plans cover comprehensive women's preventive care and screenings—and cover these recommended services at little or no cost to women. These health care services include . . . family planning services."); *id.* at 28844 (statement of Sen. Mikulski) ("[The amendment] also provides family planning.").

Congress recognized that "[w]omen are more likely than men to neglect care or treatment because of cost." *Id.* at 28801 (statement of Sen. Mikulski) ("Fourteen percent of women report they delay or go without needed health care. Women of childbearing age incur 68 percent more out-of-pocket health care costs than men . . . ."). The high out-of-pocket costs for health care, especially reproductive health care, resulted in many women not having access to necessary services. *See id.* at 29302 (statement of Sen. Mikulski) ("[C]opayments are so high that [women] avoid getting [preventive and screening services] in the first place."); *id.* at 28843 (statement of Sen. Gillibrand) ("[T]oo many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost."); *see also* Equal Benefits Hearing at 17 (statement of James Guest, President & CEO, Consumer Union) (noting women are more likely to put off a doctor's visit, not fill a prescription, or skip a treatment or procedure).

The ACA therefore ensures that critical preventive services, including contraceptive care, are provided with no out-of-pocket cost, so that women have access to basic health services.

3. Congress intended to reduce discrimination against women in access to health care by expanding comprehensive preventive services.

Congress emphasized that, in addition to promoting women's health, the ACA in general, and the preventive care provisions in particular, were critical in combating discrimination against women in the provision of health care. *See* 156 CONG. REC. 3970 (2010) (statement of Rep. Speier) ("If there ever was an issue on health care that must be addressed and is addressed in [the ACA], it is gender discrimination."); 155 CONG. REC. 28843 (2009) (statement of Sen. Gillibrand in support of WHA) ("Women must shoulder the worst of the health care crisis, including outrageous discriminatory practices in care and coverage."). Congress saw that women, "in ways both overt and beneath the radar," were discriminated against in the American health care system. 156 CONG. REC. 3978 (2010) (statement of Rep. Woolsey); *see also* 155 CONG. REC. 28842 (2009) (statement of Sen. Mikulski in support of WHA) ("[H]ealth care is [a] women's issue. Health care reform is a must-do women's issue, and health insurance reform must be a must-change women's issue . . . .").

For instance, prior to the enactment of the ACA, insurance companies were permitted to charge women higher premiums for insurance coverage. *See* 155 CONG. REC. 28859 (2009) (statement of Sen. Harkin) ("In most States, it is legal for insurance companies to charge women more than men for the same policy."); *id.* at 26533 (statement of Rep. Chu) ("Today, women are forced to settle for less health care at a higher price. We pay as much as 50 percent more than men, a practice of discrimination that is legal in 38 states."); 156 CONG. REC. 3978 (2010) (statement of Rep. Woolsey) ("Insurance companies are allowed to charge women more simply because they are women."); 155 CONG. REC. 28842 (2009) (statement of Sen. Mikulski) (noting women's preventive services provision was intended to alleviate "punitive practices of insurance companies that charge women more and give [them] less in a benefit" and to "end the punitive practices of the private insurance companies in their gender discrimination").

Congress also noted that conditions that disproportionately affect women, such as pregnancy or being a victim of domestic violence, were often treated as pre-existing conditions, which resulted in denial of coverage for essential services under many plans. *See* 155 CONG. REC. 28842–43 (2009) (statement of Sen. Mikulski); 156 CONG. REC. 3916 (2010) (statement of Rep. McCollum); *id.* at 3978 (statement of Rep. Woolsey); *see also* Equal Benefits Hearing at 36 (statement of Marcia D. Greenberger) ("Simply being pregnant or having had a Cesarean

section is grounds enough for insurance companies to reject a woman's application. And in eight States and the District of Columbia, insurers are allowed to use a woman's status as a survivor of domestic violence to deny her health insurance coverage.").

In addition, Congress understood that, even when women have equal access to coverage, health care costs are greater for women than men as a result of reproductive health needs. *See, e.g.*, 155 CONG. REC. 28843 (2009) (statement of Sen. Gillibrand) ("[W]omen of childbearing age spend 68 percent more in out-of-pocket health care costs than men."); *id.* at 24427 (statement of Sen. Shaheen) ("It should surprise no one that women and men have different health care needs. Despite this difference, it is unacceptable that women are not treated fairly by the system and do not always receive the care they require and deserve."); *see also* Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Affairs 1204, 1208 (July 2015) (finding contraception makes up a significant portion of women's out-of-pocket health care expenses).

