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In The
Supreme Court of the United States

PEGGY YOUNG,

Petitioner,

v.

UNITED PARCEL SERVICE, INC.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF HEALTH CARE PROVIDERS, THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, AND OTHER ORGANIZATIONS CONCERNED WITH MATERNAL AND INFANT HEALTH AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST

The following *amici* submit this brief, with the consent of the parties,[1] in support of Petitioner's argument that the grant of summary judgment was inconsistent with the text and intent of the Pregnancy Discrimination Act. Specifically, the *amici* – organizations concerned with improving maternal and infant health – submit this brief to highlight how denying pregnant workers job modifications that are granted to others similar in their ability or inability to work can force an impossible choice: the choice between ignoring the advice of one's health care provider for a healthy pregnancy and being forced off the job.

Because several *amici* have joined this brief, more detailed descriptions of each appear in the Appendix. The *amici* are:

- American College of Nurse-Midwives
- American College of Osteopathic Obstetricians & Gynecologists
- American Medical Women's Association
- American Nurses Association
- American Public Health Association

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[1] Counsel for *amici* authored this brief in its entirety. No person or entity other than *amici*, their staff, or their counsel made a monetary contribution to the preparation or submission of this brief. The Parties have filed blanket letters of consent to the filing of *amicus* briefs.

- National Advocates for Pregnant Women
- National Association of Nurse Practitioners in Women's Health
- National Partnership for Women & Families
- National Physicians Alliance
- Physicians for Reproductive Health
- Planned Parenthood Federation of America
- Society for Maternal-Fetal Medicine

SUMMARY OF ARGUMENT

Seventy-five percent of women entering the workforce today will become pregnant at least once while employed. Many pregnant women can work throughout their pregnancies without modifications on the job. However, for some women, physical effects or complications of pregnancy create temporary physical limitations. These women, typically on the advice of their health care providers, may ask their employers for modest job or worksite modifications – the same types of accommodations employers afford non-pregnant employees whose conditions or physical limitations make them similar in their ability or inability to work.

When employers deny pregnant workers these simple accommodations and treat them differently

than other employees, women are forced to decide whether to disregard the advice of their maternity care providers and risk compromising their own health and the health of their pregnancies, or give up jobs and incomes integral to their family's financial security. No woman should be put in that position. What is more, being forced off the job due to denial of an accommodation can also impact a pregnant woman's health by inhibiting her ability to maintain the same level of prenatal care. Many of these burdens are borne disproportionately by low-wage workers and women of color.

Allowing employers to impose these burdens through unequal treatment of pregnant workers deviates from sound health, economic, and social policy.

ARGUMENT

I. Women play a vital role in the workforce before, during, and after pregnancy.

The vast majority of families today include a woman who works. According to data reported by the U.S. Census Bureau, in 2013 only 8% of U.S. families were made up of married couples with children under eighteen where the father acted as sole breadwinner.[2]

[2] U.S. CENSUS BUREAU, *America's Families and Living Arrangements*, Tables FG1 & FG10 (2013), https://www.census.gov/hhes/families/data/cps2013FG.html (unpublished calculation: number of married family groups with own children under

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Indeed, the most recent figures from the Bureau of Labor Statistics indicate that in the United States, more than forty-three million women work full time.[3] Significantly, 75% of women entering the workforce today will become pregnant at least once while they are employed.[4] Most women return to the workforce after giving birth.[5]

When Congress passed the Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), in 1978, it did so recognizing the "devastating impact which the loss of a working mother's salary will have on the family

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eighteen years where only the husband was employed divided by the total number of family groups that include two or more people related by birth, marriage or adoption who live together).

[3] BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, LABOR FORCE STATISTICS FROM THE CURRENT POPULATION SURVEY: TABLE A-18: EMPLOYED AND UNEMPLOYED FULL- AND PART-TIME WORKERS BY AGE, SEX, RACE, AND HISPANIC OR LATINO ETHNICITY (2014), http://www.bls.gov/web/empsit/cpseea18.htm/; *see also* U.S. DEP'T OF LABOR, FUTUREWORK: TRENDS AND CHALLENGES FOR WORK IN THE 21ST CENTURY 28 (1999) (citing women's participation in the labor force at 28% in 1940, 40% in 1966, 51% in 1979, and 60% in 1998).

[4] Michelle R. Hebl et al., *Hostile and Benevolent Reactions Toward Pregnant Women: Complementary Interpersonal Punishments and Rewards That Maintain Traditional Roles*, 92(6) J. APPLIED PSYCHOL. 1499, 1500 (2007).

