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MAKING CONTRACEPTION EASIER TO SWALLOW: BACKGROUND AND RELIGIOUS CHALLENGES TO THE HHS RULE MANDATING COVERAGE OF CONTRACEPTIVES

CHAD BROOKER*

“No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother.”

—MARGARET SANGER, *WOMEN AND THE NEW RACE*, 50 (1920)

Birth control has become a staple in the lives of nearly all American women, and many have called it the most important invention for women in the last century.¹ In fact, the Centers for Disease Control and Prevention (CDC) listed contraceptives (family planning) as one of the top 10 greatest public health achievements of the 20th century.² It has revolutionized women’s freedom to make their own contraceptive choices by providing a strong rate of protection without the burdens of constant management—other than taking a daily pill in most cases.³ Contraceptive methods have been widely used with increasing regularity. In fact, 98% of women in the United States will use birth control at some point during their reproductive lives.⁴

However, access to contraception in employee benefit plans is not universal and may, in many cases, be prohibitively costly for some users without plan coverage given the expense of continuous

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1. *Healthy People 2020: Family Planning*, U.S. DEP’T OF HEALTH AND HUMAN SERVICES (May 1, 2012), <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13>.

2. *Ten Great Public Health Achievements —1900–1999* (2000), CENTERS FOR DISEASE CONTROL AND PREVENTION (April 02, 1999), *available at* <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm>.

3. Martha J. Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women’s Life Cycle Labor Supply*, 121 Q. J. ECON. 289 (2006).

4. Press Release, Planned Parenthood, Catholic Charities’ Opposition to Women’s Health Law Is Put to Rest by U.S. Supreme Court (Oct. 1, 2007), *available at* <http://www.plannedparenthood.org/newsroom/press-releases/catholic-charities-opposition-17146.htm>.

contraceptive use.⁵ It is unsurprising, then, that compared to men, women of reproductive age spend 68% more on out-of-pocket healthcare costs.⁶ Most of these costs are reproductive healthcare-related.⁷ Data from insurance companies and online brokers show that the gap between female and male expenditures, even with insurance, is wide and that many women pay hundreds of dollars more per year for insurance than men of the same age.⁸ Insurance companies report that they charge women more because women tend to see their doctors and take prescription drugs more frequently than men.⁹

Thanks to a new set of standards issued by the Obama Administration as part of the Patient Protection and Affordable Care Act¹⁰ (hereinafter ACA), non-grandfathered¹¹ health insurance providers will be required to cover all government-approved contraceptives without co-pays or other forms of cost sharing. The standards come after the Department of Health and Human Services (HHS) directed the Institute of Medicine (IOM) to conduct a study on women's preventative healthcare and provide recommendations regarding preventative care for women.¹² A study by the Guttmacher Institute found that birth control was widely used, even among religious and/or conservative women, and that most plans that have prescription coverage will provide coverage for birth control.¹³ The Obama Administration is pushing these new standards as a way to keep women healthy, keep healthcare costs down, and to help prevent some of the nearly three million unintended pregnancies in the United States—half of all pregnancies in the United States are unintended.¹⁴

5. See *Healthy People*, *supra* note 1, at 270.

6. *Id.* at 268.

7. *Id.*

8. *Id.*

9. Ayelet S. Lebovitz, Note, "Cover My Pills": Contraceptive Equity and Religious Liberty in *Catholic Charities v. Dinallo*, 16 CARDOZO WOMEN'S L.J. 267, 268 (2010).

10. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 131-32 (2010) [hereinafter ACA].

11. See *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, HEALTHREFORM.GOV (Dec. 12, 2011), http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

12. See *Affordable Care Act Rules on Expanding Access to Preventive Services for Women*, HEALTHCARE.GOV (Aug. 1, 2011), <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html>.

13. RACHEL K. JONES & JOERG DREWEKE, COUNTERING CONVENTIONAL WISDOM: NEW EVIDENCE ON RELIGION AND CONTRACEPTIVE USE 5 (2011).

