# Law and the Public's Health

The Patient Protection and Affordable Care Act (ACA) requires all health insurers and employee benefit plans to cover certain evidence-based preventive services without cost sharing. In July 2011, U.S. Department of Health and Human Services Secretary Kathleen Sebelius designated contraceptive services as such preventive services. By spring 2012, the controversy regarding what types of health plan sponsors would be able to claim an exemption from this requirement on the basis of moral or religious objections was in full bloom. This installment of *Law and the Public's Health* examines the preventive services coverage requirement and its implications for public health.

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### CONTROVERSY, CONTRACEPTION, AND CONSCIENCE: INSURANCE COVERAGE STANDARDS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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The Centers for Disease Control and Prevention identifies family planning, which includes contraceptive services, as one of the major public health achievements of the 20th century. The high position of family planning in the public health pantheon is linked to its importance in averting unintended pregnancy, which is associated with serious health outcomes for women, children, and their families. Prevention of unintended pregnancy is especially important after a woman has given birth to one child, because of the health impact of inadequately spaced births on the woman, her baby, and her previous child.

Virtually all women of reproductive age in the United States who have ever been sexually active—more than 99%—have used contraception at some point in their lives. More than 80% have taken prescribed oral contraceptives, the most common form of hormonal contraception. Contraceptives, which today come in a variety of forms, are designed to prevent unintended pregnancy. In addition, certain hormonal contraceptives are prescribed to treat medical conditions such as dysmenorrhea (severe menstrual pain), menorrhagia (excessive menstrual bleeding), acne, migraines, endometriosis, and uterine fibroids.

In the current marketplace, most large employee health benefit plans cover prescription contraception, although cost sharing varies.<sup>8</sup> Twenty-eight states have

insurance benefit mandate laws requiring plans to cover contraception, with varying accommodations for plans sponsored by religious employers. 9 Contraceptive coverage is a feature of the Federal Employee Health Benefits Plan (FEHBP) as well. Beyond the connection to preventive health, one fact underlying this widespread coverage of contraception is that the coverage costs essentially nothing, because of the savings realized from avoiding unintended pregnancy.<sup>10</sup> The National Business Group on Health, which advocates on behalf of large employers, recommends employer coverage of the full range of contraceptive services on the basis of cost savings.11 The cost neutrality of contraceptive coverage can be seen in evidence from the implementation of other mandates to cover contraception. In 1999, when the FEHBP was required by law to cover contraception,12 there was no need to increase insurance premiums, even for those plans that had not previously covered contraception, because there was no cost associated with the additional coverage.<sup>13</sup> Since that time, federal appropriations legislation has included the same language.<sup>14</sup> Hawaii's 1999 contraceptive insurance coverage mandate also did not appear to increase the costs of the insurance plans Hawaii surveyed after implementation.<sup>15</sup> This evidence may not be a precise predictor of the cost impact of the Patient Protection and Affordable Care Act (ACA)<sup>16</sup> coverage requirement because patient cost sharing can have a significant impact on estimating actuarial costs, and it is not clear whether patient cost sharing, which is prohibited by the ACA, was allowed in these earlier cases. At the same time, these earlier studies offer persuasive evidence of the cost neutrality of contraception coverage.

Whether the exclusion of contraception from an employer-sponsored health plan that otherwise covers prescription drugs constitutes a violation of federal civil rights law is open to question. This issue has arisen as a result of the Pregnancy Discrimination Act of 1978, which amended Title VII of the 1964 Civil Rights Act to specifically bar discrimination on the basis of "pregnancy, childbirth, or related medical conditions" as a type of sex discrimination.<sup>17</sup> Both the Equal Employment Opportunity Commission and at least one federal court have concluded that an exclusion of contraception for women amounts to an unlawful sex-based exclusion.<sup>18,19</sup> However, another federal court found that no discrimination exists so long as contraception used by men is also excluded.<sup>20</sup>

A separate legal question is whether religious employers—that is, employers that are churches or are affiliated with churches, or even employers that simply claim a religious or moral position—should be excused from compliance with a broadly and uniformly applicable public health law. This issue is a long-standing one that has arisen in numerous contexts, including employment law and laws regulating health-care professionals, such as laws requiring licensed pharmacies to dispense all legally prescribed medications. Under U.S. Supreme Court precedent, the right of free exercise of religion "does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)."21,22