[5] From 2005-2007, nearly 64% of women who gave birth for the first time returned to work within a year. LYNDA LAUGHLIN, U.S. CENSUS BUREAU, MATERNITY LEAVE AND EMPLOYMENT PATTERNS OF FIRST-TIME MOTHERS: 1961-2008 14 (2011), *available at* https://www.census.gov/prod/2011pubs/p70-128.pdf.

unit."[6] Today, nearly two-thirds of all mothers are either the sole, primary, or co-breadwinners for their families.[7] With women's earnings playing an ever-increasing role in the financial health and stability of families, more women than ever work late into pregnancy. Sixty-five percent of first time mothers who worked during pregnancy worked into the last month before giving birth; among full-time workers, 87% worked into the last month.[8]

This Court has recognized that Congress enacted the Pregnancy Discrimination Act so that "women as capable of doing their jobs as their male counterparts may not be forced to choose between having a child

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[6] 123 CONG. REC. 29,657 (daily ed. Sept. 16, 1977) (statement of Sen. Harrison Williams).

[7] SARAH JANE GLYNN, CTR. FOR AM. PROGRESS, BREADWINNING MOTHERS, THEN AND NOW 7 (2014), *available at* http://cdn.americanprogress.org/wp-content/uploads/2014/06/Glynn-Breadwinners-report-FINAL.pdf.; *see also* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, WOMEN IN THE LABOR FORCE: A DATABOOK 3 (2014) (discussing how the gap between what men and women contributed to the family resources is closing rapidly and how more than 28% of working women out-earned their husbands in 2011); *see also* WHITE HOUSE COUNCIL OF ECON. ADVISORS, NINE FACTS ABOUT AMERICAN FAMILIES AND WORK 4 (2014), *available at* http://www.whitehouse.gov/sites/default/files/docs/nine_facts_about_family_and_work_real_final.pdf (noting, "In 2013, the income of employed married women comprised 44 percent of their family's income, up from 37 percent of household income in 1970.").

[8] LAUGHLIN, *supra* note 5, at 5-7.

and having a job."[9] Despite the Pregnancy Discrimination Act and this Court's rulings interpreting it, some employers continue today to subject pregnant women to the impossible choice between (i) the jobs and income so vital to the well-being of their families, and (ii) following their health care providers' advice about what is best for their own health and the health of their pregnancies. Families' increased reliance on the incomes of working women today, as compared to when Congress enacted the Pregnancy Discrimination Act thirty-six years ago, makes the stakes for women and families that much higher and the need for proper interpretation of the law – treating pregnant women the same as other employees similar in their ability or inability to work – that much more urgent.

II. Denial of simple modifications can mean pregnant workers have to choose between staying on the job and following their health care providers' advice for a healthy pregnancy.

Contrary to dated stereotypes that historically pervaded both popular and medical discourse,[10]

[9] *International Union v. Johnson Controls*, 499 U.S. 187, 204 (1991) (citing 42 U.S.C. § 2000e(k)).

[10] In a 1984 report by the American Medical Association's Council on Scientific Affairs, the medical community acknowledged that it had wrongly reinforced stereotypes that pregnant women were not capable of working throughout pregnancy despite the fact that the "advice given by generations of physicians regarding work during normal pregnancy has historically been

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pregnancy does not inherently impede a woman's ability to participate in the workforce – even late into pregnancy.[11] Many women work throughout their pregnancies without appreciable change in their work or negative health effects. Of course, every pregnancy is different, and some women may require minor job modifications to continue working while maintaining their health and that of their pregnancies.

With more women working during pregnancy than ever before, it is inevitable that the demands of some jobs and some pregnancies may necessitate job modifications similar to those given to other workers. The need for such modifications depends on the individual woman's pregnancy, her job duties and her health care provider's advice.[12] Often, a confluence of

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more the result of social and cultural beliefs about the nature of pregnancy (and of pregnant women)" rather than the result of "documented medical experience" or "scientific basis." Council on Sci. Affairs, Am. Med. Ass'n, *Effects of Pregnancy on Work Performance*, 251(15) J. AM. MED. ASS'N 1995, 1995 (1984). *See also* Laura Schlichtmann, Comment, *Accommodation of Pregnancy-Related Disabilities on the Job*, 15 BERKELEY J. EMP. & LAB. L. 335, 350, nn.100-03 (1994).