14. See *In Brief: Facts on Unintended Pregnancy in the United States*, GUTTMACHER INSTITUTE (Jan. 2012), <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>. See also, Press Release, U.S. Dep't of Health & Human Services, A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Jan. 20, 2012),

Although prescription contraceptives have been available for decades, it was rare, until more recently, for employer-sponsored health insurance plans to cover them.¹⁵ The decision to cover Viagra in the mid-1990s encouraged many women's organizations to begin to fight for the coverage of female contraceptives.¹⁶ Over the last fifteen years, the number of states that currently mandate coverage of contraceptives has increased to twenty-eight.¹⁷ Even with evidence that medical costs actually decline when contraception coverage is added, due to a reduction in the costs of unintended pregnancies, some states and plans still refuse to offer such coverage.¹⁸ Although Title VII of the Civil Rights Act of 1964 prohibits employers from charging employees different rates, or providing disparate benefits on the basis of gender, employers often escape such requirements through refusing to provide any drug insurance coverage.¹⁹ The imposition of state insurance law requirements for contraceptive coverage had been one source through which the states sought to require the coverage of contraceptives prior to the enactment of the ACA; however, no state plans required employers to offer any prescription coverage, and as

available at <http://www.hhs.gov/news/press/2012pres/01/20120120a.html>. [hereinafter Sebelius].

15. [H]alf of all traditional indemnity plans in 1993 did not cover any reversible prescription methods of contraception, and only 15% covered all of the five leading methods. *The Cost of Contraceptive Insurance Coverage*, GUTTMACHER INSTITUTE (March 2003), <https://www.guttmacher.org/pubs/tgr/06/1/gr060112.html>.

16. See Sandra Jordan & Roger Rathman, *Planned Parenthood Urges Congress to Make Contraceptive Coverage a Reality This Year*, COMMON DREAMS NEWS WIRE (June 8, 1999), <http://www.commondreams.org/pressreleases/june99/060899c.htm> (The FDA approval of Viagra and its almost instantaneous insurance coverage exposed the discrimination women face from insurers.). See also Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, HARV. J.L. & PUB. POL'Y 741, 741 (2005).

17. *State Policies in Brief: Insurance Coverage of Contraceptives*, GUTTMACHER INSTITUTE (May 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf. The twenty-eight states are Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Vermont, Washington, West Virginia, and Wisconsin. [hereinafter State Policies].

18. See Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, 28 HARV. J.L. & PUB. POL'Y 741, 742 (2005).

19. See e.g., *Catholic Charities of Albany v. Serio*, 7 N.Y.S.3d 510 (2006), *aff'd* 859 N.E.2d 459 (N.Y. 2006), *cert. denied*, 128 S. Ct. 97 (2007); *Catholic Charities of Sacramento v. Super. Ct.*, 90 Cal. App. 4th 425, 442 (Cal. Ct. App. 2001), *aff'd* 85 P.3d 67 (Cal. 2004); See also Women's Health and Wellness Act, ch. 554, N.Y. Laws 3458 (2002) (stating that the law only applies to plans which cover medications).

such, there were loopholes that prevented women from accessing contraceptives.²⁰

The HHS ruling regarding coverage in August, 2011 and the statement on religious exemptions in late January 2012 will greatly increase contraceptive access.²¹ A few employers who are controlled by or affiliated with religious institutions currently do not cover contraceptives, including the Catholic Church, which has a long held and unwavering stance that birth control is “intrinsically evil.”²² Such institutions were vehemently opposed to a coverage mandate and lobbied hard for the place of worship exemption appearing in the August 2011 interim final rule.²³ While the Obama Administration had been cautious so as to not impede on religious practices and beliefs, as can be seen in the religious carve out, in the face of great pressure from both women’s organizations and groups supporting access to family planning services, Secretary Sebelius refused to damage the legislation by providing a more expansive carve out to religiously affiliated entities.²⁴ Looking to the Supreme Court’s precedent in Free Exercise cases, as well as more recent state cases in New York and California that saw challenges to state mandates, there is no requirement to provide any exemptions for religion and the rational purpose and benefits that may result from expanding coverage should easily survive any future challenges.²⁵

20. *Supra* note 19.