## THE ACA REQUIREMENT AND SUBSEQUENT REGULATION

Section 2713 of the Public Health Service Act, as added by Section 1001 of the ACA,<sup>16</sup> requires nonfederal public employer group health plans and state-regulated health insurance issuers offering group or individual health insurance coverage to provide coverage without cost sharing for certain preventive services. The ACA also extends this requirement to all employer group plans (whether self-funded or insured)<sup>23</sup> governed by the Employee Retirement Income Security Act,<sup>24</sup> which contains a general exemption for church plans,<sup>25</sup> defined as a tax-exempt plan established or maintained by a church or a convention, or an association of churches.<sup>26</sup> The preventive services provisions of the ACA do not apply to "grandfathered" health plans in effect on the date of enactment, <sup>27</sup> although the number of such exempt plans is expected to decline steeply under rules on grandfathering issued in 2010.<sup>28</sup>

On July 19, 2010, the U.S. Departments of the Treasury, Labor, and Health and Human Services (HHS) jointly issued "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Cover-

age of Preventive Services under the Patient Protection and Affordable Care Act"<sup>29</sup> (hereafter, IFR). At that point, the Health Resources and Services Administration (HRSA) had not yet issued comprehensive guidelines, but it was expected to do so by August 1, 2011.

Following a report by the Institute of Medicine (IOM) recommending comprehensive coverage of contraceptive services,30 HRSA issued guidelines on August 1, 2011, adopting the IOM recommendations.<sup>31</sup> Specifically, HRSA's guidelines recommend health insurance coverage of "[a]ll Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity," as prescribed.<sup>31</sup> Shortly thereafter, on August 3, 2011, the Departments published an Amended Interim Final Rule<sup>32</sup> (hereafter, Amended IFR) that incorporated HRSA's Required Health Plan Coverage Guidelines for Women's Preventive Services. The Amended IFR contained an additional 60-day public comment period but took effect as of August 1, 2011, so that mandatory coverage by non-grandfathered group and individual insurance plans of all preventive services without cost sharing would begin on August 1, 2012.

In response to comments on the 2010 initial IFR regarding the application of the preventive services requirement to religious employers, the Departments gave HRSA "additional discretion to exempt certain religious employers from the Guidelines where contraceptive services are concerned."33 The 2011 Amended IFR defined a religious employer, for purposes of the policy, as "one that (1) has the inculcation of religious values as its purpose, (2) primarily employs persons who share its religious tenets, (3) primarily serves persons who share its religious tenets, and (4) is a nonprofit organization under [certain sections of the Internal Revenue Code]."32 This definition was based on definitions used by states that exempt religious employers from compliance with state mandates to cover contraceptive services. It is a narrow exemption that effectively covers churches and other religious houses of worship, but not religiously affiliated nonprofit institutions, such as hospitals, universities, and social service agencies.

On January 20, 2012, in response to concern around the narrow definition of religious exemption, the Secretary of HHS announced, without amending the 2011 Amended IFR, that religiously affiliated employers not covered by the exemption would have an additional year (until August 1, 2013) to comply with the Amended IFR.<sup>34</sup> However, intense opposition to the narrow exemption, including the United States

Conference of Catholic Bishops,<sup>35</sup> led to a further refinement of the 2011 Amended IFR.

On February 10, 2012, the Obama Administration released a final rule, designed to accommodate religiously affiliated employers without broadening the original religious exemption.<sup>36</sup> The final policy<sup>37</sup> maintains the Amended IFR's religious exemption and retains the one-year grace period for religiously affiliated organizations that the Secretary had announced in January. In addition, for employers claiming a religious affiliation that are not exempted, the final rule announces the Administration's intention to adopt a new policy that insurance companies providing coverage to such employers will be required to cover contraceptive services free of charge, thereby assuring coverage while exempting employers from having to pay for it. The final rule codifies the 2011 Amended IFR without any modification, but in the preamble to the final rule, the Departments state their intent to produce a new rule during the one-year grace period for religiously affiliated employers (the "temporary enforcement safe harbor") that will set forth the requirements for insurers.38