[11] *See* AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 156 (7th ed. 2012) ("A woman with an uncomplicated pregnancy usually can continue to work until the onset of labor.").

[12] *See* Theresa Nesbitt, *Chapter 19: Ergonomic Exposures*, *in* REPRODUCTIVE HAZARDS OF THE WORKPLACE 435 (Linda M. Frazier & Marvin L. Hage eds., 1998) ("[H]ealth professionals should provide individualized advice based on the specific physical demands of the job and the woman's baseline fitness level, risk factors, and medical condition."); *see also* AM. ACAD.

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factors necessitating an accommodation will arise in low-wage jobs, which tend to involve higher levels of physical exertion, such as prolonged standing, long hours, and heavy lifting, and which provide less flexibility in terms of schedule and worksite conditions.[13] This is compounded by the fact that lower socioeconomic status can be associated with poorer reproductive health outcomes.[14]

Under the Pregnancy Discrimination Act, employers are obligated to provide these modifications to pregnant women if other workers who are similar in their ability or inability to work are provided such accommodations.

A. Some pregnant workers will need job modifications to manage their pregnancies and minimize the risk of complications.

Being pregnant involves physiologic and anatomic changes that impose increased demands on women's

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OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 11, at 156-57 (explaining that "women with medical or obstetric complications of pregnancy may need to make adjustments based on the nature of their activities, occupations, and specific complications").

[13] A BETTER BALANCE & NAT'L WOMEN'S LAW CTR., IT SHOULDN'T BE A HEAVY LIFT: FAIR TREATMENT FOR PREGNANT WORKERS 5 (2013), *available at* http://www.abetterbalance.org/web/images/stories/ItShouldntBeAHeavyLift.pdf.

[14] Nesbitt, *supra* note 12, at 433.

bodies. As a result, some pregnant women experience physical limitations that impede their activities, and some job duties or workstation designs can become temporarily problematic. Often, these limitations can be addressed with small but important accommodations.

The stories of real women help illustrate the health-related struggles women can face when modest modifications are denied.[15] One accommodation that some employers refuse is allowing pregnant women to drink water over the course of the day.[16] In one instance, a pregnant cashier in New York who was not allowed to drink water during her shift, in contravention of her doctor's recommendation to stay well-hydrated, was rushed to the emergency room after collapsing at work.[17] As the emergency room doctor who treated her explained, because "pregnant

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[15] Every woman's experience with pregnancy is different. The stories in this brief convey the experiences of individual women who have grappled with the denial of minor accommodations that would have allowed them to take the steps that they and their health care providers determined were needed to maintain a healthy pregnancy or minimize the risk of complications.

[16] *See*, *e.g.*, *Wiseman v. Wal-Mart Stores, Inc.*, No. 08-1244-EFM, 2009 WL 1617669 (D. Kan. June 9, 2009) (retail employee suffering from urinary and bladder infections denied permission to carry a water bottle despite her doctor's advice); *see also* A BETTER BALANCE & NAT'L WOMEN'S LAW CTR., *supra* note 13, at 4.

[17] Letter from Lucy Willis, M.D., N.Y. Downtown Hosp., to James Vacca, N.Y. City Council Member (Dec. 4, 2012), http://www.abetterbalance.org/web/images/stories/Willis_letter_of_support.pdf.

women are already at increased risk of fainting (due to high progesterone levels causing blood vessel dilation), dehydration puts them at even further risk of collapse and injury from falling."[18] Another pregnant worker was prohibited from carrying a water bottle while stocking grocery shelves despite her doctor's instructions that she drink water throughout the day to prevent dehydration. She experienced preterm contractions, requiring multiple hospital visits and hydration with IV fluids.[19]

A simple accommodation that some employers also deny is permitting pregnant women to take more frequent bathroom breaks.[20] Hormonal changes and increased blood volume associated with pregnancy cause blood to flow more quickly through the kidneys, increasing urine output. With the expansion of the uterus, the decreased capacity of the bladder increases the frequency and urgency of urination.[21]

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[18] *Id.*; *see also* Mayo Clinic, *Dehydration Symptoms* (Feb. 12, 2014), http://www.mayoclinic.org/diseases-conditions/dehydration/basics/symptoms/con-20030056 (describing the symptoms of dehydration).

[19] *Hearing on H.B. 8 Before the H. Comm. on Labor & Commerce*, 98th Gen. Assem. (Ill. 2014) [hereinafter *Hearing*] (statement of Autumn Davidson, M.D.).