21. Sebelius, *supra* note 14.

22. See CATECHISM OF THE CATHOLIC CHURCH § 2370 (1994) ([E]very action which, whether in anticipation of the conjugal act, or in its accomplishment or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible is intrinsically evil.) (internal citation omitted). The Church’s antipathy towards birth control dates back to the fifth century when Augustine of Hippo wrote that marriage is a legal contract designed specifically for procreation. See, e.g., ST. AUGUSTINE OF HIPPO SERMONS ON SELECTED LESSONS OF THE NEW TESTAMENT, Sermon 1, § 22, available at <http://www.newadvent.org/fathers/160301.htm> (last visited Dec. 15, 2011). The Church’s modern position against contraceptives was largely influenced by the publication of *Casti Connubii* by Pope Pius XI’s, which became the Church’s official marriage document until 1968. See also Craig Mandell, *Tough Pill To Swallow: Whether Catholic Institutions Are Obligated Under Title VII To Cover Their Employees’ Prescription Contraceptives*. 8 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 199, 201 (2008).

23. Stabile, *supra* note 16, at 749. See also, John H. Cushman, *Religious Groups Get Delay in Birth Control Insurance Requirements*, N.Y. TIMES, Jan. 20, 2012, <http://thecaucus.blogs.nytimes.com/2012/01/20/religious-groups-receive-additional-year-to-comply-with-health-law/?pagemode=print>.

24. See Sebelius *supra* note 14.

25. See *Hobbie v. Unemployment Appeals Comm’n of Fla.*, 480 U.S. 136, 144–45 (1987) (“This Court has long recognized that the government may ... accommodate religious practices ... without violating the Establishment Clause.”); *Cutter v. Wilkinson*, 504 U.S. 709 (2005) (“there is room for play in the joints between the Free Exercise and Establishment

I. THE BENEFITS OF INCLUDING CONTRACEPTION IN PREVENTATIVE CARE

The concept of preventative care,²⁶ such as contraception, is not an inventive topic in the healthcare arena. In recent years, a number of politicians, namely Hillary Clinton, John Edwards, Mike Huckabee, and current U.S. President Barack Obama, have specifically addressed the importance of preventive care in the United States.²⁷ One of the most important preventative methods that could be offered to benefit women is universal coverage of contraceptive methods. The unintended health effects and the costs associated with unintended pregnancies are underappreciated, as the effects of unintended pregnancy can be felt long after the birth of the child. According to the IOM Committee on Unintended Pregnancy, women with unintended pregnancies are more likely than those with intended pregnancies to receive later or no prenatal care, to smoke and consume alcohol during pregnancy, to be depressed during pregnancy, and to experience domestic violence during pregnancy.²⁸

In 2001, an estimated 49% of all pregnancies in the United States were unintended, and this rate has remained largely unchanged since then.²⁹ The rate in the United States is far higher than in many other developed nations.³⁰ Further, in 2001, 48% of U.S. unintended

clauses, allowing the government to accommodate religion beyond free exercise requirements, without offense to the Establishment Clause.” (quoting *Locke v. Davey*, 450 U.S. 712 (2004)); *Catholic Charities of Albany v. Serio*, 7 N.Y.S.3d 510 (2006), *aff'd* 859 N.E.2d 459 (N.Y. 2006), *cert. denied*, 128 S. Ct. 97 (2007); *Catholic Charities of Sacramento, v. Super. Ct.*, 90 Cal. App. 4th 425, 442 (Cal. 2001), *aff'd* 85 P.3d 67 (Cal. 2004).

26. According to the Institute of Medicine (IOM), “preventive services” for women are services that prevent conditions harmful to women’s health and well-being. “Conditions” are considered diseases, disabilities, injuries, behaviors, and functional states that have direct implications for women’s health and well-being. These conditions may be specific to women, such as gynecologic infections and unintended pregnancy. To “prevent” is to forestall the onset of a condition, detect a condition at an early stage, when it is more treatable, or slow the progress of a condition that may worsen or result in additional harm. See CLINICAL PREVENTATIVE SERVICES FOR WOMEN: CLOSING THE GAPS, INSTITUTE OF MEDICINE (2010) [hereinafter IOM Report].

