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POLICY FORUM

The Religious Exemption to Mandated Insurance Coverage of Contraception

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Accepting the recommendation of an Institute of Medicine (IOM) expert advisory panel, the U.S. Department of Health and Human Services (HHS) in August 2011 designated contraceptive services, supplies and counseling as women's preventive health care that private health plans are obligated to cover without consumer cost-sharing under the Patient Protection and Affordable Care Act (ACA) [1, 2]. In announcing its decision, HHS also announced its intent to exempt certain religiously affiliated employers from this requirement [3]. A substantial body of evidence indicates that expanding insurance coverage of contraception has considerable potential for improving its use and, in turn, a host of subsequent health outcomes, in the United States. At the same time, the unilateral decision by HHS to include a religious exemption raises serious questions—namely, whether it is merited at all and, when it is finalized, whether it appropriately balances the beliefs, rights, obligations, and needs of all affected parties.

The Requirement to Cover Contraceptive Services

The goal behind the ACA provision on preventive health care services is to eliminate financial disincentives to using effective preventive care, thereby improving health. Numerous studies have found that even modest cost-sharing requirements can dramatically reduce use of preventive health services, particularly among lower-income Americans [4].

The ACA refers to three sets of existing guidelines on preventive care that include, among many others, services such as breast and cervical cancer screening, screening and counseling for HIV and other sexually transmitted infections (STIs), vaccination for human papillomavirus, specified aspects of prenatal care, and reproductive health counseling for adolescents [5]. During consideration of the legislation in December 2009, the Senate approved an amendment that added "women's preventive care and screenings" as a fourth category of mandated preventive services, to fill gaps in the existing three. Although those three sets of guidelines include a range of services for women, none of the three is designed to meet all of women's preventive health care needs.

Because there were no comprehensive guidelines on women's preventive health to draw upon, HHS turned to the IOM to evaluate the evidence and advise it on what services should be included. The resulting recommendations include "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling" [1]. They also specify well-

woman visits, counseling and equipment to support breastfeeding, and screening and counseling for domestic violence, as well as enhancements to insurance coverage related to HIV, other STIs, cervical cancer, and pregnancy care.

The new requirements affect private health plans starting in August 2012, except for those that have been "grandfathered"—exempt from the requirement—so long as they make no significant, negative changes, such as cutting benefits or raising cost-sharing. HHS projects that most plans will lose grandfathered status by making those types of changes within a few years [6].

Potential Benefits of the Requirement

The HHS decision builds on major changes in private-sector contraceptive coverage over the past two decades. Since the late 1990s, 28 states have required plans to cover contraception when other prescription drugs are covered [7]. And in December 2000, the U.S. Equal Employment Opportunity Commission first made it clear that an employer's failure to cover contraception when it covers other prescription drugs and preventive care violates protections against sex discrimination under Title VII of the Civil Rights Act [8]. By 2002, the vast majority of private insurance plans were covering a comprehensive array of contraceptive services and supplies, a substantial shift from coverage practices in 1993, when the issue was first studied [9].

The result of the new requirement, therefore, will be to close most of the remaining gaps in coverage, such as in the individual and small-group markets, and bring private insurance in line with Medicaid's decades-old practice of exempting family planning—along with other key services, such as pregnancy-related care—from cost-sharing [10].

In doing so, the requirement has the potential to provide the substantial benefits for the health and well-being of women and families that come from helping women plan and space their pregnancies [11]. Correct and consistent contraceptive use dramatically reduces the risk of unintended pregnancy: in any given year, the two-thirds of U.S. women at risk (i.e., sexually active, fertile, and not seeking to become pregnant) who use contraception consistently and correctly throughout the year account for only 5 percent of unintended pregnancies [12]. Numerous studies, in turn, point to a causal link between pregnancies that are too close together and three birth outcomes that influence the future health of the child: low birth weight, preterm birth, and small size for gestational age [13, 14]. Similarly, unintended pregnancy has been linked to delayed initiation of prenatal care and reduced breastfeeding after a child is born—maternal behavior that can influence health outcomes throughout the child's life [15]. Moreover, unintended pregnancy can hinder women's educational and financial success and deprive women and couples of the ability to prepare before having children [16-19].

Despite the well-documented benefits of contraception, many women face problems using contraceptives consistently over several decades. The result is that nearly half of U.S. pregnancies—more than 3 million annually—are unintended, and unintended

pregnancy rates increased by 50 percent among poor women between 1994 and 2006 [20, 21]. Although there are myriad reasons behind these statistics, cost is one important access barrier, particularly with respect to long-acting, reversible methods (such as the IUD and the implant) that are extremely effective and cost-effective in the long run, but have high up-front costs.

Removing that barrier not only makes it easier for women to use contraception, but also allows them to choose the most effective methods. Three recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives [22-24]; one of those studies found, for example, that after controlling for socioeconomic characteristics and self-reported overall health, uninsured women were 30 percent less likely to report using prescription contraceptive methods than women with private or public health insurance [23]. And several other studies showed that when out-of-pocket costs were eliminated, women's use of long-acting methods increased substantially [25, 26].

In recognizing contraceptive services as an important aspect of preventive care, the IOM guidelines are in harmony with numerous precedents from federal programs, including Medicaid [10], the federally qualified health centers program [27] and HHS's Healthy People goals for the nation [28]. They also concur with the position of the American Medical Association [29] and many other health care professional and health promotion associations, such as the March of Dimes [30] and the National Business Group on Health [31].