[20] A BETTER BALANCE & NAT'L WOMEN'S LAW CTR., *supra* note 13, at 4.

[21] F.G. Cunningham et al., *Chapter 5: Maternal Physiology*, *in* WILLIAMS OBSTETRICS (F.G. Cunningham et al. eds., 23rd ed. 2010).

The inability to void one's bladder when needed can lead to episodes of incontinence.[22]

In addition, women suffering from urinary tract infections, which are among the most common infections during pregnancy and can be associated with other pregnancy complications, require more frequent access to a bathroom.[23] One woman, a pregnant retail worker in the Midwest who had developed a painful urinary tract infection, supplied a letter from her doctor to her employer explaining that she needed a short bathroom break more frequently than the store's standard policy. The store refused. She later suffered another urinary tract infection that required her to miss multiple days of work and receive medical treatment.[24]

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[22] *See id.* (noting many pregnant women experience some degree of urinary incontinence).

[23] John E. Delzell, Jr. & Michael L. LeFevre, *Urinary Tract Infections During Pregnancy*, 61(3) AM. FAM. PHYSICIAN 713 (2000), *available at* http://www.aafp.org/afp/2000/0201/p713.html#sec-8 (discussing urinary tract infections and pregnancy complications); Betsy Foxman, *Epidemiology of Urinary Tract Infections: Incidence, Morbidity, and Economic Costs*, 113(1) AM. J. MED. 5, 5-13 (2002) (noting that urinary tract infections "are the most common bacterial infections during pregnancy, and pyelonephritis is the most common severe bacterial infection complicating pregnancy"); Janice A. Litza & John R. Brill, *Urinary Tract Infections*, 37(3) PRIMARY CARE 491, 492 (2010) (discussing frequency of urination as a symptom of urinary tract infections).

[24] *Hearing*, *supra* note 19, at 1 (noting that "[p]regnant women need to use the restroom more frequently than non-pregnant

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Finally, some employers refuse to grant pregnant women modifications to physically demanding tasks, such as heavy lifting, prolonged standing, and bending or stooping, that may lead to musculoskeletal issues and other medical problems,[25] even though these modifications are afforded to other employees. Health care providers often recommend that a pregnant employee engaged in physically strenuous work be allowed time to sit or to decrease the amount of weight she is required to lift to lessen stress on her back. The need for a given modification depends on the interaction between a woman's physiological needs and the characteristics of her job duties.[26] For instance, pregnant women can be at risk for back pain and injury because of the weight of pregnancy, altered posture, and loosened joints caused by pregnancy hormones.[27] These physiological changes can result in an increase in pain and fatigue, which can be significant for some women.[28]

Although many women will not require job modifications during pregnancy, some will, and "[i]t

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women do, and prolonged urinary retention predisposes women to urinary tract infections").

[25] Nesbitt, *supra* note 12, at 440-46, 449-50. For a discussion of the association between physically strenuous work and adverse pregnancy outcomes, including preterm birth and low birth weight, see Section II.B, *infra*.

[26] *Id.* at 445.

[27] *Id.* at 449.

[28] *Id.* at 441-43, 450.

remains the province of the obstetric care giver to counsel women on their own personal risks and any potential activity restrictions."[29] This is true in other medical contexts as well, as some workers with cardiac conditions, back injuries, or other ailments require modifications on the advice or recommendation of their physicians. Pregnant women should not be forced to ignore the advice of their health care providers – which is exactly what happens when employers treat them differently than other workers by denying them modest modifications afforded to other employees.

B. Denial of job modifications can pose risks to infant health.

Physically demanding work, such as prolonged standing, heavy lifting and carrying, and shift work and irregular schedules, has been associated with an increased risk for preterm birth and low birth weight in some studies.[30]

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[29] *Id.* at 450.

[30] *See*, *e.g.*, Monique van Beukering et al., *Physically Demanding Work and Preterm Delivery: A Systematic Review and Meta-Analysis*, INT'L ARCHIVES OF OCCUPATIONAL & ENVTL. HEALTH (2014) (discussing association of prolonged standing, lifting and carrying, physical exertion, and a combination of those tasks with preterm birth); Ellen L. Mozurkewich et al., *Working Conditions and Adverse Pregnancy Outcome: A Meta-Analysis*, 95 OBSTETRICS & GYNECOLOGY 623, 630-31 (2000) (discussing the association of physically demanding work and prolonged standing with preterm birth, and physically demanding work

