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Religious Exemptions in Insurance Coverage and the Patient-Clinician Relationship

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The June 2014 decision by the US Supreme Court in *Burwell v. Hobby Lobby* granted certain for-profit employers a religious exemption from a federal requirement that private health plans cover the full range of contraceptive methods, services, and counseling [1]. That decision and other religious exemptions related to contraceptive insurance coverage have serious implications for the relationship between patients and their clinicians. Moreover, the logic behind religious exemptions to covering contraception could also apply to coverage of a wide range of other health care services and to coverage for specific populations. These implications have not been given sufficient attention by lawmakers, courts, the media, and the public.

The Federal Contraceptive Coverage Guarantee

The *Hobby Lobby* case stems from a provision of the Patient Protection and Affordable Care Act of 2010, commonly known as Obamacare. That provision requires private health plans (unless they are "grandfathered," i.e., temporarily exempt from the new rules) to cover dozens of preventive care services completely, without any out-of-pocket costs to the patient such as copayments and deductibles [2-4]. Included among those services is the full range of contraceptive methods, services, and counseling for women.

The federal contraceptive coverage guarantee built upon earlier policies, including similar requirements for private insurance coverage in 28 states [5], contraceptive coverage requirements under Medicaid and the insurance program for federal employees [6-8], and a December 2000 decision by the US Equal Employment Opportunity Commission that failure of an employer-sponsored health plan to cover contraception when it covers other preventive care and prescription drugs constitutes illegal sex-based discrimination [9, 10].

In response to objections from opponents of contraceptive coverage, the Obama administration established an exemption to the new requirement for health plans sponsored by houses of worship and other religious employers, narrowly defined [11]. Most of the state requirements include similar exemptions that vary in their scope; several of these exemptions have been challenged in court as too narrow but have been upheld [5].

Beyond that, the administration crafted what it called an "accommodation" for a broader range of religiously affiliated nonprofit organizations, such as universities and hospitals [11]. Employees of those organizations and their family members are still guaranteed contraceptive coverage, but it must be provided by the organization's insurance company or arranged through its third-party administrator. The organization itself does not have to "contract, arrange, pay or refer" for any contraceptive coverage to which it objects on religious grounds [11].

Despite these measures, more than 100 lawsuits have been filed challenging the federal requirement as an infringement on the religious rights of employers [12]. Roughly half have been filed by nonprofit organizations requesting a full-fledged exemption under which employees and their dependents would be denied contraceptive coverage. The other half have been brought by for-profit employers, such as the craft-store chain Hobby Lobby, requesting that the exemption or the accommodation be extended to for-profit employers.

In its June 2014 decision, a majority of the US Supreme Court found that, under the Religious Freedom Restoration Act of 1993, the federal contraceptive coverage requirement could not be enforced against "closely held" for-profit employers with religious objections [1]. Specifically, Justice Samuel Alito, writing for the majority, and Justice Anthony Kennedy, in a concurring opinion, pointed to the accommodation for nonprofits as an alternative that would be less burdensome on the employers' rights. As of August 2014, the Obama administration was seeking comments on how to expand the scope of the accommodation to encompass for-profit employers [13].

Effects on the Patient-Physician Relationship

One of the standard talking points from those supporting religious exemptions for employers is that the employers are merely seeking to remove themselves from being complicit with behavior they find immoral, not trying to either prevent the behavior itself or interfere with the health care employees receive. Despite these protestations, however, a religious exemption could have a real impact on employees' and their dependents' access to and use of contraception and could infringe on the discussions they have with their clinicians and the decisions they make.

From the perspective of clinicians, religious exemptions to insurance coverage throw into question whether the services they provide and the prescriptions they write will actually be covered. Navigating patients' coverage is already complex, expensive, and time-consuming for clinicians in private practice, many of whom must hire staff devoted to understanding insurance, coding, and billing. When individual employers are exempt from the otherwise standard policies of a given health insurer, the opportunities for confusion multiply.

By ignoring these issues and, for example, writing a prescription for a drug that is not covered by the patient's health plan, a clinician may cost the patient significant money and undermine both the patient's trust in him or her and use of the prescribed

treatment. In some cases—particularly for methods with high up-front costs, such as IUDs, implants, and sterilization—the financial burden may be large enough that the patient is unable to pay, resulting in losses for the practice.