Furthermore, Congress recognized that because women are often subject to economic discrimination, earning less for every dollar that a man earns, women spend an even greater portion of their income on health care. *See* 155 CONG. REC. 24426 (2009) (statement of Sen. Boxer) ("Women

earn less than men, and that is why it is an impossible situation.").

Congress saw that "[t]his fundamental inequity in the current system is dangerous and discriminatory," *id.* at 28843 (statement of Sen. Gillibrand), and set out to change the health insurance system in which "women have been discriminated against for decades . . . ." 156 CONG. REC. 3970 (2010) (statement of Rep. Speier); *see also* 155 CONG. REC. 28846 (2009) (statement of Sen. Dodd) ("I support the effort by Senator Mikulski . . . to see to it that women are treated equally, and particularly in preventive care, and I strongly urge the adoption of her amendment and ask to be added as a cosponsor to that amendment.").

The WHA therefore required that group health plans include preventive health care services for women without cost-sharing, so that women would have equal access to the full range of health care services for their specific health needs, including contraception. *See* 155 CONG. REC. 29307 (2009) (statement of Sen. Murray) ("Women will have improved access to well-women visits—important for all women; family planning services; mammograms, which we have all talked about so many times, to make sure they maintain their health.").

4. Congress did not authorize HHS to exempt health insurance plans from the contraceptive coverage requirement.

Petitioners argue incorrectly that the provision of the WHA authorizing the Health Resources and Services Administration ("HRSA") to determine the scope of contraceptive coverage also authorizes HHS to craft wholesale exemptions from those requirements. This interpretation defies a plain reading of the statute, which states that health plans and insurance issuers "shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for . . . preventive care . . . provided for in comprehensive guidelines supported by [HRSA]." 42 U.S.C. § 300gg–13(a)(4). This provision requires HRSA to determine which preventive services must be provided cost-free in insurance plans but does not authorize HHS to exempt certain plans from the coverage requirement.[4]

Petitioners' misreading also conflicts with Congress's intent in passing the WHA and delegating authority to HRSA to employ its medical expertise. Congress's goal was to "ensure that the coverage of women's preventive services is based on

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[4] Petitioners' argument that RFRA was intended to require or authorize such exemptions is addressed in Section II, *infra*.

a set of guidelines developed by women's health experts." 155 CONG. REC. 28843 (2009) (statement of Sen. Gillibrand); *see also id.* at 29306 (statement of Sen. Stabenow) (stating that Sen. Mikulski's amendment "requires coverage of women's preventive services developed by women's health experts to meet the unique needs of women"); *id.* at 28876 (statement of Sen. Cardin) (noting that HRSA "focuses on maternal and child health . . . [and] strives to develop 'best practices' and create uniform standards of care . . . ."). It would be irrational to conclude that, having directed HHS to identify and require cost-free coverage of essential preventive services, Congress intended to grant blanket authority to HHS (or HRSA) to exempt employers from this requirement, depriving women of such coverage.

HRSA relied on a respected non-partisan group of experts in the health care field—the Institute of Medicine ("IOM"), a division of the National Academies of Sciences, Engineering, and Medicine—to evaluate and recommend the specific preventive care and screening services that should be included in the minimum coverage requirement. *See* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8725–26 (Feb. 15, 2012). IOM released its research and recommendations on the necessary preventive services for women's health in *Clinical Preventive Services for Women: Closing the Gaps* ("IOM Report") (2011). The IOM Report

concluded that the full range of women's preventive services, including contraceptive methods and counseling, was necessary to ensure women's health and well-being. 77 Fed. Reg. at 8727.

Further, IOM advised that, because "even moderate copayments for preventive services" can "deter patients from receiving those services," IOM Report at 19, the elimination of cost-sharing for these contraceptive services for women would increase the use of more effective and long-term contraceptive methods. *Id.* at 109. Furthermore, consistent use of contraception improves women's health outcomes because short intervals between pregnancies increase the risk of maternal mortality and pregnancy-related complications. *See id.* at 103–04; *see also* Hrg. Before Comm. on Oversight and Reform, 116th Cong. 71, Testimony of Dr. Colleen McNicholas, Chief Medical Officer, Planned Parenthood of the St. Louis Region and Sw. Mo., at 22 (2019) ("[O]ne of the best strategies we have to reduce unintended pregnancy is . . . providing [women] access to the available contraceptive method of their choice when they need it, and without barrier . . . making sure that it is affordable for them, and making sure that they can change that method as often as they need to. . . .").