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Preterm delivery and low birth weight are among the leading causes of infant morbidity and mortality.[31] These conditions can have serious consequences, including compromised immune systems, lung complications, and cardiovascular and neurological issues, and can lead to long-term health problems and

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with small-for-gestational-age infants); Agathe Croteau et al., *Work Activity in Pregnancy, Preventive Measures, and the Risk of Delivering a Small-for-Gestational-Age Infant*, 96(5) AM. J. PUB. HEALTH 846, 850-52 (2006), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470590/pdf/0960846.pdf (discussing the association of irregular or shift work, standing posture, lifting, and combination thereof with low birth weight, and noting that "[t]he elimination of these occupational conditions by preventive measures taken early, before 24 weeks' gestation, brought workers' risk close to those of women who were not exposed to those conditions at the beginning of pregnancy"); Stine Bjerrum Runge et al., *Occupational Lifting of Heavy Loads and Preterm Birth: A Study Within the Danish National Birth Cohort*, 70 OCCUPATIONAL & ENVTL. MED. 782, 782 (2013) (noting that occupational lifting of heavy loads is associated with an increased risk of preterm birth, with the strongest associations for very and extremely preterm birth); RENEE BISCHOFF & WENDY CHAVKIN, THE RELATIONSHIP BETWEEN WORK-FAMILY BENEFITS AND MATERNAL, INFANT, AND REPRODUCTIVE HEALTH: PUBLIC HEALTH IMPLICATIONS AND POLICY RECOMMENDATIONS 13-16 (2008), *available at* http://otrans.3cdn.net/70bf6326c56320156a_6j5m6fupz.pdf (discussing the association between physically demanding work and preterm birth and low birth weight).

[31] Ctrs. for Disease Control & Prevention, *Infant Mortality* (Aug. 12, 2014), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm; MATERNAL & CHILD HEALTH BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD HEALTH USA 2013 (2013), *available at* http://mchb.hrsa.gov/chusa13/perinatal-health-status-indicators/pdf/imorbidity.pdf.

lifelong disabilities including cerebral palsy, vision problems, and intellectual disabilities.[32]

The tolls of preterm delivery are illustrated by the story of one pregnant cashier who was forced to disregard her doctor's advice on how to reduce the risk of pregnancy complications when she was refused the simple modification of being allowed to sit on a stool instead of stand at her register. Because she had a shortened cervix which put her at higher risk for a premature delivery, her doctor instructed her to avoid prolonged periods of standing.[33] Despite presenting her employer with a letter from her doctor requesting that she be allowed to sit at the register for short intervals, the accommodation was denied. Instead, she was required to stand for extended periods, suffered from severe pelvic pressure, and went

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[32] COMM. ON UNDERSTANDING PREMATURE BIRTH & ASSURING HEALTHY OUTCOMES, INST. OF MED., PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION 313 (Richard E. Behrman & Adrienne Stith Butler eds., 2007); Ctrs. for Disease Control & Prevention, *Preterm Birth* (Dec. 9, 2013), http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm.

[33] *Hearing*, *supra* note 19, at 2; *cf*. Soc'y of Obstetricians & Gynaecologists of Can., *Cervical Insufficiency and Cervical Cerclage*, 35(12) J. OBSTETRICS & GYNAECOLOGY CAN. 1115, 1121 (2013), *available at* http://sogc.org/wp-content/uploads/2013/11/December2013-CPG301-ENG-REV-Dec-13-13.pdf (noting that conservative observational management of cervical insufficiency can include "advising the patient to reduce physical activity, especially those with physical employment, prolonged periods of standing, or frequent and repetitive lifting").

into labor early. Her baby required seven days of critical care in the neonatal intensive care unit.[34]

In addition to the human costs, preterm birth and its attendant complications have high financial costs. The Institute of Medicine (IOM) has reported that the cost associated with premature birth in the United States is over $26 billion each year.[35] This total includes $16.9 billion in medical and health care expenditures for children born prematurely and an additional $1.9 billion in labor and delivery costs for women.[36] During the first year, a premature infant's average medical care costs, including both inpatient and outpatient services, are ten times greater than those for an infant born full-term.[37] The IOM's estimate also includes the cost of special education services related to certain disabilities that are more

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[34] *Hearing*, *supra* note 19, at 2. The story of a cashier at a Dollar Tree store in New York is strikingly similar. Her employer rejected her modest request to sit while at the register instead of having to stand for eight to ten hours at a time. She experienced bleeding and premature labor pains, and required frequent emergency room visits. Her doctor then put her on bed rest, which required her to take unpaid leave. *See* A BETTER BALANCE & NAT'L WOMEN'S LAW CTR., *supra* note 13, at 13.