The Exemption for Religiously Affiliated Employers

When it made its decision in August 2011 on women's preventive services, HHS also put forward an exemption to the required coverage of contraception for health plans provided by "religious employers" [3]. That key term is defined as an organization that has the inculcation of religious values as its purpose, primarily employs and serves people who share its religious tenets, and is a nonprofit organization under sections of U.S. law that refer to "churches, their integrated auxiliaries, and conventions or associations of churches" and to "the exclusively religious activities of any religious order" [32]. The language mirrors the religious exemptions to contraceptive coverage laws established, and upheld by courts, in California and New York [33, 34]. Public comments on this proposal were accepted through September 2011.

Reproductive health advocates and clinicians have criticized the decision to establish a religious exemption at all [35]. They noted that such an exemption was called for repeatedly during ACA debates by policymakers and advocates opposed to contraception, but Congress did not agree to include one for contraception, despite including several other religious exemptions as part of the ACA.

In fact, the decision by Congress not to include a religious exemption in this case was far from unprecedented. Nine of the 28 states that have required insurance coverage of contraception have done so without including any religious exemption

for employers [7]. Neither are religious employers exempt from the Title VII protections against sex discrimination [8].

Finally, these critics point out that the definition of religious employer established by HHS is not precisely tailored to its stated purpose, to "provide for a religious accommodation that respects the unique relationship between a *house of worship* and its employees *in ministerial positions*" (emphasis added) [3]. Rather, this exemption would also affect numerous other employees, including clerical and administrative staff, cafeteria workers, and custodians.

The Catholic hierarchy and some conservative "pro-family" groups—which oppose contraceptive use more broadly on doctrinal or social grounds and objected to its inclusion as required preventive care—have criticized the exemption from a different perspective [36-38]. They argue that it should encompass a far broader range of employers, including religiously affiliated schools, universities, hospitals, and charities that serve and employ the general public, suggesting that the current definition of "religious employer" could force them to limit whom they hire and serve. Such groups also assert that the exemption should be expanded to include insurers and even individual purchasers with religious or moral objections, arguing that a requirement to provide or purchase coverage for contraception amounts to religious discrimination and violates their conscience rights. Some have also called for an exemption for health care providers, although the coverage requirement imposes no obligations on clinicians or institutions to provide the care itself.

Analysis of the Objections

These arguments do not stand up well to scrutiny. Although the founders or sponsors of an institution may have a religious motivation, it does not follow that the institution is serving a religious function *per se*. Religiously affiliated schools, hospitals, social service agencies, and insurers serve and employ members of the general public and are a part of the public arena, with an obligation to abide by public rules.

Moreover, it is not clear why the religious beliefs of any employer or insurer should take precedence over those of its employees or enrollees. Expanding the exemption would affect millions of teachers and guidance counselors, doctors and nurses, clerks and janitors, by interfering with their access to preventive health care that they deem necessary and in line with their *own* religious and moral beliefs. Indeed, the opposition to contraceptive use by some religious leaders does not reflect the beliefs of the laity: 99 percent of U.S. women who have ever had sex with a man have used a contraceptive method other than natural family planning, and that figure is virtually the same across religious groups, including 98 percent among sexually experienced Catholic women [39]. For those employees who do adhere to their employer's religious position on contraception, providing coverage of contraception would not in any way force them to use it in violation of their beliefs.

Objections to financial entanglement with someone else's use of contraception are also problematic. It is difficult to see why an employer has any more right to veto an employee's use of her health benefits than it does to veto her use of her salary, sick leave, or other aspects of her compensation for the same contraceptive services. Moreover, everyone paying for insurance is paying for some services they expect never to need or use, and allowing individuals to pick and choose what specific benefits to cover would undermine the ability of insurance to pool peoples' risks. That type of self-selection is what leads insurers to impose the sort of restrictions on coverage—such as limitations for preexisting conditions or maternity care—that the ACA was designed to eliminate.

Protections for Patients Under a Religious Exemption

The benefits to women and families of the contraceptive coverage requirement will be undercut by a religious exemption, and simple math says that the broader the exemption, the greater the potential harm. In that regard, an HHS announcement in January 2012 that it would retain the narrow definition of a religious employer exempt from the coverage requirement that it proposed in August 2011 is highly significant [40]. The HHS press release also announced a 1-year grace period (until August 2013) for compliance with the requirement for other nonprofit employers certifying that, based on their religious beliefs, they do not currently provide coverage of contraception. (Final regulations have not been issued as of this writing but are expected shortly; in addition, HHS could choose to release additional subregulatory guidance.)

Meanwhile, the fact remains that some people will be harmed even by the narrow religious exemption to the contraceptive coverage requirement. In implementing the requirement and the religious exemption, HHS could and should mitigate harm by explicitly including three key protections.

First, employees and their dependents should still be able to acquire coverage for contraception without cost-sharing through an alternate means. Under several state laws, for example, enrollees of an employer invoking a religious exemption are given the right to purchase contraceptive coverage directly from an insurer. In its January 2012 announcement, HHS pointed to safety-net providers, such as community health centers, as an alternative source of affordable care for those women affected by the religious exemption.

Second, any entity invoking a religious exemption should be required to provide advance notice of that decision. That includes notice to current and potential enrollees about what is excluded and alternate means of accessing coverage and notice to the appropriate regulatory agency, certifying eligibility for the exemption to allow for transparency and enforcement. The January 2012 announcement addressed this issue in part, stating that HHS intended to require employers who do not cover contraception to notify their employees.

Not addressed at all by HHS so far, however, is the critical issue of enforcement of the religious exemption and the preventive services requirement more broadly. For the religious exemption specifically, that includes guarding against abuse, such as allowing ineligible employers to invoke the exemption (for example, by acquiring health coverage through another organization that does qualify for the exemption).

Such protections would constitute the minimum effort necessary to uphold and honor the beliefs, rights, obligations, and needs of all affected parties.

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