Based on IOM's review, HRSA recommended coverage of the full range of contraceptive methods approved by FDA, effectuating Congress's intent to provide affordable coverage for contraceptive benefits and services. Nothing in the statute or the

legislative history suggests that Congress delegated authority to HHS to exempt plans from providing the services included in HRSA's "comprehensive guidelines." [5] Indeed, Congress later rejected a statutory conscience amendment that would have operated similarly to the Exemptions. *See* 158 CONG. REC. 1162, 1172–73 (2012).

5. The ACA's existing exemptions from the contraceptive coverage requirement do not undermine Congress's intent to provide maximum reproductive health care coverage.

The existence of certain exemptions from the ACA's contraceptive coverage requirement does not undermine Congress's intent to maximize the number of women who have cost-free access to contraception. *See Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 266 (D.C. Cir. 2014), *vacated and remanded sub nom. Zubik v. Burwell*, 136 S. Ct. 1557 (2016) ("The government's

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[5] As the Third Circuit correctly explained, the Departments' previous promulgation of a narrow exemption for houses of worship does not undermine this conclusion because the First Amendment's special protection for the internal affairs of houses of worship, not the ACA, permitted that exemption. *See Pennsylvania v. Trump*, 930 F.3d 543, 570 n.26 (3d Cir. 2019); *see also* Respondents' Br. at 34–35 (collecting cases).

interest in a comprehensive, broadly available system is not undercut by . . . the exemptions for religious employers, small employers and grandfathered plans. The government can have an interest in the uniform application of a law, even if that law allows some exceptions."); *see also Burwell vs. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 763 (2014) (Ginsburg, J., dissenting) (noting that federal statutes "often include exemptions for small employers, and such provisions have never been held to undermine the interests served by these statutes").[6]

In addition, although qualifying grandfathered plans do not have to comply with certain ACA requirements, including but not limited to coverage of cost-free preventive care services, plans lose grandfathered status if they are modified so that they no longer meet specified minimum coverage requirements. 42 U.S.C. § 18011; Final Rules for Grandfathered Plans, 80 Fed. Reg. 72,192, 72,192–72,193 (Nov. 18, 2015). This exemption was intended as a temporary means for transitioning

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[6] *See, e.g.*, Family and Medical Leave Act of 1993, 29 U.S.C. § 2611(4)(A)(i) (applicable to employers with 50 or more employees); Age Discrimination in Employment Act of 1967, 29 U.S.C. § 630(b) (applicable to employers with 20 or more employees); Americans with Disabilities Act, 42 U.S.C. § 12111(5)(A) (applicable to employers with 15 or more employees); Title VII, 42 U.S.C. § 2000e(b) (applicable to employers with 15 or more employees).

employers to full compliance. *See* 78 Fed. Reg. at 39,887 n.49; *Hobby Lobby*, 573 U.S. at 763–64 (Ginsburg, J., dissenting). The number of employer-sponsored grandfathered plans in fact has decreased steadily since 2010. *See* Kaiser Family Foundation, *2019 Employer Health Benefits Survey* 210 (Sep. 25, 2019) (showing decrease in grandfathered employer plans from 56 percent to 13 percent during 2011–19).

B. The ACA is Fulfilling Congress's Goal of Improving Women's Health Care, Including Reduced Out-of-Pocket Costs for Contraception.

In the years since the ACA's enactment, women's access to health care has improved dramatically, as reflected in women's ability to obtain critical services, including contraception, and the reduced out-of-pocket costs of those services. The Exemptions, which would allow many more employers to opt out of the coverage requirement, threaten this important progress and should be invalidated.

Since the passage of the ACA, inequities in women's health care have declined. Women, particularly in lower-income groups, have reported greater affordability of coverage, access to health care, and receipt of preventive services. *See* Lois Kaye Lee et. al., *Women's Affordability, Access, and Preventive Care After the Affordable Care Act*, Am. J. Preventive Med. (May 1, 2019). Cost-free contraceptive coverage, a critical component of

Congress's intent in improving women's health care, has resulted in substantial savings for millions of women. The Third Circuit credited record evidence and found that "[a]fter the ACA removed cost barriers [to contraceptive use and access], women switched to the more effective and expensive methods of contraception. Because the Rules allow employers to opt out of providing coverage for contraceptive services, some women may no longer have insurance to help offset the cost for these and other contraceptives." *Pennsylvania*, 930 F.3d at 560.