[35] COMM. ON UNDERSTANDING PREMATURE BIRTH & ASSURING HEALTHY OUTCOMES, *supra* note 32, at 399.

[36] *Id.*

[37] MARCH OF DIMES, P'SHIP FOR MATERNAL, NEWBORN & CHILD HEALTH, SAVE THE CHILDREN & WORLD HEALTH ORG., BORN TOO SOON: THE GLOBAL ACTION REPORT ON PRETERM BIRTH 12 (2012), *available at* http://www.marchofdimes.com/materials/born-too-soon-the-global-action-report-on-preterm-birth.pdf.

common following premature births, as well as lost household and market productivity associated with those conditions.[38] The estimate does not, however, include the cost of caregiving, which can exceed medical costs.[39]

Given the serious and long-lasting implications of preterm birth and low birth weight for infants and families, the denial of modest job modifications where a woman's health and job duties may pose an increased risk to her pregnancy is a significant concern.

C. Job loss can also undermine a healthy pregnancy.

Denial of job modifications means that pregnant workers are either required to labor under conditions their health care providers have advised against, or find themselves out of work at an especially vulnerable time. When women in this situation are forced off the job, the loss of income and benefits such as employer-sponsored health insurance can make it difficult for them to obtain the same level of prenatal care and can create uncertainty about options for care around the time of birth and in the postpartum period.

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[38] COMM. ON UNDERSTANDING PREMATURE BIRTH & ASSURING HEALTHY OUTCOMES, *supra* note 32, at 399.

[39] *Id.* at 401.

Having to change health coverage during pregnancy can disrupt women's continuity of care and ability to access essential services. Women may lose access to their maternity care providers or hospitals because their providers or preferred facilities are now out-of-network. Worse, women may face elevated or prohibitive cost-sharing requirements if they are unable to afford individual policies that match the value of their former employer's health plan. Particularly when a pregnant woman's lost income creates significant financial burdens for her family, higher cost-sharing for covered services in the form of co-pays, co-insurance, and deductibles could make medical care cost-prohibitive at exactly the time when it is needed the most. For some women, if private individual policies remain financially out of reach and public programs like Medicaid are unavailable, loss of employer-sponsored insurance during a pregnancy could mean falling out of coverage entirely and shouldering the burden of prenatal and maternity care out-of-pocket.[40]

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[40] In 2009, the average cost of prenatal care and delivery without complications was nearly $10,000 – an amount that most working families in America cannot afford to absorb. The costs for a complicated pregnancy can be much higher. *See* STEVEN MACHLIN & FREDERICK ROHDE, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH CARE EXPENDITURES FOR UNCOMPLICATED PREGNANCIES, 2009 (2012), *available at* http://meps.ahrq.gov/mepsweb/data_files/publications/rf32/rf32.pdf.

Consistent prenatal care is one of the most critical contributors to a healthy pregnancy.[41] When women go without prenatal care, they are three to four times more likely to suffer fatal pregnancy-related complications.[42] Similarly, infants whose mothers did not receive prenatal care are three times more likely to be low birth weight and five times more likely to die than those whose mothers were able to obtain care.[43]

III. Denial of simple modifications may disproportionately affect women of color, who already suffer existing health disparities.

Denial of requested workplace modifications in violation of the Pregnancy Discrimination Act may disproportionately impact women of color, their families and their health. Women of color are often overrepresented in low-wage jobs that are physically

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[41] Nat'l Inst. of Child Health & Human Dev., Nat'l Insts. of Health, U.S. Dep't of Health & Human Servs., *What Is Prenatal Care and Why Is It Important?* (July 12, 2013), http://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx.

[42] Debra Bingham, Nan Strauss & Francine Coeytaux, Ass'n of Reprod. Health Profs., *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189, 190 (2011), *available at* https://www.arhp.org/publications-and-resources/contraception-journal/march-2011.