27. Adam Marks, *Good Health and Low Costs: Why the PPACA’s Preventive Care Provisions May Not Produce Expected Outcomes*, 23 LOY. CONSUMER L. REV. 486, 486 (2011).

28. THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 250–51 (Sarah S. Brown & Leon Eisenberg eds., 1995).

29. Stanley Henshaw, *Issues in Contraception and Abortion: The Debate Rages*, in PUBLIC HEALTH IN THE 21ST CENTURY 347 (Madelon L. Finkel ed., 2011).

30. James Trussell, & L. L. Wynn, *Reducing Unintended Pregnancy In The United States*, 77 J. CONTRACEPTION 1, 4 (2008).

pregnancies ended in abortion.³¹ When the rate is broken down for various income and racial characteristics, the problem of unintended pregnancies become even more concerning. Unintended pregnancy is more likely among women who are between the ages of eighteen and twenty-four, who are unmarried, who have a low household income, who are not high school graduates, and who are members of a racial or ethnic minority group.³² The rate of unintended pregnancies in 2001 was almost three times higher among women with incomes below the federal poverty level as among those with income twice the poverty level.³³ Of the estimated 750,000 American teenagers between the ages of fifteen and nineteen that become pregnant each year,³⁴ 82% are unintended.³⁵ Non-Hispanic black women were almost three times as likely as non-Hispanic white women to have an unintended pregnancy, with rates of unintended pregnancy among Hispanic women falling in between.³⁶

There already exists a concerted effort to reduce the number of unintended pregnancies as the Healthy People 2020 initiative of HHS seeks to increase the number of intended pregnancies from 51% to 56%.³⁷ One of the easiest and most cost-effective ways to deal with the concern is through the use of contraceptives. In a 2001 report, the 11% of women not using any contraceptive method accounted for 52% of unintended pregnancies and 46% of abortions.³⁸ According to the Guttmacher Institute, increased contraceptive use has been found to be responsible for 77% of the decline in pregnancies among 15 to 17-year-olds between 1995 and 2002, and for the entire decline among 18 to 19-year-olds over the same period.³⁹ Increased access to contraception among publically funded programs alone accounted for

31. Henshaw, *supra* note 29, at 348.

32. Lawrence Finer & Stanley K. Henshaw, *Disparities In Rates Of Unintended Pregnancy In The United States, 1994 And 2001*, 38 PERSPECTIVES ON SEXUAL AND REPROD. HEALTH 90, 92 (2006).

33. *Id.*

34. GUTTMACHER INSTITUTE, U.S. TEENAGE PREGNANCIES, BIRTHS AND ABORTIONS: NATIONAL AND STATE TRENDS AND TRENDS BY RACE AND ETHNICITY 2 (2010).

35. *In Brief: Facts on American Teens' Sexual and Reproductive Health*, GUTTMACHER INSTITUTE (Feb. 2012), <http://www.guttmacher.org/pubs/FB-ATSRH.html>.

36. *Id.*

37. IOM Report, *supra* note 26. *See also Healthy People 2020: Topics & Objectives*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2011), *available at* <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>.

38. Henshaw, *supra* note 29, at 350 (while the reasons for not using contraception varied, the most often cited reason was the cost of the drug or device itself).

39. ADAM SONFIELD, GUTTMACHER INST., THE CASE FOR INSURANCE COVERAGE OF CONTRACEPTIVE SERVICES AND SUPPLIES WITHOUT COST-SHARING 7, 8 (2011) *available at* <http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.pdf>.

the avoidance of 1.94 million unintended pregnancies in 2006.⁴⁰ The public funding of these services has been particularly effective among poor populations where the access to contraception has reduced the number of unintended pregnancies by half.⁴¹