The record evidence cited by the Third Circuit included a study published in the journal *Health Affairs*, which showed that "[b]efore the [requirement's] implementation, out-of-pocket expenses for contraceptives for women using them represented a significant portion (30–44 percent) of these women's total out-of-pocket health care spending." Nora V. Becker & Daniel Polsky, *Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 Health Affairs 1204, 1208 (July 2015). Between June 2012 (before the contraceptive coverage requirement went into effect) and June 2013 (six months after), the out-of-pocket expense for oral contraceptives and intrauterine devices fell by an estimated 38 percent and 68 percent, respectively. *See id.* In addition, the ACA eliminated the high up-front costs of long-acting reversible contraceptive methods, which previously may have deterred women from using them. *See id.*

at 1204. The median out-of-pocket per prescription cost dropped to zero for almost all contraceptives, indicating that the majority of women no longer faced out-of-pocket costs for contraception—as intended by the ACA. *See id.*; *see also* Hrg. Before Comm. on Ways and Means, 116th Cong. 1, Testimony of Karen Pollitz, Senior Fellow, Kaiser Family Foundation, at 114 (2019) ("[N]ow only about [two] percent of young women end up having to pay out-of-pocket costs for a contraceptive. It was much higher before the ACA.").

These data show that the ACA is effectively fulfilling Congress's intent to make health insurance costs and coverage more equal for women and to improve women's access to contraceptive care. Maintaining access to contraception without cost-sharing will be all the more critical as the current COVID-19 pandemic and impending recession make women even more vulnerable to increased costs.

II. RFRA Was Not Intended to, and Did Not, Delegate Rulemaking Authority to Federal Agencies to Craft Exemptions to General Laws, and Thus Does Not Authorize the Exemptions.

Petitioners' argument misconstrues both Congress's intent in passing RFRA and the authority RFRA grants to federal agencies. Congress passed RFRA to reinstate a long-standing legal test that Congress believed had effectively balanced individual religious liberty and compelling public

interests for decades. RFRA did not, and was not intended to, grant authority to federal agencies to craft exemptions to laws enacted by Congress—and thereby to negate Congress's own legislative intent. Nor was RFRA intended to allow some individuals' religious liberties (or agencies' own perceptions about those religious liberties) to be used as a sword to limit the rights of others. The decades of case law that Congress explicitly intended to restore repeatedly held that individual religious liberties do not justify discrimination and other harm to third parties. The Departments' expansive interpretation of RFRA would upset the careful balance Congress preserved between protecting religious beliefs and furthering compelling governmental interests, including protecting the rights of others.

A. RFRA Was Intended to Restore Prior Jurisprudence, Not to Expand Agencies' Regulatory Authority.

RFRA was enacted in response to this Court's decision in *Employment Division, Department of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990), which eliminated the compelling interest test previously applicable to free exercise claims challenging laws of general applicability. Concerned that *Smith* would "dramatically weaken[] the constitutional protection for freedom of religion," Congress enacted RFRA to restore the compelling interest standard and require the government to justify substantial restrictions on the exercise of religion. S. REP. No. 103–111, at 5, 8 (1993).

RFRA's text establishes the judicial standard of review for constitutional challenges to federal laws as applied to specific individuals. Sections 2000bb–1(a) and (b) outline the standard and Section 2000bb–1(c) provides that "[a] person whose religious exercise has been burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding." Nothing in RFRA grants administrative agencies *carte blanche* to determine what constitutes a substantial burden on the exercise of religion. The statute refers to federal agencies only in the definition of the governmental entities whose actions are subject to judicial review. 42 U.S.C. § 2000bb–2. This does not grant federal agencies authority, much less require them, to undermine policy decisions made by Congress. *See Bureau of Alcohol, Tobacco & Firearms v. Fed. Labor Relations Auth.*, 464 U.S. 89, 97 (1983) (rejecting "unauthorized assumption by an agency of major policy decisions properly made by Congress").[7]