On March 16, 2012, the Departments announced an Advanced Notice of Proposed Rulemaking to seek input on how the preventive services coverage rule should apply to religiously affiliated employers that self-insure.39 Sixty percent of workers with health insurance were covered by a self-insured plan in 2011, including 96% of those who work at firms with more than 5,000 employees. 40 Because self-insured employers pay for any health claims of their employees, rather than an insurance company holding the risk and paying the claims, the employers are directly responsible for paying for their employees' contraceptive coverage. The Departments seek to balance the two goals of (1) maintaining contraceptive coverage without cost sharing for "individuals who receive coverage through nonexempt, nonprofit religious organizations with religious objections to contraceptive coverage in the simplest way possible," and (2) protecting "such religious organizations from having to contract, arrange, or pay for contraceptive coverage."41

The Departments announced their intention to require insurance companies that provide third-party administration services to self-insured religiously affiliated employer health plans or some other independent entity to provide contraceptive coverage without cost sharing to the beneficiaries of the plan, separate from the religious organization. Thus, for "nonexempt, nonprofit religious organizations with religious objections to contraceptive coverage" that contract for insurance for their employees, the insurer would provide contraceptive coverage without cost sharing under the previously announced rule. For such organizations that self-insure, the Departments propose that the employer will be exempt from the coverage requirement if it contracts with a third-party administrator to manage the plan and contractually obligates the third-party administrator to provide equivalent contraceptive coverage with no cost sharing.42 At the time of this writing, the Departments are seeking comment on how such coverage could be arranged and financed to meet both stated goals.

### **OUTLOOK AND IMPLICATIONS** FOR PUBLIC HEALTH PRACTICE

Whether a satisfactory accommodation of employer objections to the coverage requirement can be reached is anything but settled. Advocates seeking a broader religious exemption quickly rejected the compromise announced in the final rule<sup>43</sup> and sought a broad legislative exemption, far beyond the narrow church exemption offered by the Administration. On March 1, 2012, a proposal that would have added a broad exemption to the ACA was defeated in the U.S. Senate by only two votes. The proposal would have allowed any health plan or provider to opt out of providing any ACA-required health service, including but not limited to contraception, on the basis of religion or other moral conviction.44 The provision also would have given any person or entity the right to sue in federal court another person or entity that ostensibly threatened their "conscience" in violation of the provision.

Action to broaden religious exemptions also has been taken at the state level. In March 2012, Arizona's House of Representatives passed a bill allowing all employers (not just religiously affiliated ones) to opt out of providing contraception and allowing them to require female employees to first pay for contraception and then submit a claim for reimbursement with evidence that the contraceptives are being used for medical conditions.<sup>45</sup> The bill also would overturn a state law preventing religious employers from discriminating "against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source,"45 essentially allowing an employer under state law to punish or fire an employee for obtaining contraception for the purpose of preventing pregnancy.<sup>46</sup> Because this law appears to contravene the ACA coverage requirements, as well as other federal laws, it is likely that courts would find it invalid. The laws implicated are not only the ACA but also the Health Insurance Portability and Accountability Act of 1996 Privacy Rule<sup>47</sup> and the

Pregnancy Discrimination Act (as part of Title VII of the 1964 Civil Rights Act),<sup>17</sup> given the impact of such a requirement on privacy and on the rights of female employees to be free from discrimination. However, other states may follow Arizona's example and Congress may revisit the issue of conscience in connection with employee health benefits.

The question becomes whether more should be done to provide women with direct access to contraception rather than treating it as an employee benefit. This could be done, for example, through a major expansion of Title X of the Public Health Service Act,<sup>48</sup> the purpose of which is to directly fund family planning for people who need it, as a public health service. However, this strategy may prove elusive as well, given the high level of political resistance to the program for several decades, as well as the significant decline in real-dollar funding that the program has experienced. In the end, although the ACA has made significant headway in expanding insurance coverage of contraception, the controversy surrounding religious and moral objections to contraception means that policy makers continue to struggle to ensure access to this important public health service while respecting religious freedom.

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