While its effectiveness and utility have been almost universally proven,⁴² the use of preventative services is still a concern, as statistics show that Americans use preventive services at approximately half the recommended rate.⁴³ One of the biggest problems leading to the depressed usage of preventative care is cost.⁴⁴ Preventative care, prior to the ACA, was often expensive. Brand-name versions of the contraceptive pill, patch or ring, the most commonly used contraceptive methods, can cost over sixty dollars per month if paid out-of-pocket, not including the cost of a visit to the healthcare provider.⁴⁵ The longer lasting contraceptive methods, such as IUDs⁴⁶ and sterilization, require thousands of dollars in upfront costs.⁴⁷ These facts underlie the reasons why the rate of unintended pregnancies and contraceptive usage are highest among the uninsured population.⁴⁸ Four out of every ten low-income women of reproductive age in the United States have no insurance at all, while more than six in ten are not covered by Medicaid.⁴⁹ This leaves a large number of those most in need without access to contraceptives.

Even for plans that cover contraceptives, the cost sharing was often cost prohibitive. A 2010 study found that women with private insurance covering prescription drugs paid 53% of the cost of their

40. *Id.*

41. *Id.*

42. *Id.* at 7.

43. *Background: The Affordable Care Act's New Rules on Preventive Care*, U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTHCARE.GOV (July 14, 2010), available at <http://www.healthcare.gov/news/factsheets/2010/07/preventive-care-background.html>.

44. See Sonfield, *supra* note 39, at 7.

45. *Id.* at 9.

46. Intrauterine Devices are inserted into the uterus and deliver doses of contraception over long periods of time without requiring the woman to maintain a daily pill regimen. These longer lasting methods are largely considered to be more effective given that they greatly reduce human error attributed to missing or mistimed pills, or incorrect usage. CONTRACEPTION FAQ: INTRAUTERINE DEVICE, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (2012), available at <http://www.acog.org/~media/For%20Patients/faq014.pdf?dmc=1&ts=20120511T2039015416>

47. Sonfield, *supra* note 39, at 9.

48. See *id.*

49. *State Medicaid Programs and Pregnancy Prevention*, PLANNED PARENTHOOD ACTION FUND (2011), <http://www.plannedparenthoodaction.org/positions/medicaid-pregnancy-prevention-625.htm>.

oral contraceptives, and what they paid for a full year of contraceptive pills amounted to 29% of their annual out-of-pocket expenditures for all health services.⁵⁰ Across the board, the costs and the number of preventative tests are greater for women than men,⁵¹ due largely to the reproductive concerns and gender-specific conditions that require more frequent and numerous testing.⁵² A 2010 Commonwealth Fund survey found that 44% of adult women (compared with 35% of adult men) reported that they had either a problem paying medical bills or indicated that they were paying off medical debt—a steep increase from 38% in 2005.⁵³

Recognizing that cost constraints prevent many women from taking advantage of family planning services, the IOM recommended and HHS adopted a mandate that private plans offer such services free of cost.⁵⁴ However, HHS is not alone in its acknowledgments of the need to offer coverage of contraceptive methods. The National Business Group on Health (NBGH), in a health-plan purchasing guide created in partnership with the CDC and the Agency for Healthcare Research and Quality (AHRQ), advises large employers to purchase health plans that cover family-planning services as a minimum preventive-service benefit.⁵⁵ The NBGH, with funding from the Health Resources and Services Administration (HRSA), advises employers to invest in maternal and child health through no-cost coverage of family-planning care.⁵⁶ The NBGH's model benefits plan recommends coverage of family-planning care with no cost sharing and with no limits on counseling services, medications, or procedures

50. *Id.*

51. See Steven M. Asch et al., *Who Is At Greatest Risk For Receiving Poor-Quality Health Care?*, 354 NEW ENG. J. MED. 1147, 1151 (2006).

52. See Klea D. Bertakis et al., *Gender Differences In The Utilization Of Health Care Services*, 49 J. FAMILY PRACTICE 2, 147–52 (2000); see also K.H. Kjerulff, K. D. Frick, J. A. Rhoades & C. S. Hollenbeak, *The Cost Of Being A Woman: A National Study Of Healthcare Utilization And Expenditures For Female-Specific Conditions*, 17 WOMEN'S HEALTH ISSUES 1, 13–21 (2007).