The legislative history confirms that Congress's intent, in passing RFRA in 1993 and amending it in 2000, was only to correct what it perceived as *Smith's* incorrect formulation of the test courts must apply when evaluating an individual's claim that a law of general applicability improperly

[7] For additional discussion of the absence of delegation of rule-making authority, *see* Br. of Legal Scholars as *Amici Curiae* Supporting Respondents (Seth Davis, *et al.*), *Little Sisters of the Poor v. Pennsylvania et al.* (2020) (No. 19–431).

burdens the free exercise of religious belief. Congress did not intend to grant federal agencies a roving mandate to apply federal statutes in ways inconsistent with their text and purpose in order to implement the agencies' own interpretations of RFRA.

The congressional record from RFRA's passage in 1993 does not discuss expanding federal agencies' authority. Instead, members of Congress consistently asserted their intent that RFRA only restore the judicial standard of review federal courts applied prior to *Smith*. *See, e.g.*, 139 CONG. REC. 9680 (1993) (statement of Rep. Brooks) ("[RFRA] will restore the standard for addressing claims under the free exercise clause of the first amendment as it was prior to the Supreme Court's *Smith* decision in 1990."); *id.* at 9681 (statement of Rep. Edwards) ("[RFRA] simply restores the compelling governmental interest test."); *id.* at 9682 (statement of Rep. Hyde) ("[t]he bill now clearly imposes a statutory standard that is to be interpreted as incorporating all Federal court cases prior to *Smith*," and "[t]he changes made to the bill as introduced in the 103d Congress make clear that [RFRA] is not seeking to impose a new and strengthened compelling State interest standard, but is seeking to replicate, by statute, the same free exercise test that was applied prior to *Smith*").

The "[f]ederal court cases prior to *Smith*" that Congress intended to restore were challenges to laws of general applicability as applied to specific

individuals, which required an individualized analysis of the specific facts in the case before the court. *See, e.g.*, *Hobbie v. Unemployment Appeals Comm'n of Fla.*, 480 U.S. 136 (1987) (challenge to unemployment laws as applied to plaintiff); *Sherbert v. Verner*, 374 U.S. 398 (1963) (same); *Torcaso v. Watkins*, 367 U.S. 488 (1961) (challenge to public commission law as applied to plaintiff); *Fowler v. State of R.I.*, 345 U.S. 67 (1953) (challenge to plaintiff's criminal conviction). The case law Congress intended to "restore" through RFRA did not authorize federal agencies to rewrite statutes but merely reestablished a standard of judicial review for individual claims. That agencies must amend regulations in response to court orders—as the Departments did following this Court's opinions in *Hobby Lobby* and *Wheaton College*—does not mean that agencies have discretion to craft exemptions based on their own interpretation of the law. Congress thus did not intend RFRA to grant HHS the authority it claims for itself in the Exemptions.

B. RFRA Is Also Inapplicable Because the Accommodation Did Not Substantially Burden Religion.

In enacting RFRA, Congress sought to protect individuals against generally applicable laws that "substantially burden" their free exercise of religion. 42 U.S.C. § 2000bb–1(a). The word "substantially" was not included in the original draft but was added following an amendment offered by Senators Kennedy and Hatch. *See* 139 CONG. REC. 26180

(1993). That amendment specified that "[RFRA] does not require the government to justify every action that has some effect on religious exercise." *Id.* (statement of Sen. Hatch). Instead, the amendment confirms Congress's intent to restore the law in effect before this Court's decision in *Smith*, under which only "governmental action that places a *substantial* burden on the exercise of religion . . . must meet the compelling interest test set out in [RFRA]." *Id.* (statement of Sen. Kennedy) (emphasis added).

The substantial burden inquiry focuses on the actions a law requires of plaintiffs, not those of third parties. *See, e.g.*, *Lyng v. Nw. Indian Cemetery Protective Ass'n*, 485 U.S. 439, 450–51, 453 (1988) (rejecting free exercise challenge to government's plan to permit logging on federal land, which plaintiffs used for religious purposes, because the law concerned only the government's use of its own land and did not coerce plaintiffs to act contrary to their religious beliefs); *Bowen v. Roy*, 476 U.S. 693, 699–701 (1986) (holding that the government's use of individuals' social security numbers to process benefits did not violate the Free Exercise Clause despite plaintiff's objections because the statute regulated the government's conduct, not the plaintiff's).

