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## Maryland's Bundle of Joy: A Constitutionally Stronger, More Comprehensive Take on Contraception Coverage

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# MARYLAND'S BUNDLE OF JOY: A CONSTITUTIONALLY STRONGER, MORE COMPREHENSIVE TAKE ON CONTRACEPTION COVERAGE

ALEXI NATHAN\*

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### I. INTRODUCTION

The Affordable Care Act’s contraception mandate (“the Mandate”) requires employers to provide insurance coverage of contraceptive methods to employees at no cost.<sup>1</sup> The Act demonstrates Congress’ growing recognition of the correlation between a woman’s reproductive anatomy and her equal participation in both society and the economy.<sup>2</sup> Although publicized as a “comprehensive” plan, the Mandate fails to provide contraception coverage to all women.<sup>3</sup> The Mandate’s failure to eliminate the burdens and barriers to contraception access is attributed to several factors, such as exemptions in the Act’s language and non-compliance on the part of insurance companies.<sup>4</sup> The Mandate contains several exemptions that create intentional, albeit necessary, barriers to contraception access; however,<sup>5</sup> these barriers have been permitted on constitutional grounds.<sup>6</sup> Along with intentional barriers, the Mandate has created unintentional barriers that make it ineffective at providing coverage and equality for women.<sup>7</sup>

In *Roe v. Wade*, the Supreme Court established the right to privacy is

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1. The Patient Protection and Affordable Care Act, 42 U.S.C. § 300gg-13(a)(4) (2012).

2. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (upholding a woman’s right to receive an abortion).

3. See *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1143 (10th Cir. 2013) (stating the Mandate does not provide coverage for private employers with grandfathered plans, for employers with fewer than fifty employees, and for religious employers).

4. See *id.* (detailing the exemptions contained in the Mandate that excuse certain employers from complying with the provision).

5. See *id.*; see also 42 U.S.C. § 300gg-13(a)(4)(4) (2016); The Religious Freedom Restoration Act, 42 U.S.C.A. § 2000bb-1(a) (West 1997) (protecting the free exercise of religion, which provided the basis for the religious exemption in the Mandate).

6. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2759 (2014) (discussing the religious exemption for for-profit corporations).

7. See *Hobby Lobby*, 723 F.3d at 1124 (stating that over 100 million people remain uncovered by the Mandate); see also *Committee Opinion No. 615: Access to Contraception*, AM. COLL. OBSTETRICIANS AND GYNECOLOGISTS (Jan. 2015), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co615.pdf?dmc=1&ts=20160722T1016341074> [hereinafter *Access to Contraception*] (describing the importance and difficulties of access to contraception).

fundamental; therefore, the right cannot be infringed upon unless the government can show the intrusion served a narrowly tailored and compelling state interest.<sup>8</sup> The Court also found that the right to privacy encompassed the right to marital privacy, including the constitutional right to decide whether or not to have children.<sup>9</sup> Therefore, as contraception affects the right to make this decision, the Court found contraception to be a constitutional right.<sup>10</sup> Although the Mandate has succeeded in lowering the nationwide cost of contraception, barriers to contraceptive access still exist.<sup>11</sup> These barriers have placed huge burdens on women in the United States, violating their constitutional right to privacy.<sup>12</sup>

This Comment argues that the Mandate violates the constitutional right to privacy, and therefore a stronger contraception mandate is necessary. In addition, this Comment asserts that states must enact more comprehensive contraceptive plans, using Maryland's Contraceptive Equity Act of 2016 as the best example of such a plan.<sup>13</sup> Part II of this Comment provides a history of the constitutional right to privacy and the legislation surrounding an individual's right to contraceptive accessibility.<sup>14</sup> Part III argues that the Mandate contains unlawful barriers to contraception access and is unconstitutional under the right to privacy.<sup>15</sup> Additionally, Part III contends that the Maryland Contraceptive Equity Act provides the most comprehensive contraception coverage and is a constitutional alternative to the Mandate.<sup>16</sup> Part IV concludes that because the Maryland Contraceptive Equity Act fills the gaps left by the Mandate it should be a model for other

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8. See *Roe v. Wade*, 410 U.S. 113, 129 (1973) (concluding fundamental rights must be free from government intrusion).

9. See *id.* at 153.

10. See *id.* at 154.

11. See *Hobby Lobby*, 723 F.3d at 1124 (stating that at least 50 million people do not have coverage due to exempt health plans).

12. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 872 (1992) (clarifying that health regulations that have the purpose or effect of a substantial obstacle to a woman's reproductive life impose undue burdens on that right and are unconstitutional).

13. See MD. CODE ANN., HEALTH-GEN. § 15-148 (2016); MD. CODE ANN., INS. § 15-826.1 (2016).

14. See *infra* Part II (describing the history and enactment of Maryland's Contraceptive Equity Act of 2016 to illustrate its potential success).

15. See *infra* Part III (explaining that barriers from the Mandate create substantial burdens on women's access to birth control).

16. See *infra* Part III (arguing that the Maryland Contraceptive Equity Act provide coverage which eliminates the barriers the Act's religious exemption will survive judicial scrutiny).

states to create similar contraceptive coverage.<sup>17</sup>

## II. BACKGROUND

### A. *The Constitutional Right to Privacy*

The Constitution does not provide an explicit right to privacy; however, the Supreme Court has ruled that the Bill of Rights contains penumbras that establish such a right.<sup>18</sup> Existing within the peripheral of the First, Third, Fourth and Ninth Amendments, the right to privacy protects each individual's authority to make decisions regarding her body and private life absent government intrusion.<sup>19</sup> Since Justice Brandeis described this right as the "right to be let alone," it has been interpreted by the Courts and has taken many forms, such as the right to protections against wire-tapping, the right to view pornography in one's home, and the right to contraception.<sup>20</sup> Although comprehensive in scope, the right to privacy has been narrowly applied to government intrusions related to family, marriage, motherhood, procreation, and child-rearing.<sup>21</sup>

#### 1. *Right to Privacy as a Fundamental Right*

The controversial case *Roe v. Wade* cemented the constitutionality of the right to privacy.<sup>22</sup> Although the Court acknowledged that some intrusive government regulations are necessary and appropriate under certain

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17. See *infra* Part IV (concluding that the Affordable Care Act's contraception mandate fails to protect a women's right to privacy and states need to enact more comprehensive contraception coverage mandates).

18. See *Griswold v. Connecticut*, 381 U.S. 479, 484-86 (1965) (finding a right to privacy within the First, Third, Fourth, Fifth, and Ninth Amendments of the U.S. Constitution).

19. See *NAACP v. Alabama*, 357 U.S. 449, 462 (1958) (upholding an individual's freedom to associate and privacy in one's association under the First Amendment's right of assembly); *Boyd v. United States*, 116 U.S. 616, 630 (1886) (describing the Fourth Amendment right against unreasonable search and seizure as a "protection(s) against all governmental invasions of the sanctity of a man's home and the privacies of life").

20. See *Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (finding the right to privacy includes intellectual and emotional needs, including an individual's decision to watch pornography); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (concluding wiretapping is an invasion of the right to privacy).

21. See *e.g.*, *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972) (motherhood); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (marriage); *Prince v. Massachusetts*, 321 U.S. 158, 170-71 (1944) (family); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (procreation); *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534-35 (1925) (child-rearing).

22. See *Roe v. Wade*, 410 U.S. 113, 152-54 (1973) (protecting the right to privacy from government intrusion through strict judicial scrutiny).

circumstances, the Court found that the right to privacy was fundamental.<sup>23</sup>

The Court recognized that the right to privacy was not absolute and must be weighed against important state interests.<sup>24</sup> Any regulation that may impede on the right to privacy must be narrowly tailored to express only the legitimate state interest involved.<sup>25</sup> For example, the Court in *Roe v. Wade* concluded that a Texas statute criminalizing abortions failed to demonstrate a compelling state interest to justify infringement upon an individual's right to privacy.<sup>26</sup> In this case, the Court established a temporarily expansive constitutional right to abortion.<sup>27</sup>

## 2. *The Right to Marital Privacy and Contraception*

A significant extension of the right to privacy is the right to contraception, established by the Supreme Court in *Griswold v. Connecticut*.<sup>28</sup> In *Griswold*, the Court upheld the right to marital privacy when it struck down a statute criminalizing the use, distribution, and recommendation of the use of contraceptives.<sup>29</sup> Justice Douglas reasoned that it would be “repulsive” to permit police officers to enter the private bedrooms of couples to look for evidence of contraceptive use.<sup>30</sup> The Court effectively established a constitutional right for married couples to

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23. *See id.* at 154 (holding that government interference may be justified when a “state’s interests as to protection of health, medical standards and prenatal life, become dominant”).