53. IOM Report, *supra* note 26, at 19–20; Ruth Robertson & Sara Collins, *Women At Risk: Why Increasing Numbers of Women Are Failing To Get The Health Care They Need And How The Affordable Care Act Will Help*, THE COMMONWEALTH FUND (2011), <http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/May/Women-at-Risk.aspx>.

54. IOM report, *supra* note 26, at 18.

55. NATIONAL BUSINESS GROUP ON HEALTH, A PURCHASER'S GUIDE TO CLINICAL PREVENTIVE SERVICES: MOVING SCIENCE INTO COVERAGE, (2011), available at <http://www.businessgrouphealth.org/benefitsttopics/topics/purchasers/fullguide.pdf>.

56. *Id.*; NATIONAL BUSINESS GROUP ON HEALTH, INVESTING IN MATERNAL AND CHILD HEALTH: AN EMPLOYER'S TOOLKIT 41 (2010), available at http://businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_allpages.pdf.

when issued by an approved provider.⁵⁷ The NBGH notes that coverage of family-planning services and all FDA-approved prescription contraceptive methods is cost effective for plans.⁵⁸ As such, there is wide support among industry and women's groups to mandate coverage.

II. COVERAGE OF CONTRACEPTION PRIOR TO THE PASSAGE OF THE ACA

A. State Mandated Coverage and Federal Coverage

The coverage landscape prior to the passage of the ACA and the subsequent HHS rule exhibited little standardization for services covered or cost sharing requirements.⁵⁹ While there was more coverage and standardization among the federal programs, the extent of coverage in the private sector, especially for services like contraception, has depended largely on the state in which the plan was being administered.⁶⁰ As a foundation point, states have broad powers over the manufacture, sale and distribution of contraceptive products and may regulate the coverage of such products as a valid exercise of police powers.⁶¹

Even in the face of this variability in coverage, contraceptives are still widely used and the majority of plans cover FDA-approved contraceptives, even in states where there is no requirement of coverage.⁶² In 2002, more than 89% of insurance plans covered some type of contraceptive methods.⁶³ A 2010 survey of employers found that 85% of large employers and 62% of small employers covered

57. NATIONAL BUSINESS GROUP ON HEALTH, INVESTING IN MATERNAL AND CHILD HEALTH: AN EMPLOYER'S TOOLKIT 41 (2010).

58. *Id.*

59. IOM Report, *supra* note 26, at 47.

60. *Id.* at 49.

61. See *Planned Parenthood Comm. of Phoenix, Inc. v. Maricopa Cnty.*, 375 P.2d 719 (Ariz. 1962); *Sanitary Vendors, Inc. v. Byrne*, 178 A.2d 259 (N.J. Super. 1962), *aff'd*, 190 A.2d 876 (N.J. 1963). See also *Griswold v. Connecticut*, 381 U.S. 479 (1965) and *Baird v. Eisenstadt*, 429 F.2d 1398 (1st Cir. 1970), *judgment aff'd*, 405 U.S. 438 (1972) (Statutes which absolutely prohibit the use of contraceptives or prohibit the delivery of contraceptives do not bear a real and substantial relation to public health, safety, morals or some other phase of general welfare so as to be constitutional.)

62. See LAW STUDENTS FOR REPROD. JUSTICE, CONTRACEPTIVES AND EMERGENCY CONTRACEPTION FACTSHEET (2011), available at http://lsrj.org/documents/factsheets/11_Contraception.pdf.

63. Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives And The Impact Of Contraceptive Coverage Mandates*, 2002, 36 PERSPECTIVES ON SEXUAL & REPROD. HEALTH 72, 72 (2004).