The Exemptions are not required or justified by RFRA because the religious accommodation does not "substantially burden" any employer's exercise of religion. The religious accommodation permits

certain nonprofit employers to opt out of the contraceptive mandate by submitting a Form 700 to their insurance issuers certifying that they object on religious grounds to providing contraceptive coverage. *See* Coverage of Certain Preventive Services Under the Affordable Care Act, 80 Fed. Reg. 41,318, 41,323 (July 14, 2015). Alternatively, the employer could simply notify HHS in writing of its decision to opt out. *See id.* In either case, the issuer or third-party administrator ("TPA") would then be responsible for making separate payments for contraception to plan beneficiaries. *See id.*

All but one federal circuit court to address this issue have held that the accommodation does not "substantially burden" an employer's religious exercise because the ACA and its implementing regulations, not an employer's *de minimis* administrative actions in invoking the religious accommodation, require the provision of contraceptive coverage by insurance issuers and TPAs. *See, e.g., Priests for Life*, 772 F.3d at 252 ("[T]he insurers' or TPAs' obligation to provide contraceptive coverage originates from the ACA and its attendant regulations, not from Plaintiffs' self-certification or alternative notice.").

C. RFRA Was Intended to Protect the Free Exercise Rights of Individuals, Not to Permit the Imposition of Religious Beliefs on Others.

Congress enacted RFRA as a shield, not a sword. RFRA was intended as an important defense of religious liberties, but it does not permit the religious beliefs of employers to interfere with their employees' access to the preventive health care coverage the ACA mandates. In arguing that the Exemptions are required, or at least permitted, by RFRA, Petitioners are attempting to wield RFRA to hinder women's access to contraceptive care.

The cases that Congress intended to restore as the proper standard consistently held that the government is not required to accommodate religious beliefs if doing so imposes burdens on interests of third parties. *See, e.g.*, *Bob Jones Univ. v. United States*, 461 U.S. 574, 592–95 (1983) (rejecting university's claim—that it was entitled to tax exempt status since its policies on interracial dating were based on sincere religious beliefs—because "racial discrimination in education violates deeply and widely accepted views of elementary justice"); *Braunfeld v. Brown*, 366 U.S. 599, 604 (1961) (recognizing that religious accommodations should be granted if "[t]he freedom asserted by [an objector] does not bring [the objector] into collision with rights asserted by any other individual"). This Court recognized these principles in *Hobby Lobby*. 573 U.S. at 729 n.37 ("It is certainly true that in

applying RFRA courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." (internal citation omitted)); *id.* at 739 (Kennedy, J., concurring) ("[N]either may that same exercise unduly restrict other persons, such as employees, in protecting their own interests, interests the law deems compelling.").

When individuals have sought exemptions from laws or regulations based on their religious beliefs, the Court has recognized the importance of balancing those religious rights against the interests of the government in the efficient administration of its statutes and the impact any exemption would have on the rights of third parties. For example, in *United States v. Lee*, an Amish business owner claimed that paying social security taxes interfered with his free exercise rights because the Amish have a religious responsibility to take care of their own elderly and needy. 455 U.S. 252, 254–55 (1982). The Court refused to grant an exemption, holding that the government had a compelling interest in the efficient and consistent application of the social security system and that "[w]hen followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity." *Id.* at 259–61; *see also Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005) ("Our decisions indicate that an accommodation must be measured so that it does not override other significant interests."); *Estate of*

Thornton v. Caldor, Inc., 472 U.S. 703, 710 (1985) ("The First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities.") (citation omitted).

The ACA's requirement that employers provide insurance coverage for women's preventive health care ensures that contraceptive services are affordable and accessible for any woman who needs or wants to use them. This Court's remand in *Zubik v. Burwell* was specific in limiting the parties, including the government, to "an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise *while at the same time ensuring that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage*.'" 136 S. Ct. at 1560 (emphasis added).