24. *See Kramer v. Union Free Sch. Dist.*, 395 U.S. 621, 627 (1969); *cf. Shapiro v. Thompson*, 394 U.S. 618, 634 (1969) (holding any classification penalizing the exercise of right of interstate travel is unconstitutional unless justified by a compelling government interest).

25. *See Griswold v. Connecticut*, 381 U.S. 479, 485 (1965); *see also Baird*, 405 U.S. at 463-64 (White, J., concurring) (finding a regulation requiring a prescription to obtain dangerous contraceptive material was not unnecessarily broad, and therefore constitutional under a strict scrutiny analysis).

26. *See Roe*, 410 U.S. at 164 (holding that the state’s interest in protecting health and potential life did not justify broad limitations on a woman’s ability to receive an abortion in the early stages of pregnancy).

27. *But see Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 873-74 (1992) (weakening the constitutional right to choose abortion by replacing strict scrutiny test with an undue burden test, which invalidates a statute if it is too burdensome on a fundamental right).

28. *See Griswold*, 381 U.S. at 485-86 (finding a law that forbids contraceptives an unconstitutional intrusion on marital privacy).

29. *See id.* (concluding that a law criminalizing contraceptive use instead of regulating manufacture or sale, achieves goals by “having a maximum destructive impact upon that relationship”).

30. *See id.* at 486 (ruling that a law regulating contraception is not only a violation of the Constitution, but also a threat to the privacy inherent in marital relationships).

use contraception.<sup>31</sup> Applying a strict-scrutiny test, the Court decided the regulation banning contraceptive use achieved its purpose by “means having a maximum destructive impact upon a marital relationship.”<sup>32</sup> The regulation failed to be narrowly applied and was therefore an infringement on the right to privacy.<sup>33</sup>

Following *Griswold*, women’s rights were expanded further by *Eisenstadt v. Baird*, which extended the right to contraception to single individuals.<sup>34</sup> The Court found no rational basis to ban the distribution of contraceptives to unmarried persons but not married couples.<sup>35</sup> The Court further expanded contraceptive rights in *Carey v. Population Services International*, holding that strict scrutiny must also be applied to state regulations that burden an individual’s right to contraception by substantially limiting an individual’s ability to actually exercise that right.<sup>36</sup>

### B. The Importance of Contraception Access

Unplanned pregnancy remains one of the biggest public health problems in our country today.<sup>37</sup> Approximately half of all pregnancies are unplanned or unwanted, with that number steadily increasing since 2006.<sup>38</sup> Unplanned pregnancies come with a multitude of issues that can have negative effects on the mother, the child, and society.<sup>39</sup> Unplanned

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31. *See id.*

32. *See id.* at 485 (establishing that legislation regulating privacy interests, such as contraception, must pass a strict-scrutiny analysis, meaning the legislation must be narrowly tailored to achieve a compelling government interest by the least restrictive means).

33. *See id.* (explaining regulations that are unnecessarily broad are an invasion of protected freedoms).

34. *See Eisenstadt v. Baird*, 405 U.S. 438, 446 (1972) (finding that no ground exists for according different treatment to married and unmarried persons regarding contraceptives).

35. *See id.* at 448 (acknowledging the widespread availability of contraceptives to all persons, unmarried and married, and applying a rational basis test under the Equal Protection Clause, rather than a strict-scrutiny analysis under the Due Process Clause).

36. *See Carey v. Population Servs. Int’l*, 431 U.S. 678, 684 (1977) (expanding upon the *Griswold* strict-scrutiny test).

37. *See Priests for Life v. U.S. Dep’t. of Health and Hum. Servs.*, 772 F.3d 229, 261-62 (D.C. Cir. 2014) (concluding that the government sought to expand contraceptive access to assist in reducing unintended pregnancies); *see also Unintended Pregnancy Prevention*, CTR. FOR DISEASE CONTROL AND PREVENTION, [www.cdc.gov/reproductivehealth/unintendedpregnancy/](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/) (last visited Aug. 21, 2016) [hereinafter CDC].

38. *See Priests for Life*, 772 F.3d at 261-62 (finding that the rate of unplanned pregnancies increased from forty-eight percent to fifty percent since 2006).

pregnancies can result in delayed prenatal care, premature birth, and negative physical and mental health effects for both the children and the mother.<sup>40</sup>

The Center for Disease Control and Protection states that the main cause of unintended pregnancies is not using contraception, or using it inconsistently or incorrectly.<sup>41</sup> Women who do not use contraception or use it inconsistently or incorrectly account for around ninety-six percent of unintended pregnancies.<sup>42</sup> Conversely, those women who use contraceptives consistently and correctly account for less than five percent of unintended pregnancies.<sup>43</sup> The most effective way to prevent unintended pregnancy is to improve access to consistent, effective, and affordable contraception.<sup>44</sup>

By preventing unintended pregnancies, contraception plays a major role in improving public health and wellbeing, reducing global maternal mortality, encouraging female engagement in the work force, and allowing women more economic independence.<sup>45</sup> However, cost and access remain major barriers to contraception.<sup>46</sup> The Institute of Medicine notes that even small increases in cost reduce the use of contraception and other preventative services.<sup>47</sup> For instance, a national survey from 2004 of women ages eighteen to forty-four who were using reversible contraception found that “[w]omen citing cost concerns were twice as likely as other

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39. *See id.* at 262 (including dangerous pregnancy complications, delayed prenatal care or premature birth, future infertility, and mental health issues once the child is born); *see also* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,727 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147).

40. *See Priests for Life*, 772 F.3d at 262 (listing depression, anxiety, and domestic violence as consequences of unplanned pregnancies).

41. *See CDC, supra* note 37; *see also Priests for Life*, 772 F.3d at 262 (stating that couples using no method of contraception have an eight-five percent chance of an unintended pregnancy within twelve months).

42. *See Priests for Life*, 772 F.3d at 262 (recognizing that stronger contraception access will decrease unwanted pregnancies).

43. *See id.* at 261-62 (proving that contraception access plays a major role in preventing unintended pregnancies).

44. *See Access to Contraception, supra* note 7 (stating that universal coverage of contraceptives is cost-effective and assists in reducing unintended pregnancy and abortion rates).

45. *See Priests for Life*, 772 F.3d at 259-63.

46. *See id.* at 260 (describing that people are hindered from preventative steps because costs and efforts are “immediate”); *see also Access to Contraception, supra* note 7.

47. *See Priests for Life*, 772 F.3d at 261 (observing that high costs of contraception cause women to forego preventative care altogether).

women to rely on condoms or less effective methods like withdrawal or periodic abstinence.”<sup>48</sup> In addition, a 2009 study found that economic hardships, such as the 2008 recession, significantly affect contraception use and family planning.<sup>49</sup> The study of low- and middle-income sexually active women reported that in 2009, 34% said they had a harder time paying for birth control, 30% had put off a gynecological or birth control visit to save money, and 25% of pill users saved money through inconsistent use.<sup>50</sup> Further, the methods that are most effective are often only available with a prescription or administered by a medical professional, which often come with higher costs.<sup>51</sup> However, the no-cost coverage of contraceptive methods could greatly increase contraception use and decrease unintended pregnancies, therefore increasing public health.<sup>52</sup>

### C. *The Affordable Care Act Contraception Mandate*

One of the more criticized legislation is the Affordable Care Act (ACA), also known as “Obamacare.”<sup>53</sup> Formally known as The Patient Protection and Affordable Care Act, the “comprehensive” plan is known as President Obama’s crowning achievement, despite intense criticism from Republican leaders.<sup>54</sup> Since the ACA was signed into law, over half of the states have filed lawsuits questioning its constitutionality.<sup>55</sup> The Mandate is a provision of the ACA that has received continued disapproval.<sup>56</sup> The Mandate requires health insurance companies to provide all women with access to contraceptives, sterilization, and preventative services.<sup>57</sup>

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48. *Testimony Submitted to Committee on Preventive Services for Women, Institute of Medicine* 8 (Guttmacher Inst., Jan. 12, 2011), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/CPSW-testimony.pdf> (finding that cost plays a key role in the use and method of contraceptives).