Contraception-Specific Effects
From an ethical standpoint, a clinician should, instead, help the patient understand whether any or all methods of contraception are excluded from her health plan. Differences in cost are unfortunate but important considerations for a patient in making an informed decision about her health care. In fact, eliminating cost as a consideration is precisely the point of the federal contraceptive coverage guarantee: it is designed to allow every woman to choose the contraceptive method that best fits her health needs and her personal circumstances without regard to her socioeconomic status, which is critical for practicing contraception consistently, correctly, and effectively [14].

The results of those discussions have multiple implications. If the clinician and patient decide that the best method for her is one that is excluded from her health plan, one option might be to send the patient elsewhere for that care—for example, to a safety-net clinic that can provide the services and supplies at no cost or at a discount. That may create hurdles for the patient, such as delays in receiving care, additional time off from work, or costs for transportation or child care. It also may mean losses for the referring clinician, especially if the patient concludes she is better served permanently at the safety-net clinic. And it is a greater burden on the already-strained taxpayer-supported safety net. (Insurance plans, meanwhile, would reap a windfall; they would gain the financial benefits of averted unplanned pregnancies without incurring the cost of the contraceptive care.)

Alternatively, the clinician and patient may decide on a contraceptive method with fewer up-front or long-term costs, which tend to be less effective than more costly methods. For example, with typical use, a couple relying on oral contraceptives is 45 times as likely to have an unplanned pregnancy in a given year as a couple relying on a hormonal IUD [15]. Beyond average effectiveness, a woman's choice of methods may also depend on factors such as concerns about side effects and drug interactions, how frequently she expects to have sex, her perceived risk for STIs, and concerns about partner knowledge and interference. So using a second- or third-choice method may result in less consistency; according to one study, women who are less than satisfied with their contraceptive method are more than twice as likely to have a gap in use that leaves them at risk of an unplanned pregnancy [16].

A third possibility, particularly if a plan excludes all contraceptive methods, might be for the clinician and patient to settle on her paying out of pocket for the method of her choice. That may also lead to gaps in use or inconsistent use and higher risk of unplanned pregnancy, especially for low-income women. A survey of women during the recent recession found that substantial numbers of low-income women resorted to tactics like delaying refills of their birth control prescriptions to save money [17].

One final concern for the patient-clinician relationship and the informed consent process is that some employers—including the plaintiffs in the recent Supreme Court case—assert religious objections not only to coverage of some or all contraceptive methods but also to coverage of the counseling and education pertaining to those methods [18]. It is unclear how those employers envision their objection playing out, and it was not mentioned in the Court's decision. Put into practice, it might mean a gag rule: a ban on talking with patients about the full range of contraceptive options if the office visit is to receive any insurance reimbursement. That would constitute a clear threat to a woman's ability to provide informed consent to her care and to a clinician's ability to practice in accordance with ethical medical standards and legal obligations.

Potential Impact beyond Contraception

The logic behind religious exemptions to health insurance clearly extends well beyond contraception, with all of the same implications for patients, clinicians, and the patient-clinician relationship. Justice Alito's majority opinion singles out two other services for which a religious exemption to coverage would clearly be required, in the majority's view: third-trimester abortion and assisted suicide [1]. Justice Ginsburg's dissent highlighted a range of other services to which some religious groups have objections, including "blood transfusions (Jehovah's Witnesses); antidepressants (Scientologists); medications derived from pigs, including anesthesia, intravenous fluids, and pills coated with gelatin (certain Muslims, Jews, and Hindus); and vaccinations (Christian Scientists, among others)" [19]. Moreover, religious objections could also be used to discriminate against specific groups of people in a health care context—for example, denying coverage of certain services for those of a given sexual orientation, marital status, or age.

In a practical sense, whether the restriction is imposed by the employer for religious reasons, the government for ideological reasons (for example, bans on public or private coverage for abortion), or an insurer for cost reasons (such as recent moves to limit coverage of an effective but expensive new treatment for hepatitis C [20]), the effect on patients and clinicians is the same: interference in quality care. In all of these cases, whatever the motive, restrictions on insurance coverage can interfere with patients' and clinicians' considering what services are medically appropriate and necessary. The ethical principle at stake is the same whether the excluded service is contraceptive care, abortion care, or expensive pharmaceuticals. The implications can be significant and deserve serious attention and consideration by policymakers, health plans, the courts, and other key actors as they regulate and restructure public and private health coverage going forward.

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