That directive is fully consistent with Congress's intent in passing the ACA, as particularly reflected in its later consideration and rejection of an amendment that would have allowed employers to refuse to provide coverage for contraception and other medical services on the basis of religious beliefs. "[The] simple, nondebatable fact [is] that the power to decide whether a woman will use contraception lies with her, not her boss, not her employer." 158 CONG. REC. 2083 (2012) (statement of Sen. Gillibrand); *see also id.* at 1047 (statement of Sen. Shaheen) ("That is [women's] decision. It is not their employer's."). The ACA and its implementing

regulations were intended to "preserve[] the freedoms of conscience and religion for every American," but also "protect[] the rights of the millions of Americans who do use contraceptives, who believe family planning is the right choice for them personally, and who do not deserve to have politics or an extreme minority's ideology prevent them from getting the coverage they deserve." *Id.* (statement of Sen. Murray); *id.* at 1050 (statement of Sen. Feinstein) ("Women should have access to comprehensive reproductive care and should be able to decide for themselves how to use that care.").

The Exemptions abandon the government's compelling interest in ensuring that women have access to comprehensive coverage of preventive health care services, including contraception. By vastly expanding the number of entities that can deny women the right to obtain that coverage, and by failing to provide any workable mechanism by which these women can receive coverage from third parties, the Departments have undermined that compelling interest.

D. Petitioners' Arguments Threaten the Critical Balance between Protection of Religious Beliefs and the Government's Ability to Protect the Public Health and Welfare and Prohibit Discrimination Against Women.

This Court's jurisprudence has carefully balanced the protection of religious beliefs with the

compelling government interest in promoting public health and prohibiting discrimination. In *Hobby Lobby*, this Court reaffirmed its holding in *Cutter v. Wilkinson* that "courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." 573 U.S. at 729 n.37. This Court reached its holding extending the religious accommodation to certain closely held companies only after concluding that the harm to women of doing so would be "precisely zero." *Id.* at 693.

In *Zubik*, the Court reiterated that harm to third parties must be taken into account when it directed the parties on remand to arrive at a solution that "ensur[es] that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage.'" 136 S. Ct. at 1560. Here, by contrast, Petitioners ask this Court to uphold a rule that they estimate would cause between 70,500 and 126,400 women to lose coverage in one year. *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536, 57,578–80 (Nov. 15, 2018). Accepting Petitioners' arguments would require the Court to abandon the critical balance between burdens on religion and harm to others that it has maintained for decades and so recently reaffirmed.

Moreover, Petitioners' arguments, if accepted, could alter this careful balance between accommodating religious freedom and protecting

compelling governmental interests, not only with respect to contraceptive coverage but also in other areas. Similar arguments might be advanced to support harmful policies such as the elimination of coverage for children's immunizations and prenatal care for children born to unmarried parents, or to allow an employer to refuse to cover domestic violence screenings. *See* 158 CONG. REC. 2334–37 (2012) (statements of Sens. Durbin, Reid, and Boxer, in rejecting a proposed amendment to the ACA allowing employers to refuse to provide coverage for contraceptive services and other medical services on the basis of religious beliefs).

The fears voiced by members of Congress and others following this Court's decision in *Hobby Lobby* have materialized in numerous rulemakings over the last three years. For example, the Department of Labor relied heavily on RFRA and *Hobby Lobby* to justify a proposed rule that would allow federal contractors to assert religious beliefs to justify discriminatory employment actions such as firing an employee on the basis of sexual orientation or non-marital sexual activity. Implementing Legal Requirements Regarding the Equal Opportunity Clause's Religious Exemption, 84 Fed. Reg. 41,677, 41,679, 41,684 (Aug. 15, 2019). The Administration for Children and Families at HHS cited RFRA in granting all religiously affiliated foster agencies in South Carolina an exemption from federal regulations that prohibit discrimination on the basis of religious belief. Letter from Admin. for Children & Families, Office of the Asst. Sec'y, U.S. Dep't of

Health & Human Servs., to Gov. Henry McMaster, Re: Request for Deviation or Exception from HHS Regulations 45 CFR § 75.300(c) (Jan. 23, 2019).[8] HHS also referred to RFRA and *Hobby Lobby* to justify its rule, subsequently vacated, that attempted to create new rights for individuals and institutions in the health care field to refuse to provide patient care if they assert a religious reason for the refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,194 (May 21, 2018); *New York v. U.S. Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019).

The accommodation of sincerely held religious beliefs cannot be permitted to upend the careful, necessary balance between respect for religious freedom and the government's interest in protecting public health and welfare and prohibiting discrimination against women. Nor can RFRA's protections for such individual beliefs become the basis for rulemaking by federal agencies that directly undercuts Congress's legislative authority.