49. *Id.*

50. *Id.*

51. *See Priests for Life*, 772 F.3d at 261 (finding that barriers such as needing a prescription from a medical professional deter women from obtaining contraception).

52. *See id.*

53. *See* 42 U.S.C. § 300gg-13(a)(4) (2016).

54. *See House v. Burwell*, 130 F. Supp. 3d 53, 57 (2015) (consolidating challenges to the insurance subsidies under the ACA brought by thirty-eight Republican lawmakers).

55. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (discussing lawsuits filed by twenty-six states challenging the constitutionality of the ACA because of the barriers that impede the access to contraceptives).

56. *See* § 300gg-13(a)(4); *see also* *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1143 (10th Cir. 2013) (challenging the Mandate’s constitutionality).

57. *See* § 300gg-13(a)(4); *see also* *Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and*

*1. Barriers to Contraception Access Under the Mandate*

Despite its early success, the Mandate has received criticism since its inception, most notably from religious organizations.<sup>58</sup> The Obama Administration attempted to combat the religious opposition by making a minor concession in the form of a religious exemption, which did little to fix the resistance.<sup>59</sup> The Mandate exempted religious employers, such as churches, houses of worship, and non-profit religious organizations from providing health care plans that cover contraception at no cost.<sup>60</sup> The exemption allows certain religious employers to give notice of their beliefs to their insurance provider.<sup>61</sup> Then the insurance company or the government, rather than the religious employer, is required to cover the costs of contraceptives.<sup>62</sup> This accommodation allowed the government to respect religious beliefs, while still providing women with access to contraceptives.<sup>63</sup>

The Mandate's religious exemption was eventually expanded to exempt closely held for-profit entities with a religious objection to providing coverage.<sup>64</sup> This exemption, combined with those employers that are exempt under grandfathered plans, places many women at a disadvantage

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Affordable Care Act, 77 Fed. Reg. 8,725, 8,726 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147) (providing mammograms and prenatal care with no consumer cost sharing).

58. See *Little Sisters of the Poor Home for the Aged, Denver, Colorado v. Sebelius*, 134 S. Ct. 1022, 1229 (2014) (challenging the Mandate's religious exemption); *Hobby Lobby*, 723 F.3d at 1123; *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 245 (D.C. Cir. 2014).

59. See generally *Little Sisters of the Poor*, 134 S. Ct. 1022 (demonstrating that organizations continue to file lawsuits against the Mandate and its religious exemption despite extension of the Mandate's exemption to for-profit corporations).

60. See 42 U.S.C. § 300gg-13(a)(4) (2016); see also *Hobby Lobby*, 723 F.3d at 1123 (describing the exemptions from the Mandate contraceptive-coverage requirement).

61. See *Coverage of Certain Preventative Services Under the Affordable Care Act*, 78 Fed. Reg. 39,870, 39,874 (July 2, 2013) (to be codified at 45 C.F.R. pt. 147, 156) (providing religious employers with an accommodation to protect the employers from government infringement upon their religious beliefs).

62. See *id.* (allowing women to still receive contraception free of cost, despite their employer's exemption serves the government's interests while protecting individuals' and organizations' religious beliefs).

63. See *Priests for Life*, 772 F.3d at 263 (ruling that the accommodation for women meets both goals of protecting religious freedom while also ensuring women obtain contraceptives, resulting in an acceptable constitutional balance).

64. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2759 (2014) (defining "closely-held" as corporations in which fewer than five people own more than half of company stock).

because they cannot receive the same contraception access as women whose employers are not exempt.<sup>65</sup> This is an issue because, as Justice Sotomayor noted in a recent contraceptive mandate case, “[s]ome women don’t adhere to the religious tenet of their employers and have a real need for contraceptives.”<sup>66</sup>

In addition to those women who still face difficulties obtaining contraceptives due to employer exemption, there are millions of women who continue to face barriers to affordable and effective contraceptive care from their insurance companies.<sup>67</sup> Many women are still victims of their insurance companies which often charge copayment for methods other than birth control pills, require prior approval from a doctor, or simply do not cover their preferred method of contraception.<sup>68</sup>

#### *D. Maryland’s Contraceptive Equity Act of 2016*

Maryland’s Contraceptive Equity Act (MCEA) was passed with overwhelming bi-partisan support and is one of the more comprehensive state contraception plans.<sup>69</sup> The MCEA has several provisions aimed at providing greater access to contraceptives.<sup>70</sup> It prohibits co-payment for most contraceptives with few exceptions.<sup>71</sup> Additionally, the MCEA provides coverage for up to thirteen months of birth control and eliminates the need for a prescription in order to receive no-cost coverage of over-the-counter birth control such as Plan B.<sup>72</sup> Lastly, the MCEA covers the cost of

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65. See *Hobby Lobby*, 723 F.3d at 1124 (discussing the exemptions within the Mandate and their effects on contraception access).

66. See Transcript of Oral Argument at 32, *Zubik v. Burwell*, 2016 WL 1134578 (No. 14-1418) (consolidating the religious objections of several groups of religious employers who lost in the lower court).

67. See *Access to Contraception*, *supra* note 7 (explaining the barriers are attributable to a variety of factors including knowledge deficits, the restrictive legal and legislative climate, and cost and insurance coverage).

68. See *id.*; see also 42 U.S.C. § 300gg-13(a) (4) (2012); *Priests for Life*, 772 F.3d at 265 (revealing that one purpose of the Mandate was to end the harsh gender discrimination practices of private insurance companies).

69. See MD. CODE ANN., HEALTH-GEN. § 15-148 (West 2016); MD. CODE ANN., INS. § 15-826.1 (West 2016) (receiving 138 “yeas” out of 184 votes from the General Assembly).

70. See MD. CODE ANN., HEALTH-GEN. § 15-148; see also MD. CODE ANN., INS. § 15-826.1 (enabling more comprehensive coverage and easy access to multiple birth control methods and procedures to eliminate burdens left by the Mandate).

71. See MD. CODE ANN., INS. § 15-826.1(e)(1)-(2).

72. See *id.* § 15-826.1(e)(1)(i) (providing women with more freedom in their contraception choices).

male sterilization procedures, including vasectomies.<sup>73</sup> These aspects of the plan make the MCEA the first contraceptive coverage plan to provide contraception access to both men and women.<sup>74</sup>

### III. ANALYSIS

#### A. *Burdens Created by the Mandate Are a Violation of the Constitutional Right of Privacy*

The Mandate's over burdensome features are not narrowly applied to serve a compelling government interest.<sup>75</sup> In order to protect the constitutional right to privacy, the Mandate must be amended to better serve the government's interests in promoting public health and gender equality.<sup>76</sup> In order to better serve the government's interests, the Mandate should allow women to choose the method of contraception that works best for them, regardless of cost or the presence of a prescription.<sup>77</sup>

The right to privacy has been deemed "the most comprehensive of rights" not only because of how much the right encompasses, but also because at its most rudimentary level, the right to privacy is essentially the right to choose whether or not to engage in certain acts or have certain experiences.<sup>78</sup> The fundamental right to privacy has evolved over time to include an individual's decision to procreate, which inherently includes a right to contraception.<sup>79</sup> As a fundamental right, a woman's right to

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73. *See id.* § 15-826.2(a)(4).

74. *See* MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1.

75. *See* *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (stating that the contraceptive mandate serves a variety of important interests; however, many of the interests are phrased in very broad terms).

76. *See id.* at 2770; *see also* *Roe v. Wade*, 410 U.S. 113, 154 (1973) (providing the constitutional standard the Mandate is required to uphold).

77. *See* *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 835 (1992) (finding that a woman's ability to control her reproductive health directly facilitates her ability to participate socially and economically); *see also* *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 265 (D.C. Cir. 2014) (noting that providing contraceptives without cost sharing or administrative burdens is necessary).

78. *See* *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (describing the right of privacy as protection against invasions into the "sanctities of a man's home and the privacies of life").

