Op-Ed

Contraception as a Health Insurance Right: What Comes Next?

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THE AFFORDABLE CARE ACT (ACA) REQUIRES BOTH individual insurance policies and plans sold or administered in the employer group market to cover preventive health services that public health authorities deem highly effective. Under the law, preventive care and screenings for women constitute a specific preventive benefit category.¹ Regulations issued by the Obama administration in consultation with the National Academy of Medicine² interpret this category to include contraceptive methods approved by the US Food and Drug Administration (FDA).

To say that this contraceptive coverage guarantee has been controversial is an understatement. Under the Trump administration, what might come next?

The controversy surrounding this rule has focused on how it should be applied to employers that object to some or all contraception on religious grounds. Adhering to long-standing tradition, the rule completely exempts church-sponsored plans. Furthermore, in compliance with the Religious Freedom Restoration Act (RFRA),³ the rule also contains an “accommodation” for plans sponsored by religious organizations, that is, nonprofit organizations that claim a religious affiliation (eg, universities and hospitals) but whose employees are not insured through church plans.⁴ In these situations, the religious organization notifies its insurer of its objection, and the insurer provides coverage directly as an additional benefit offered outside the technical scope of the employer plan.

A blizzard of lawsuits, falling into two camps, followed in the rule’s wake. The first group of lawsuits consists of challenges brought by for-profit, closely held employers that thus are not “religious organizations” covered by the accommodation. The second group is made up of religious organizations covered by the accommodation that insist that anything less than a full exemption amounts to a “hijacking” of their plans

(in the words of Chief Justice John Roberts) for the purpose of delivering contraceptives to their employees.

RFRA itself is controversial. Signed into law in 1993—decades before the ACA—RFRA was designed to overturn a US Supreme Court decision (written by Justice Antonin Scalia) that held that health and welfare laws could survive a First Amendment freedom-of-religion challenge as long as they were rational and applied impartially. With RFRA, Congress essentially restored the previously applicable First Amendment “strict scrutiny” test that applied to religious-freedom cases. RFRA demands that courts uphold laws alleged to “substantially burden” a person’s “sincerely held” religious beliefs only if they further a compelling governmental interest and are the least restrictive means of achieving their aims. Although RFRA initially applied to both federal and state laws, a subsequent Supreme Court ruling limited its reach to federal laws.

In 2014, the Court decided the first group of challenges in *Hobby Lobby v Burwell*, 134 S. Ct. 2751 (2014), which held that closely held (ie, not publicly traded) for-profit companies are persons who can claim RFRA protections. In response, the Obama administration broadened its accommodation rule to cover these employers. Writing for the majority, Justice Samuel Alito went further, expressing his deep skepticism that advancing access to contraception amounted to a compelling governmental interest and asserting that the government had failed to show how piggybacking contraceptive coverage onto employee plans was the least restrictive means of achieving such an aim. In passing judgment, Justice Alito offered no response to extensive evidence in the record showing the profound public health benefits of contraceptives, the high cost of the most effective forms of contraception, or the fact that the United States lacks the essential public health infrastructure that could make coverage through employer plans unnecessary.

The second group of challenges, focusing on the accommodation itself, reached the Court in 2015. This case, *Zubik v Burwell*, was argued in 2016, one month after Justice Scalia died. With one exception, the lower courts agreed with the government, finding that the rule effectively separated the contraceptive coverage from the employers’ own plans. The employers, however, insisted that the rule made them complicit in the very practice they opposed, by requiring insurers to use their own plans to deliver coverage. The plaintiffs insisted that the insurers instead issue separate contraceptive-only policies for women to buy.

With the death of Justice Scalia and following a tempestuous argument before a sharply divided bench, the Court took the rare, but not unprecedented, step in a unanimous opinion issued in May 2016, of sending the case back to the lower courts to work out a settlement. The justices' settlement instructions—accompanied by a separately signed concurrence by Justices Sonia Sotomayor and Ruth Bader Ginsburg—essentially sought to steer the parties toward a compromise that would preserve the seamless approach achieved by using employer plans as the means to deliver coverage while at the same time letting religious employers disentangle themselves from the process by taking no part in it, that is, by eliminating the notification requirement.

Rather than hashing out a compromise with the plaintiffs—probably because there is basically none to be had, since without notice, how would insurers know what they must do?—the government issued a Request for Information in July 2016.⁵ In its request, the Obama administration sought public comments regarding the workability of contraceptive-only plans, which do not exist today. It also asked for comments regarding what to do about self-insured plans, which cover about 60% of all people with employer coverage and which therefore lack an independent insurer to provide separate coverage. The comment period closed on September 20, 2016, and as of mid-November 2016, the government had not yet issued a new policy. It is not clear that there is one to be had.

What might happen under President Trump? The new administration might decide simply to settle the cases by modifying the existing accommodation rule to grant a broad exemption from the coverage obligation to any entity, nonprofit or otherwise, that claims a religious objection. (Studies suggest that most employers do offer coverage, so the ultimate impact of such a step might be relatively modest.) The administration could propose to eliminate the contraceptive coverage rule altogether, but to reverse the rule, it would have to show evidence as to why contraceptives should no longer be treated as basic to a preventive benefit package. Congress could, of course, eliminate preventive services altogether as part of an ACA repeal.

At the heart of the matter, perhaps, lies the nation's shamefully underfunded public health system, not only for the millions who remain uninsured, but also for those with coverage. Even in nations whose populations rely on insurance, basic public health services such as immunizations and contraceptives are made universally available and are furnished free at the point of care.

The United States lacks such a tradition. Nearly 50 years after its enactment, Title X of the Public Health Service Act, the nation's most important public commitment to contraceptive access, continues to remain subject to political attack and to be systematically starved for funding. To the extent that a new president and Congress will choose to walk away from a policy of near-universal contraceptive coverage through employer plans, we can only hope that they couple their abandonment of women and families with a renewed investment in the public's health.

References

1. 42 U.S.C. § 300gg-13.
2. 45 C.F.R. § 147.130[a][1][iv], pertaining to health insurance policies sold in the individual and group markets; 29 C.F.R. § 715-2713[a][1][iv].
3. 42 U.S.C. § 2000-1bb.
4. 45 C.F.R. § 147.131; 29 C.F.R. § 2590.715-2713.
5. Centers for Medicare and Medicaid Services. Requests for information: coverage for contraception services. *Federal Register*. <https://www.regulations.gov/document?D=CMS-2016-0123-0001>. Published July 22, 2016. Accessed December 8, 2016.

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