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[8] *Available at* https://governor.sc.gov/sites/default/files/Documents/newsroom/HHS%20Response%20Letter%20to%20McMaster.pdf.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court reject Petitioners' attempt to create expanded exemptions to the ACA's contraceptive coverage requirements, and affirm the judgment of the Third Circuit.

Respectfully submitted,

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APPENDIX

APPENDIX

List of Participating *Amici*

Senators

Tammy Baldwin
Michael F. Bennet
Richard Blumenthal
Cory A. Booker
Sherrod Brown
Maria Cantwell
Benjamin L. Cardin
Tom Carper
Bob Casey Jr.
Chris Coons
Catherine Cortez Masto
Tammy Duckworth
Richard J. Durbin
Dianne Feinstein
Kirsten Gillibrand
Kamala D. Harris
Margaret Wood Hassan
Mazie K. Hirono
Tim Kaine
Amy Klobuchar
Edward J. Markey
Robert Menendez
Jeffrey A. Merkley
Patty Murray
Gary C. Peters
Jack Reed
Jacky Rosen
Bernard Sanders
Charles E. Schumer
Jeanne Shaheen
Tina Smith
Debbie Stabenow
Chris Van Hollen
Mark Warner
Elizabeth Warren
Sheldon Whitehouse
Ron Wyden

Appendix

Members of the U.S. House of Representatives

Alma Adams
Colin Allred
Nanette Diaz Barragán
Karen Bass
Joyce Beatty
Ami Bera, M.D.
Donald S. Beyer Jr.
Earl Blumenauer
Lisa Blunt Rochester
Suzanne Bonamici
Brendan F. Boyle
Julia Brownley
Tony Cárdenas
Matthew Cartwright
Ed Case
Sean Casten
Kathy Castor
Judy Chu
David N. Cicilline
Gilbert R. Cisneros Jr.
Katherine Clark
Wm. Lacy Clay
Steve Cohen
Gerald E. Connolly
Jim Cooper
Angie Craig
Jason Crow
Danny K. Davis
Susan A. Davis
Madeleine Dean
Peter DeFazio
Diana DeGette
Rosa L. DeLauro
Suzan DelBene
Theodore E. Deutch
Debbie Dingell
Lloyd Doggett
Mike Doyle
Eliot L. Engel
Veronica Escobar
Anna G. Eshoo
Adriano Espaillat
Lizzie Fletcher
Bill Foster
Lois Frankel
Marcia L. Fudge
Ruben Gallego
Jesús G. "Chuy" García
Sylvia R. Garcia
Jimmy Gomez
Al Green
Raúl M. Grijalva
Deb Haaland
Alcee L. Hastings
Jahana Hayes
Denny Heck
Brian Higgins
Jim Himes

Eleanor Holmes Norton
Steven Horsford
Jared Huffman
Pramila Jayapal
Sheila Jackson Lee
Henry C. "Hank" Johnson Jr.
William R. Keating
Robin L. Kelly
Joseph P. Kennedy III
Ro Khanna
Daniel T. Kildee
Derek Kilmer
Ann McLane Kuster
John B. Larson
Brenda L. Lawrence
Barbara Lee
Susie Lee
Andy Levin
Mike Levin
Ted W. Lieu
Dave Loebsack
Zoe Lofgren
Alan Lowenthal
Nita M. Lowey
Ben Ray Luján
Stephen F. Lynch
Tom Malinowski
Carolyn Maloney
Sean Patrick Maloney
Doris Matsui
Betty McCollum
A. Donald McEachin
James P. McGovern
Jerry McNerney
Grace Meng
Gwen Moore
Joseph D. Morelle
Seth Moulton
Grace F. Napolitano
Jerrold Nadler
Richard E. Neal
Joe Neguse
Donald Norcross
Alexandria Ocasio-Cortez
Ilhan Omar
Frank Pallone, Jr.
Jimmy Panetta
Chris Pappas
Nancy Pelosi
Ed Perlmutter
Scott Peters
Chellie Pingree
Mark Pocan
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Adam Smith
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Jackie Speier
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Thomas Suozzi
Eric Swalwell
Mark Takano
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Rashida Tlaib
Norma Torres
Lori Trahan
Lauren Underwood
Juan Vargas
Nydia Velázquez
Debbie Wasserman Schultz
Maxine Waters
Bonnie Watson Coleman
Peter Welch
Frederica Wilson
John Yarmuth