79. *See* *Eisenstadt v. Baird*, 405 U.S. 438, 454 (1972) (defining the right to privacy as, "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").

contraception is protected by strict judicial scrutiny.<sup>80</sup> Therefore, any government regulation controlling contraception access or use must be narrowly tailored to achieve a compelling state interest.<sup>81</sup>

The Court in *Roe* recognized that a government regulation denying women access to abortions would have detrimental results.<sup>82</sup> Denying women access to abortions results in unwanted pregnancies, which can have damaging effects on the psychological health of both the mother and child.<sup>83</sup> The Court concluded that an unplanned or unwanted pregnancy could leave the woman unprepared for motherhood and the accompanying stress, which could have negative impacts on the mental and physical health of all individuals involved.<sup>84</sup> For these reasons, the Court concluded that the government must be limited when regulating a woman's decision to have an abortion.<sup>85</sup> Similarly, statutes denying women access to contraception will also lead to an increase in unwanted pregnancies.<sup>86</sup> The unwanted pregnancies arising from contraception restrictions result in the same negative effects on mothers and children as the statutes denying abortions in *Roe*.<sup>87</sup> In analyzing statutes and contraceptive coverage plans,

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80. See *Roe*, 410 U.S. at 155-56, 163 (creating the strict scrutiny analysis for application in the right to privacy cases, including cases related to infringements upon the right to receive an abortion); see also *Griswold v. Connecticut*, 381 U.S. 479, 479, 485 (1965) (establishing the right to contraception as fundamental and subject to judicial scrutiny).

81. See *Roe*, 410 U.S. at 153.

82. See *id.* (concluding that the state's decision to deny a pregnant woman an abortion altogether is obviously detrimental).

83. See *id.* (stating that unwanted pregnancies or offspring can result in a more stressful life for the woman in the future by causing depression and anxiety, among other mental health issues).

84. See *id.*; see also *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 853 (1992) (expressing that unwanted pregnancies can result in a mother's inability to nurture and care for the infant, which causes distress to both the mother and offspring).

85. See *Roe*, 410 U.S. at 153 (explaining that there would be a great detriment to women and society if the state was to impose such a burden of removing her choice altogether).

86. See *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 262 (D.C. Cir. 2014) (finding that couples without access to contraception were eighty-five percent more likely to get pregnant than couples with access) (citing *Clinical Preventive Services for Women Closing the Gaps*, INSTIT. OF MED., July 19, 2011, [https://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief\\_updated2.pdf](https://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf)).

87. See *id.* at 261-62 (listing the negative effects of no contraception, including pregnancy risks); see also *Roe*, 410 U.S. at 153.

any regulation that is created must have a compelling state interest that is narrowly tailored and does not infringe on a woman's right to privacy.<sup>88</sup> Therefore, the same limitations should apply to statutes that result in contraception restrictions that are detrimental to a woman's right to choose and the right to privacy, including the Mandate.<sup>89</sup>

The Court in *Roe* also recognized that the government possessed legitimate interests in regulating abortions.<sup>90</sup> Consequently, the Court established a balancing test, intended to protect the right to privacy while considering the government's interests.<sup>91</sup> When the government's interests become dominant, limitations on the right to privacy may be permitted to achieve and protect those compelling government interests.<sup>92</sup> Likewise, similar compelling government interests have supported the Mandate, and these interests must be narrowly tailored and balanced against the burdens placed on women as a result of the Mandate's restrictions.<sup>93</sup> Although the Mandate must comport with the *Roe* balancing test, it fails to comport because it is not narrowly tailored nor does it appropriately balance the burdens to contraception access left on women.<sup>94</sup>

During the Mandate's inception, the U.S. Department of Health and Human Services (HHS) partnered with the Institute of Medicine to determine which preventive services the Mandate should cover to create a comprehensive plan.<sup>95</sup>

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88. See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (applying a balancing test to determine if a regulation banning the sale of contraceptives was narrowly tailored to achieve a compelling government interest).

89. See *Roe*, 410 U.S. at 155-56, 164-65 (providing the strict scrutiny analysis that should be applied to determine constitutionality of infringements upon the right to privacy).

90. See *id.* at 154 (noting specific government interests for regulating abortions, such as safeguarding an individual's health and protecting any potential life that might be harmed).

91. See *id.* (explaining that there are constitutionally sound reasons for why and how a right to privacy in abortion might be limited and regulated).

92. See *id.* at 163-64 (concluding that regulations that may impede on the right to privacy are constitutionally sound if protection of fetal life becomes necessary because of "logical and biological justifications").

93. See *id.* at 165; see also *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 258-59 (D.C. Cir. 2014) (reporting the government's interests in implementing the Mandate, including an interest in the physical health and safety of the public); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (applying a strict scrutiny analysis to a Massachusetts contraception regulation).

94. See *Access to Contraception*, *supra* note 7, at 3 (describing the barriers to contraception access that exist despite the Mandate).

95. See *Priests for Life*, 772 F.3d at 265 (describing the Mandate's creation and implementation); see also *Clinical Preventive Services for Women: Closing the Gaps*,

Throughout the Mandate's creation, the HHS mentioned several government interests that the Mandate is intended to serve.<sup>96</sup> Specifically, HHS mentioned the Mandate's interest in protecting public health, safety, and morals, and ensuring that all women have access to all Food and Drug Administration (FDA) approved contraceptives without cost sharing.<sup>97</sup> Throughout the Supreme Court's history, it has considered all of these interests compelling enough to allow regulation and infringement upon the individual's right to privacy, so long as they are applied narrowly.<sup>98</sup>

The government's central interest in creating and enforcing the Mandate was to increase the quality and access to preventative services, which was accepted as compelling by the Supreme Court in *Hobby Lobby*.<sup>99</sup> HHS also maintains that the Mandate serves the government's interest in promoting public health.<sup>100</sup> The Supreme Court has continuously held in assessing the right to privacy that the government's interest in safeguarding the public's health should be considered a compelling one.<sup>101</sup> Lastly, HHS sustains an interest in increasing gender equality, and the Supreme Court has considered this interest to be compelling because sex discrimination deprives women of their individual dignity and "denies society the benefits of wide participation in political, social and economic life."<sup>102</sup>

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INSTIT. OF MED. 1-2 (July 2011), [http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief\\_updated2.pdf](http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf) [hereinafter *Closing the Gaps*].

96. See *Closing the Gaps*, *supra* note 95, at 4.

97. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014); see also *Priests for Life*, 772 F.3d at 257 (concluding that the government asserted an interest in supporting more comprehensive, cost-free access to contraceptive services).

98. See *Priests for Life*, 772 F.3d at 257-61 (explaining that there are circumstances, often pertaining to the health of the individual, in which a right to privacy can be limited and regulated for certain state interests).

99. See *Burwell*, 134 S. Ct. at 2759 (holding "[u]nder RFRA, a Government action that imposes a substantial burden on religious exercise must serve a compelling government interest, and we assume that the HHS regulations satisfy this requirement.").

100. See *id.* at 2779 (asserting that any coverage of contraceptives adds to promoting public health).

101. See *Roe v. Wade*, 410 U.S. 113, 153-54 (1973); see also *Prince v. Massachusetts*, 321 U.S. 158, 165-67 (1944) (upholding child labor laws because government interest in protecting the health and welfare of children was compelling).

102. See *Roberts v. United States Jaycees*, 468 U.S. 609, 623 (1984) (recognizing a compelling interest in promoting women's equal enjoyment of leadership skills); see also *Priests for Life*, 772 F.3d at 263 (finding compelling the government's interest as an effort to eradicate lingering effects of sex discrimination).