[43] Office on Women's Health, U.S. Dep't of Health & Human Servs., *Prenatal Care Fact Sheet* (July 16, 2013), http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html#h.

demanding and do not offer workers the autonomy to sit rather than stand, avoid lifting heavy loads, carry a water bottle or take more frequent bathroom breaks.[44] Indeed, as compared to white women, black and Hispanic women are more than two times as likely to work in service occupations, and less than a fifth of Hispanic women work in "professional and related" occupations.[45]

These workplace challenges can exacerbate existing health disparities faced by pregnant women of color. For example, women of color disproportionately suffer from complications related to pregnancy, including gestational diabetes and hypertensive disorders.[46] They also face barriers to accessing high quality prenatal care, which is central to maintaining a healthy pregnancy. In 2010, the U.S. government set a goal that 90% of women would receive "adequate prenatal care." However, nearly one-third (32%) of African American women and 41% of American

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[44] NAT'L LATINA INST. FOR REPROD. HEALTH & NAT'L WOMEN'S LAW CTR., ACCOMMODATING PREGNANCY ON THE JOB: THE STAKES FOR WOMEN OF COLOR AND IMMIGRANT WOMEN (2014), *available at* http://www.nwlc.org/sites/default/files/pdfs/the_stakes_for_woc_final.pdf (unpublished calculations).

[45] ARIANE HEGEWISCH ET AL., INST. FOR WOMEN'S POL'Y RESEARCH, THE GENDER WAGE GAP BY OCCUPATION (2012), *available at* http://www.iwpr.org/publications/pubs/the-gender-wage-gap-by-occupation-1#sthash.98Tkoven.dpuf.

[46] Andreea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis*, 2008-2010, 210 AM. J. OBSTETRICS & GYNECOLOGY 435.e1, 435.e2 (2014).

Indian and Alaskan Native women fell short of this goal, compared with only one-quarter (25%) of pregnant women overall.[47]

The morbidity and mortality rates for black infants similarly reflect these disparities. Within their first year, black infants are more than two times as likely to die as white infants.[48] This difference has not significantly changed in more than fifty years.[49] Much of the disparity is due to the increased rates of preterm birth and low birth weight among black newborns.[50] Nearly one in five infants born to black women are preterm, which is 60% higher than the rate of preterm birth for white women.[51]

In short, women of color both (i) face existing health disparities and barriers to care and (ii) are overrepresented in jobs that are physically strenuous and inflexible. As such, denials of workplace

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[47] Bingham, Strauss & Coeytaux, *supra* note 42, at 190 (citing U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010: MIDCOURSE REVIEW (2000)).

[48] Michael C. Lu et al., *Closing the Black-White Gap in Birth Outcomes: A Life Course Approach*, 20 ETHNICITY & DISEASE S2-62 (2010).

[49] *Id.*

[50] *Id.* at S2-62.

[51] MARIAN F. MACDORMAN & T.J. MATHEWS, NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, NCHS DATA BRIEF NO. 74: UNDERSTANDING RACIAL AND ETHNIC DISPARITIES IN U.S. INFANT MORTALITY RATES 3 (2011).

modifications can have particularly stark impacts on women of color and their families.

CONCLUSION

Denying pregnant workers the same modest modifications afforded to other employees with similar work restrictions not only violates the Pregnancy Discrimination Act, it contravenes sound health, economic, and social policy. When an employer forces a pregnant woman to choose between her health care provider's advice and her job, that choice can risk compromising her health and the health of her pregnancy. We all have a stake in ensuring that women can pursue healthy pregnancies and minimize the risk of adverse outcomes. Where a woman and her provider have determined that a modification is needed to maintain a healthy pregnancy or to reduce harm, that accommodation may very well improve maternal health and decrease the risk of bad pregnancy outcomes.

Were this Court to rule for Ms. Young, employers across the country could no longer conduct business as though they are exempt from their obligations under the Pregnancy Discrimination Act. A ruling for Ms. Young would clarify the law, settling that the Pregnancy Discrimination Act requires employers to treat pregnant women the same as they treat other workers, including by providing pregnant women with temporary physical limitations the same

accommodations that they provide to other workers who are similar in their ability or inability to work.

For the above reasons, the *amici* respectfully suggest that the judgment of the Fourth Circuit should be REVERSED.

Respectfully submitted,

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APPENDIX

APPENDIX

Descriptions of the *Amici Curiae*

The American College of Nurse-Midwives (ACNM) is the professional association that represents certified nurse-midwives (CNMs) and certified midwives (CMs) in the United States. With roots dating to 1929, ACNM sets the standard for excellence in midwifery education and practice in the United States and strengthens the capacity of midwives in developing countries. ACNM's members are primary care providers for women throughout the lifespan, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. ACNM reviews research, administers and promotes continuing education programs, and works with organizations, state and federal agencies, and members of Congress to advance the well-being of women and infants through the practice of midwifery.

Founded in 1934, the American College of Osteopathic Obstetricians & Gynecologists (ACOOG) is a nonprofit, nonpartisan organization committed to excellence in women's health. The ACOOG strives to educate and support osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant.

Founded in 1915, the American Medical Women's Association (AMWA) is the oldest, national multispecialty organization for women in medicine. AMWA has consistently championed issues pertaining to

women's health, leadership, and gender equity. AMWA's mission focuses on all areas of women's health, including treatment and prevention of disease, reproductive health, education, and socioeconomic determinants of health; AMWA advocates for equal rights for women, both in the workplace and in society. As the vision and voice of women in medicine for nearly a century, AMWA empowers women to lead in improving health for all within a model that reflects the unique perspective of women.

The American Nurses Association (ANA) represents the interests of the nation's 3.1 million registered nurses. Founded over a century ago and with members in every state across the nation, ANA is comprised of state nurses associations and individual nurses. Collectively, ANA and its organizational affiliates represent more than 300,000 nurses who practice across the continuum of care and in all health care settings. ANA is an advocate for quality health care and the protection of rights that support appropriate care.

The American Public Health Association (APHA) champions the health of all people and all communities and strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research. APHA is the only organization that combines a 140-plus year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health. APHA is committed to supporting

healthy and safe work environments and improving maternal and infant health outcomes to advance the health and well-being of individuals and the broader public health.

National Advocates for Pregnant Women (NAPW) works to secure the human and civil rights, health and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable, such as low income women and women of color. NAPW seeks to ensure that women do not lose their constitutional, civil, and human rights as a result of pregnancy, and that pregnant and parenting women have access to a full range of reproductive health service without penalty for seeking the care they need. By focusing on the rights of pregnant women, NAPW broadens and strengthens the reproductive justice and other interconnected social justice movements in America today.

The National Association of Nurse Practitioners in Women's Health (NPWH) is a nonprofit, nonpartisan professional membership organization dedicated to ensuring women's access to quality primary and specialty healthcare by women's health and women's health focused nurse practitioners. NPWH's constituents are at the front line of providing pregnancy related health care to women, and recognize the importance of fair employment policies that support women's continued contributions to the workforce and a healthy pregnancy outcome. Since its inception in 1980, as the National Association for Nurse Practitioners in Reproductive Health, NPWH has worked to

improve women's wellness and health outcomes – including pregnancy outcomes – and to promote policies that decrease health disparities and inequities that adversely impact the health of women and their families. NPWH continues to be committed to improving women's health care delivery and health outcomes through research and education efforts.

The National Partnership for Women & Families is a nonprofit, nonpartisan national advocacy organization dedicated to promoting fairness in the workplace, access to quality health care, and policies that help workers in the United States meet the dual demands of work and family. Since its founding as the Women's Legal Defense Fund in 1971, the National Partnership has worked to advance equal employment opportunities through several means, including by taking a leading role in the passage of the Pregnancy Discrimination Act of 1978 and by challenging discriminatory employment practices in the courts. The National Partnership is likewise committed to improving the quality of maternity care and maternal health outcomes through research and advocacy.

The National Physicians Alliance (NPA) creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a professional home to physicians across medical specialties who share a commitment to professional integrity and health justice.

Physicians for Reproductive Health (PRH) is a doctor-led, national, not-for-profit organization that relies upon evidence-based medicine to advance its mission of improving access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients. PRH believes that women should be able to follow the advice of their doctors regarding their health, including in the course of their employment, without fear of negative consequences or retaliation.

Planned Parenthood Federation of America is the leading provider of reproductive health care in the United States, delivering medical services through over 700 health centers operated by 67 affiliates across the United States. Planned Parenthood Federation of America's mission is to provide comprehensive reproductive health care services and education, to provide educational programs relating to reproductive and sexual health, and to advocate for public policies to ensure access to health services. One out of every five women in the United States has received care from Planned Parenthood.

The Society for Maternal-Fetal Medicine (SMFM) was established in 1977 to give Maternal-Fetal Medicine physicians and scientists a place to share knowledge, research, and clinical best practices in order to improve care for moms and babies. SMFM's vision is to lead the global advancement of women's and children's health through pregnancy care, research, advocacy, and education. SMFM and its

members dedicate themselves to improving maternal and child outcomes and raising the standards of prevention, diagnosis, and treatment of maternal and fetal disease. SMFM is committed to improving the quality of maternity care and maternal and infant health outcomes through research, education/training, advocacy, and health policy leadership.