Although several compelling government interests support the Mandate, this does not automatically lead to the conclusion that the Mandate is constitutionally sound.<sup>103</sup> A constitutional issue arises with the Mandate because of the government limitations that are consequently placed on a women's right to privacy.<sup>104</sup> Even though the regulations may further a compelling government interest, they are applied in an overly broad manner, placing substantial burdens on a woman's control over her right to privacy.<sup>105</sup> Specifically, the Mandate allows insurance companies to cover only one FDA-approved method under each category of contraceptives,<sup>106</sup> a notion that is in conflict with the Supreme Court's ruling in *Planned Parenthood*.<sup>107</sup> Even though a statute may further a compelling government interest, if that statute has "the effect of placing a substantial obstacle in the path of a woman's choice," then it is constitutionally burdensome.<sup>108</sup>

The Supreme Court has continuously held that the government cannot freely further its interests at the expense of an individual's right to privacy, and the same standard must apply to the Mandate.<sup>109</sup> For example, the Supreme Court is currently in conflict with the Mandate's regulations through its ruling in *Carey*.<sup>110</sup> Specifically, the Court in *Carey* invalidated a similar statute that restricted access to contraception because several of the statute's provisions placed significant burdens on individuals.<sup>111</sup> In

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103. See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992); see also *Burwell*, 134 S. Ct. at 2780 (implying that free contraception was a compelling state interest); *Priests for Life*, 772 F.3d at 259 (holding that the protection of the health and safety of the public supports the government's interest in enforcing the Mandate's contraceptive coverage requirement).

104. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684 (1977) (holding that even minor restrictions on access to contraceptives that work to significantly burden the right to decide to have a child must also pass constitutional scrutiny).

105. See *id.* at 685-86; see also *Planned Parenthood*, 505 U.S. at 877.

106. See 42 U.S.C. § 300gg-13(a)(4) (2012) (restricting coverage for women's preventative care to services supported by the Health Resources and Services Administration).

107. See *Planned Parenthood*, 505 U.S. at 877 (ruling that any burdensome regulation is not a permissible means of serving even a legitimate end).

108. See *id.*

109. See *id.* at 851-52 (holding that the Constitution places limits on the government's right to interfere with an individual's decisions about his/her body and his/her future); see also *Roe v. Wade*, 410 U.S. 113, 153 (1973) (establishing the strict scrutiny analysis to determine if a statute places significant burdens on individuals).

110. See *Carey*, 431 U.S. at 685-86 (stating that the Constitution protects individuals to be free from unwarranted governmental intrusion into the decision whether to procreate).

111. See *id.* at 696 (concluding that a regulation which prohibited the distribution of

*Carey*, the Court invalidated a provision that prohibited the distribution of nonmedical contraceptives to adults except through licensed pharmacists.<sup>112</sup> The Court found that the provision “clearly burden[ed]” and limited an individual’s decision to use contraception because not every individual would be able to easily access a licensed pharmacist.<sup>113</sup> Furthermore, the Court disagreed that the provision could be justified by an interest in protecting health as it applied to nonhazardous contraceptives.<sup>114</sup>

Similarly, the Mandate works to burden a woman’s decision to use contraception by limiting the contraceptive options available.<sup>115</sup> Unlike other challenged contraception statutes, the Mandate appears to be narrowly tailored to a compelling state interest because it does not ban or restrict access to contraception.<sup>116</sup> However, it is unconstitutional because, similar to the regulations in *Carey*, the Mandate restricts a woman’s right to privacy by limiting access to her preferred method of birth control.<sup>117</sup> Limiting a woman’s access to her preferred method of birth control is not narrowly tailored enough for it to be constitutional.<sup>118</sup> Therefore, the Mandate should not be considered a permissible means to a legitimate end because the barriers placed on women are not sufficiently narrow to a legitimate end.<sup>119</sup>

The Mandate places significant barriers on a woman’s ability to access

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contraceptives to those younger than sixteen years of age placed unjustifiable burdens on young women attempting to gain access to contraception).

112. *See id.* at 690-91.

113. *See id.* at 689 (finding that restricting the distribution of contraception to licensed pharmacists “reduces the opportunity for privacy of selection and purchase, and lessens the possibility of price competition,” both of which place a burden on individuals seeking to purchase contraception).

114. *See id.* at 690-91 (concluding that “preventing young people from selling contraceptives,” “facilitating enforcement of the other provisions of the statute,” and “preventing anyone from tampering with the contraceptives,” were not compelling state interests justifying infringement).

115. *See* 42 U.S.C. § 300gg-13(a)(4) (2012) (limiting a woman’s ability to choose her preferred method of contraceptives by limiting coverage to only methods supported by the Health Resources and Services Administration).

116. *See Carey*, 431 U.S. at 685-86 (assessing the Mandate under strict scrutiny analysis); *see also id.*

117. *See Carey*, 431 U.S. at 689-92 (concluding that limitations on the distribution of contraceptives burden the freedom to make such decisions and are therefore unconstitutional under a strict scrutiny analysis).

118. *See id.* at 686 (stating that a regulation effecting the private decision of whether to have children requires compelling state interests that are narrowly drawn to express only those interests); *see also* § 300gg-13(a)(4).

119. *See Carey*, 431 U.S. at 687-88 (noting that restrictions on distribution of contraception may limit a woman’s ability to choose the method that she prefers).

and use contraception, and therefore her right to privacy, because insurance providers are allowed to cover only one form of each approved category of contraception.<sup>120</sup> By restricting the contraception coverage to only one method in each of the twenty FDA-approved categories, the Mandate places significant barriers on a woman's right to choose when and how to prevent or terminate a pregnancy.<sup>121</sup> This can result in a woman's inability to choose and receive the method that is going to be the best for her body.<sup>122</sup> This also impedes the concept that patient choice and efficacy should be the principal factors in choosing one method of contraception over another.<sup>123</sup>

Contraceptive methods are not interchangeable, and a dramatic difference exists between methods depending on the product and the woman.<sup>124</sup> Furthermore, women who are dissatisfied with their prescribed method are more likely to use the contraception incorrectly, inconsistently, or sporadically.<sup>125</sup> To combat this misuse, women need access to not just any method of contraception, but to the "[o]ne most suitable for their individual needs and circumstances at any given time in their reproductive lives."<sup>126</sup>

An additional barrier to contraception access under the Mandate can be attributed to the fact that some insurance companies, clinics, and pharmacies require women to "fail" at using a less expensive method before they provide more expensive methods.<sup>127</sup> This procedure runs

120. *See id.*; *see also* *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992) (holding that regulations which place significant barriers to a woman's access to reproductive services is a violation of the right to privacy); *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 261 (D.C. Cir. 2014) (concluding that limited access to contraception can result in a woman being forced to choose a less effective method).

121. *See Access to Contraception*, *supra* note 7, at 3.

122. *See id.* at 2-3.

123. *See id.* at 1-5 (noting that health care facilities and insurance providers should focus on patient care and choice to provide comprehensive contraception care).

124. *See* Adam Sonfield, *Rounding Out the Contraceptive Coverage Guarantee: Why 'Male' Contraceptive Methods Matter for Everyone*, 18 GUTTMACHER POL. REV. 34, 35 (2015), <https://www.guttmacher.org/about/gpr/2015/06/rounding-out-contraceptive-coverage-guarantee-why-male-contraceptive-methods> [hereinafter Sonfield] (explaining why comprehensive contraception access is important to gender equality).

125. *See id.* at 35; *see also Priests for Life*, 772 F.3d at 265 (stating that women are unlikely to use contraception coverage when it is costly or complicated to obtain).

126. *See* Sonfield, *supra* note 124, at 35.

127. *See Access to Contraception*, *supra* note 7, at 3 (noting that many providers require an unsuccessful trial and error period before better and more expensive contraception may be provided).

counter to the government's interest in promoting public health and expanding access to contraceptive methods.<sup>128</sup> To serve the government's interest in promoting public health, the Mandate must require coverage of all contraception methods from the beginning, not only after cheaper methods have proven ineffective.<sup>129</sup>

In addition, HHS revealed that even modest or less expensive co-payments deter some women from purchasing contraception.<sup>130</sup> This causes some women who only have access to one method at no cost to decide not to purchase an alternative better method simply because it requires a co-payment.<sup>131</sup> Accordingly, access to more than one method in each FDA approved category at no cost must be provided in order to lawfully serve the government's interest in expanding the quality and access to preventive care.<sup>132</sup>

Conclusively, by limiting no-cost coverage to only one method in each FDA approved category, the Mandate places significant barriers to a woman's ability to control her reproductive life.<sup>133</sup> This limitation works against the interests proposed by the government because the restriction not only limits women's access to her preferred method of contraception, but also hurts public health and welfare.<sup>134</sup> These aspects of the Mandate are not narrowly tailored enough even for government interests that may be compelling.<sup>135</sup> Therefore, the Mandate fails the strict scrutiny analysis and

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128. See *Priests for Life*, 772 F.3d at 260 (finding that even minor added steps dissuade women from obtaining contraceptives, and such obstacles fail to meet the government's interest in enhancing access to contraception).

129. See *id.* at 263 (stating that to serve the government's interest in expanding contraception access, the contraception must be effective).

130. See *id.* at 261 (resulting in women being deterred from using contraception because the cost is too high).

131. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2780 (2014) (demonstrating that even minor co-payments deter women from receiving contraception opposed to using the alternative and cheaper method).

132. See *Priests for Life*, 772 F.3d at 260 (restating that even minor barriers, such as cost, deter women from receiving contraception, defeating the government's interest in providing comprehensive contraception access).

133. See *Access to Contraception*, *supra* note 7, at 2 (denying women the choice of contraceptive method results in her inability to exercise her right to reproductive health care); see also *Sonfield*, *supra* note 124, at 36 (noting that contraception allows people to plan if and when to reproduce).

134. See *Sonfield*, *supra* note 124, at 36 (noting that reproductive planning enabled by contraception access helps prevent public health issues such as premature births and pregnancy complications).

135. See *Roe v. Wade*, 410 U.S. 113, 152-53, 155 (1973) (establishing the strict scrutiny standard that applies here).

should be invalidated as unconstitutional.<sup>136</sup>

*B. The Maryland Contraceptive Equity Act Eliminates Those Burdens, Becoming a More Constitutionally Sound Statute*

The MCEA's broad coverage of contraceptive options firmly uphold a woman's right to privacy by allowing the minimal amount of government intrusion, while placing little to no burden on the women's ability to obtain the best contraceptives.<sup>137</sup> The MCEA provides women with more options, while eliminating a variety of barriers to actual possession of contraception that currently exist under the Mandate.<sup>138</sup>

Unlike the Mandate, the MCEA requires insurance companies to cover multiple contraceptive methods under each FDA-approved category at no-cost.<sup>139</sup> By requiring insurance companies to cover the costs of multiple contraception methods, the statute expands upon the Mandate, eliminating a huge barrier to contraception access.<sup>140</sup> The MCEA stipulates that employers should provide coverage for methods of contraception that are not already covered.<sup>141</sup> This assists women in acquiring an effective, uncovered contraception method if the covered method has been ineffective in treating the condition or if it has caused an adverse reaction to the woman.<sup>142</sup> This allows women to receive the method that works best for them and it better serves the state's compelling interest in safeguarding women's health.<sup>143</sup> This type of coverage helps to eliminate certain

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136. *See id.* at 153 (holding that laws criminalizing abortion are not narrowly tailored to the government's interest in women's health and potential human life); *see also* 42 U.S.C. § 300gg-13(a)(4) (2012).

137. *See* MD. CODE ANN., HEALTH-GEN. § 15-148 (West 2016); MD. CODE ANN., INS. § 15-826.1 (West 2016) (providing more comprehensive contraception access reduces burdens on women in relation to preventative care).

138. *See* MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1 (providing women with more comprehensive contraception coverage through the elimination of almost all co-payments).

139. *Compare* MD. CODE ANN., HEALTH-GEN. § 15-148; *and* MD. CODE ANN., INS. § 15-826.1, *with* 42 U.S.C. § 300gg-13(a)(4) (2012) (comparing the MCEA, which covers multiple methods in each FDA approved category of contraception to the Mandate, which permits coverage of only one method from each category).

140. *See* MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1 (allowing women to choose which contraceptive measure is right for them, not just choosing the option that best fits with the contraceptive coverage plan).

141. *See* MD. CODE ANN., INS. § 15-826.1 (expanding upon the Mandate's coverage of contraceptive methods).

142. *See id.* (expanding the access to contraceptives that are available to women under the contraceptive plan by providing coverage of more than one method).

143. *See* *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 259-60 (D.C. Cir. 2014) (applying the strict scrutiny test for a compelling government

contraception barriers left by the Mandate's requirement that insurance companies only cover one method in each FDA-approved category.<sup>144</sup>

The MCEA also allows women to obtain up to thirteen months of birth control at a time, which provides more security for women seeking to prevent pregnancy.<sup>145</sup> According to the American College of Obstetricians and Gynecologists, a major insurance barrier to contraception access includes "[l]imits on the number of contraceptive products dispensed."<sup>146</sup> Insurance plan restrictions prevent seventy-three percent of women from receiving more than a single month's supply of contraception at a time.<sup>147</sup> When combined with the fact that most women are unable to obtain contraceptive refills on a timely basis, these dispersal restrictions place major burdens on women who need to receive more than a one-month supply of contraception at a time.<sup>148</sup> As opposed to the Mandate, which does not currently provide for long-term contraception access, the MCEA's thirteen-month coverage allows women to plan for their reproductive future.<sup>149</sup>

In addition, the MCEA also requires no-cost insurance coverage of over-the-counter medications, including emergency contraceptives such as Plan B.<sup>150</sup> This provision helps to expand contraception coverage under the Mandate, which currently provides no cost-coverage of strictly generic brands.<sup>151</sup> Often times, women need immediate and effective care when making the decision to have a child.<sup>152</sup> Emergency contraception allows

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interest with a narrowly tailored regulation).

144. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; § 300gg-13(a)(4).

145. See *Priests for Life*, 772 F.3d at 261; see also *Access to Contraception*, *supra* note 7 (providing up to a year of contraception is cost effective and increases adherence and continuance rates).

146. See *Access to Contraception*, *supra* note 7, at 3 (noting that the more barriers that are placed on contraceptives, the smaller the market place for contraceptives).

147. See *id.* at 3 (detering women from ordering their contraceptives because of the inconvenience of refilling the prescription every month, as opposed to receiving multiple months at a time).

148. See *id.*

149. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; § 300gg-13(a)(4).

150. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; § 300gg-13(a)(4) (increasing access to over-the-counter medications, preventative, and emergency measures that are currently unavailable in the Mandate).

151. See § 300gg-13(a)(4).

152. See *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 261 (D.C. Cir. 2014) (finding that enabling women to have more control over the time and space of their pregnancy improves health outcomes).

women an immediate solution when preventing unwanted or unplanned pregnancies by preventing pregnancy up to five days after sex.<sup>153</sup> However, these methods are often far more expensive than other methods, and cost is one of the biggest barriers to contraception access.<sup>154</sup> For example, some emergency contraception methods can cost anywhere from \$60 to \$900 without insurance coverage.<sup>155</sup> For some women, the high cost makes it virtually impossible to purchase emergency contraception and therefore, those women are denied control over their contraception access under the Mandate.<sup>156</sup> This high cost unconstitutionally restricts contraception access because it impedes on a woman's ability to exercise her right to privacy by limiting her ability to purchase the contraception method she so chooses.<sup>157</sup>

Moreover, the MCEA requires insurance coverage for over-the-counter contraception, permitting women to purchase emergency contraception quickly and easily.<sup>158</sup> This provision of MCEA helps to further the state's compelling interest in promoting and protecting women's health and welfare.<sup>159</sup> By eliminating cost barriers to contraception access, the MCEA serves the government's interests better than the Mandate.<sup>160</sup> The MCEA does not place any cost burden on women who need to use an emergency

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153. See *Committee Opinion No. 544: Over-the-Counter Access to Oral Contraceptives*, AM. COLL. OBSTETRICIANS AND GYNECOLOGISTS (Dec. 2012) <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co544.pdf?dmc=1&ts=20170315T2132390923> [hereinafter *Over-the-Counter Access*]; see also *Morning-After Pill (Emergency Contraception)*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/morning-after-pill-emergency-contraception> (last visited Mar. 15, 2017).

154. See *Priests for Life*, 772 F.3d at 261 (asserting that some prescription methods of contraception cost “nearly a month’s full-time pay for workers earning the minimum wage”).

155. See *Over-the-Counter Access*, *supra* note 153; see also *Morning-After Pill (Emergency Contraception)*, *supra* note 153.

156. See *Priests for Life*, 772 F.3d at 260 (revealing that over fifty percent of women delay or avoid preventative care because of the high costs associated with contraception).

157. See *id.* (explaining that people do not prioritize or plan for using preventative care when they are required to pay for it).

158. See MD. CODE ANN., HEALTH-GEN. § 15-148 (West 2016); MD. CODE ANN., INS. § 15-826.1 (West 2016) (providing no-cost coverage for Plan B and other contraception increases the likelihood that women will use contraception).

159. See *Priests for Life*, 772 F.3d at 259 (concluding that a variety of adverse health conditions and costly care can be evaded with access to preventative services such as contraception).

160. See *id.* at 260 (finding that the elimination of co-payments for contraception would result in an increase of its use).

contraceptive method, as opposed to the Mandate, which permits insurance companies and pharmacies to charge for name brands.<sup>161</sup>

Lastly, the MCEA provides no-cost coverage for male sterilization, which further eases the burden on women.<sup>162</sup> In contrast, the Mandate does not currently require no-cost coverage of male vasectomies and condoms, two preventative methods approved by the FDA.<sup>163</sup> The absence of no-cost coverage of male contraception in the Mandate places women and couples at a disadvantage because the women are required to bear the burden of contraceptive coverage, which further limits their access to contraception by restricting their options.<sup>164</sup> By expanding coverage to provide no-cost contraception to men, women are no longer the sole party with access to no-cost preventative services.<sup>165</sup> This expansion furthers the government's interest in promoting public health and gender equality.<sup>166</sup> In addition, this provision helps to further the government's interest in increasing social and economic welfare by decreasing unwanted pregnancies.<sup>167</sup> Studies show that vasectomies are the second most effective contraceptive method, and are therefore more successful at preventing unplanned pregnancy.<sup>168</sup> Providing no-cost coverage of male contraception will further the government's interest in promoting public health by providing couples with access to an even more effective method than those already covered by the Mandate.<sup>169</sup> Furthermore, providing contraception methods to both sexes

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161. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1.

162. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1 (providing coverage for male sterilization provides women with a safer contraceptive alternative).

163. See 42 U.S.C. § 300gg-13(a)(4) (2012) (lacking no-cost coverage for male contraception).

164. See *id.*; see also *Priests for Life*, 772 F.3d at 263 (stating that in comparing men and women, women pay sixty-eight percent more in out-of-pocket health care costs than men, placing women at a significant economic and social disadvantage).

165. See *Priests for Life*, 772 F.3d at 263 (stating that reproductive and preventative healthcare costs fall women disproportionately over men).

166. See *id.*; see also *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (noting that an interest of the government is to promote and strengthen gender equality through the Mandate).

167. See *Priests for Life*, 772 F.3d at 261 (explaining that expanding access to contraception allows women to forgo the physical burdens and risks of pregnancy unless they consciously make the choice to do so).

168. See Sonfield, *supra* note 124, at 35.

169. See 42 U.S.C. § 300gg-13(a)(4) (2012); MD. CODE ANN., HEALTH-GEN. § 15-148 (West 2016); MD. CODE ANN., INS. § 15-826.1 (West 2016); see also *Priests for Life*, 772 F.3d at 263.

allows the MCEA to uphold the right to marital privacy because it allows couples to choose which partner will engage in the preventing of pregnancy.<sup>170</sup> Currently, approximately one-fourth of females rely on condoms and vasectomies as their main method of contraception.<sup>171</sup> Therefore the Mandate, unlike the MCEA, fails to provide effective no-cost coverage for women relying on male contraception.<sup>172</sup> This supports the conclusion that the Mandate fails to serve the interest in providing comprehensive contraception coverage and promoting public health.<sup>173</sup> In contrast, the MCEA's coverage of vasectomies helps eliminate barriers left by the Mandate, better serving the government's interests.<sup>174</sup>

The MCEA provides more comprehensive coverage, passing strict judicial scrutiny to protect individuals' fundamental right to privacy.<sup>175</sup> The MCEA helps to eliminate the burdens left by the Mandate by expanding upon the Mandate's provisions to provide women with more contraception options at no cost.<sup>176</sup> The inclusiveness of the MCEA better serves the state's interest in safeguarding public health by providing coverage for a broader range of preventive services.<sup>177</sup> By providing this broader coverage, both women and men have access to more contraceptive methods, resulting in stronger protections for public health.<sup>178</sup> Not only is the MCEA more successful at promoting public welfare and increasing contraception access, but also more compatible with the Court's ruling that infringements on the right to privacy must be narrowly tailored to serve

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170. See *Priests for Life*, 772 F.3d at 263 (concluding that a preventative care package that fails to cover contraception would result in unequal access to the full range of health care services between the sexes).

171. See Sonfield, *supra* note 124, at 36 (choosing options that include male participation).

172. See *id.* (describing the statute's failure to the quarter of women that rely on male coverage who are unprotected under the Mandate).

173. See *Priests for Life*, 772 F.3d at 260 (failing the strict scrutiny analysis necessary for any infringement or regulation on the right to privacy).

174. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1.

175. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; see also *Roe v. Wade*, 410 U.S. 113, 153 (1973).

176. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; 42 U.S.C. § 300gg-13(a)(4) (2012).

177. See *Priests for Life*, 772 F.3d at 260 (providing coverage for emergency contraception, male sterilization, and other preventive methods that are not easily accessible through the Mandate's provisions).

178. See *id.* (promoting the government interest that protection of public welfare is compelling enough to support a statute regulating contraception access).

compelling government interests.<sup>179</sup>

*C. The Maryland Contraceptive Equity Act Will Survive Religious Objection and Strict Judicial Scrutiny*

State contraceptive equity laws can help to close the gaps left by the Mandate by providing even more comprehensive contraception coverage.<sup>180</sup> However, many of these statutes contain religious exemptions similar to the exemptions provided for by the Mandate.<sup>181</sup> Specifically, the MCEA contains a religious exemption that allows religious organizations to request exclusion from contraception coverage.<sup>182</sup> The MCEA religious exemption stipulates that religious organizations may request exclusion if the required coverage conflicts with the religious organization's "bona fide" religious beliefs and practices.<sup>183</sup> The exemption also requires religious employers that obtain an exclusion to provide their employees with reasonable and timely notice of the exclusion.<sup>184</sup> The religious exemption can reduce contraception access by restricting no-cost coverage to women who are employed by religious organizations but may not share the same religious objections.<sup>185</sup>

State contraception laws often garner the same religious criticism received by the Mandate.<sup>186</sup> For example, in 2004, several Catholic groups challenged the religious exemption contained in California's Women's

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179. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1; see also *Roe*, 410 U.S. at 154 (governing right to privacy infringements and the restrictions that may or may not be placed on the right to privacy).

180. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1 (providing an example of a comprehensive state contraception equity law).

181. See § 300gg-13(a)(4).

182. See MD. CODE ANN., INS. § 15-826(c) (allowing religious organizations that provide coverage to be exempt from providing their employees with contraceptive coverage in their plans).

183. See *id.* (the statute's broad language does not explicitly specify what qualifies as a "bona fide" religious belief).

184. See *id.* (explaining the statute's broad language does not explicitly specify what qualifies as "reasonable and timely notice").

185. See *Priests for Life v. U.S. Dep't of Health and Hum. Servs.*, 772 F.3d 229, 265 (D.C. Cir. 2014) (finding that there are millions of Americans that work for religious nonprofits but do not share the organization's beliefs).

186. See *Catholic Charities of Sacramento v. Superior Court of Sacramento City*, 10 Cal. Rptr. 3d 283, 290 (2004) (challenging the constitutionality of California's Women's Contraception Equity Act); *Catholic Charities of Diocese of Albany v. Serio*, 859 N.E.2d 459, 465 (N.Y. 2006) (challenging the constitutionality of New York Women's Health and Wellness Act).

Contraception Equity Act (WCEA).<sup>187</sup> These groups claimed that the statute forced the religious organizations to either refuse to provide health insurance coverage for its employees or facilitate the sin of contraception, both of which violated the organization's religious beliefs.<sup>188</sup> The California Supreme Court upheld the WCEA, applying a strict scrutiny analysis to conclude that the statute did not impermissibly impair the religious rights of Catholic Charities.<sup>189</sup> Although a strict scrutiny analysis is not required for a state's contraception equity statute to withstand a religious objection, several courts have applied this standard.<sup>190</sup> Under this standard, a law cannot substantially burden a religious belief or practice unless it can be shown that the law used the least restrictive means to achieve a compelling interest.<sup>191</sup>

As previously stated, the religious exemption contained in the Mandate has been challenged by multiple religious organizations, and in these cases, the Court has applied a strict scrutiny analysis under the Religious Freedom Restoration Act.<sup>192</sup> Specifically in *Hobby Lobby*, the Court concluded that the Mandate did not satisfy the strict scrutiny analysis because the Mandate substantially burdened the religious practice of for-profit corporations and did not satisfy the least-restrictive-means requirement.<sup>193</sup> The Court concluded the government could achieve its goals through less restrictive means because it has already done so through its accommodations to other religious non-profit organizations.<sup>194</sup>

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187. See *Catholic Charities of Sacramento*, 10 Cal. Rptr. 3d at 290.

188. See *id.* at 290-91 (arguing that notifying the government of their exemption facilitated the way contraceptives are provided).

189. See *id.* at 315 (concluding that no less restrictive alternative exists because "any broader exemption increases the number of women affected by discrimination in the provision of health care benefits").

190. See *id.* (choosing to apply strict scrutiny analysis because no interpretation of the free exercise clause of California's Constitution existed at the time).

191. See *id.* (applying a strict scrutiny analysis similar to the judicial scrutiny applied to infringements upon fundamental rights).

192. See *Little Sisters of the Poor Home for the Aged, Denver, Colorado v. Sebelius*, 134 S. Ct. 1022, 1022 (2014); *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1143 (10th Cir. 2013) (requiring "the government to demonstrate that mandating a plaintiff's compliance with the objected-to requirement is the least restrictive means of advancing a compelling interest").

193. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2767 (2014) (finding that the Mandate substantially burdened the exercise of religion when applied to for-profit, closely-held corporations).

194. See *id.* at 2757-58 (concluding that a less restrictive method would require the "[g]overnment [to] assume the cost of providing the contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers' religious objections").

Alternatively, applying a strict scrutiny analysis to the MCEA leads to the conclusion that the MCEA will withstand religious scrutiny if challenged.<sup>195</sup> Unlike the Mandate, which explicitly did not provide an exemption to for-profit religious corporations, the MCEA provides the opportunity for an exemption to any religious organization.<sup>196</sup> The MCEA contains a broader exemption, helping to eliminate the unconstitutional religious burdens created by the Mandate's limited religious exemption.<sup>197</sup> Under the MCEA, no religious organization should be faced with a religious burden or ethical dilemma because the language provides an exemption for any organization with a genuine religious belief.<sup>198</sup>

To defeat religious objection, the MCEA must be supported by compelling state interests.<sup>199</sup> Several government interests, including increasing access to contraception and protecting public health and welfare, support the MCEA.<sup>200</sup> Similarly, identical government interests support the Mandate, and the Court has concluded that these interests are compelling for the purposes of the government's intrusion into religious practice.<sup>201</sup> Therefore, it is safe to assume the MCEA religious exemption will satisfy the compelling interest requirement of a strict scrutiny analysis because the interests are identical to the compelling interests achieved by the Mandate.<sup>202</sup>

For the MCEA's religious exemption to withstand judicial scrutiny, the government must also show that the statute achieves its compelling interests through the least-restrictive means.<sup>203</sup> The MCEA succeeds in

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195. See MD. CODE ANN., HEALTH-GEN. § 15-148 (West 2016); MD. CODE ANN., INS. § 15-826.1 (West 2016) (narrowly tailoring restrictions to the right to privacy to promote more access to contraceptives and public welfare).

196. See 42 U.S.C. § 300gg-13(a)(4)(2012); MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c).

197. See § 300gg-13(a)(4); MD. CODE ANN., HEALTH-GEN. § 15-148 (2016); MD. CODE ANN., INS. § 15-826.1.

198. See § 300gg-13(a)(4); MD. CODE ANN., HEALTH-GEN. § 15-148 (2016); MD. CODE ANN., INS. § 15-826.1.

199. See *Catholic Charities of Sacramento v. Superior Court of Sacramento City*, 10 Cal. Rptr. 3d 283, 315 (2004) (applying a strict scrutiny analysis to determine the validity of religious objections to state contraception statutes).

200. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1.

201. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014) (assuming the interest in guaranteeing no-cost access to contraceptive methods is compelling within the meaning of the Religious Freedom Restoration Act).

202. See *id.*; see also MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826.1.

203. See *Burwell*, 134 S. Ct. at 2779 (detailing the requirements under strict

achieving the government's interests through the least restrictive means because it provides an accommodation to all religious employers with "bona fide" religious beliefs.<sup>204</sup> This accommodation is counter to the Mandate's religious exemption, which fails to satisfy the least-restrictive means requirement because it grants religious accommodations to certain religious organizations but not others.<sup>205</sup> Furthermore, the MCEA satisfies this requirement by providing contraception coverage in the least-restrictive means possible, unlike the Mandate.<sup>206</sup> When analyzing the Mandate's religious exemption, the Court found that by restricting the religious exemption to only exemptions for non-profit religious organizations that the regulation resulted in a statute that was under-inclusive.<sup>207</sup> Because the Mandate does not provide an exemption to all religious organizations, the statute substantially burdens those organizations that are not religious non-profits.<sup>208</sup> Therefore, the Court concluded that the Mandate's religious exemption fails the least-restrictive means test.<sup>209</sup> On the other hand, the MCEA allows for a broad exemption, which will satisfy the least-restrictive means test, because it provides an accommodation for all reasonable religious affiliations.<sup>210</sup>

To accommodate religious beliefs while furthering the state's interest in protecting and promoting women's health, the MCEA religious exemption applies to all religious organizations with a legitimate belief.<sup>211</sup> This helps

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scrutiny analysis of religious exemptions).

204. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c).

205. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c) (finding that the Mandate, as applied to for-profit, closely-held corporations, failed to satisfy the least restrictive means requirement).

206. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c) (providing an accommodation to religious organizations regardless of whether they are a for- or non-profit organization); see also *Burwell*, 134 S. Ct. at 2779 (holding that the government had other means of achieving its goal without imposing a substantial burden on the exercise of religion by the objecting parties in these cases).

207. See generally *Burwell*, 134 S. Ct. 2751 (finding that the Mandate provided an accommodation to some religious organizations but not others.)

208. See *id.* at 2785 (pointing out that the government has previously demonstrated that it has an approach that is less restrictive than requiring employers to fund contraceptive methods that impinge upon their religious beliefs).

209. See *id.* (finding that the government has the ability to achieve its interests through less restrictive means and therefore, the more restrictive method is constitutional).

210. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c).

211. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c) (providing broad language that does not include a definition for "bona fide")

satisfy the least-restrictive means test required by the statute because it appears the government lacks other means to achieve both of these goals.<sup>212</sup>

The MCEA's constitutionally sound religious exemption further helps to fill the gaps left by the Mandate.<sup>213</sup> The MCEA better serves the government's interest in ensuring comprehensive contraception coverage while providing legitimate religious organizations with an accommodation that does not infringe upon the organization's free practice of religion.<sup>214</sup>

#### IV. CONCLUSION

Despite the fact that the Mandate has increased contraception access in the United States, it has been unsuccessful in eliminating all of the barriers to contraception. In contrast, many states have begun enacting comprehensive contraception laws that help remove unconstitutional barriers left by the Mandate. The MCEA is the strongest of these state statutes, providing more constitutionally comprehensive coverage than the Mandate. The MCEA fulfills the compelling governmental interest requirement necessary for the Supreme Court's strict scrutiny test by helping protect public health and welfare, eliminating gender discrimination, and providing preventative services at no cost to women. By providing no-cost coverage for almost all contraception methods, as well as male sterilization, the MCEA fills the gaps left by the Mandate while providing a strong guideline for other states' contraception equity acts to follow. By eliminating the burdens left by the Mandate, the MCEA serves as the most effective statute in upholding the constitutional right to privacy through narrowly tailored means.

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beliefs).

212. See MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c).

213. See 42 U.S.C. § 300gg-13(a)(4) (2012); MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c) (providing a broad exemption helps to accommodate religious beliefs in the least restrictive means, eliminating the Mandate's infringements upon certain religious organization's beliefs).

214. See § 300gg-13(a)(4); MD. CODE ANN., HEALTH-GEN. § 15-148; MD. CODE ANN., INS. § 15-826(c).