FDA-approved contraceptives.⁶⁴ The majority of states mandate insurance coverage of contraceptive prescription drugs, devices, and outpatient services.⁶⁵ Some other states require coverage for only particular types of contraceptives.⁶⁶ Some states, like Texas, “require only that insurers give employers the option of purchasing contraceptive coverage.”⁶⁷ As of November 2011, contraceptive coverage by insurance companies was mandated in twenty-eight states, and seventeen of those states also required coverage of the related outpatient services.⁶⁸ Of this group, Arkansas and North Carolina allow for the exclusion of coverage of emergency contraception.⁶⁹ In addition, West Virginia does not provide coverage of minor dependents.⁷⁰ Twenty of these states offset that mandatory benefit by allowing a “religious exemption” or a “loophole that permits businesses and/or insurance companies to refuse contraception coverage based on a religious view held by the employer and/or insurance company, though not necessarily by the employees and/or policy holders,” and Missouri allows an employer the right to refuse to cover contraception for any reason.⁷¹ Four states require those insurers who choose to not cover contraceptives to provide coverage through another entity or on their own, but at the group rate.⁷² However, just because a state mandates coverage does not mean that all plans in the state were in compliance, and a 2002 study found that there were large disparities in coverage between HMOs, PPOs and POS plans, even in states that mandated coverage.⁷³

64. IOM Report, *supra* note 26, at 49. (Small employers are defined as those having less than 500 employees, and large employers have more than 500.)

65. *State Policies*, *supra* note 17. (Maryland mandates contraceptive coverage under § 15–826 and reports compliance by most entities.)

66. *See State Policies*, *supra* note 17.

67. *Id.* *See also* Westlaw Fifty–State Statutory Surveys, Mandated Benefits: Mandated Contraceptive Coverage, (Oct. 2011).

68. *See State Policies*, *supra* note 17.

69. *See* GUTTMACHER INSTITUTE, *supra* note 39.

70. *Id.*

71. *Id.* These states are Arizona, Arkansas, California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, and West Virginia.

72. *State Policies*, *supra* note 17.

73. Adam Sonfield, *The Movement Against Health Insurance Benefit Mandates: Assessing the Dangers*, GUTTMACHER INSTITUTE (2006), <http://www.guttmacher.org/pubs/gpr/09/2/gpr090207.html>. [The 2002 figures are as follows (plans with coverage in states with mandates – no mandates): Health Management Organizations (HMOs) (92% – 61%), Preferred Provider Organizations (PPOs) (92% – 47%), Point-of-Service (POS) (87% – 59%)].

These state law mandates take the form of insurance law provisions requiring that insurance plans providing prescription coverage must also provide for coverage of prescription contraceptives. That is, the statutes do not actually mandate that an employer provide employees with contraceptive coverage, but that if medical benefits are provided to its employees through an insured plan, and if the plan provides for any prescription coverage, it must also cover prescription contraceptives.⁷⁴ This yields an undesired, but potential roundabout whereby the employer can avoid covering contraceptives by refusing to cover prescription drugs at all or by not offering health welfare benefits.

Another way plans can escape these requirements is through federal preemption by the Employee Retirement Income Security Act of 1972 (ERISA).⁷⁵ State mandates requiring coverage of contraceptives only apply to insured plans and not to self-insured plans that are exclusively governed by ERISA. Under the “insurance savings clause” of ERISA, all state laws that govern the business of insurance, such as mandated benefits, are exempt from ERISA preemption as it is established in ERISA § 512.⁷⁶ All insured employee benefit plans, due to ERISA’s “deemer clause,” are deemed to be included in the umbrella of the insurance savings clause, and as such, state insurance law mandates will apply to these plans in addition to ERISA mandates.⁷⁷ Conversely, self-funded plans⁷⁸ are not deemed to be in the business of insurance, and are therefore exclusively under the guidance of ERISA and federal mandates that apply to this law, and do not have to comply with state mandates that go beyond federal minimum coverage.⁷⁹

74. *Stabile*, *supra* note 16, at 742.

75. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

76. *Id.* at § 514 (Any state law that governs an area that is *also* governed by ERISA is preempted and the state law will be invalid to those plans. The Federal coverage requirements had not covered contraceptives or many other female preventative treatments or products until ERISA was amended as part of ACA.).

77. *Id.*

78. Insured plans involve the employer contracting with an insurance company to cover the risk associated with having a health plan. Self-funded plans are those employee welfare plans where the entity establishing the plan assumes all of the risk associated with paying out and distributing claims as in accordance with the plan. Since they don't involve insurance companies, which are under the purview of states, self-funded plans cannot be regulated by states. *See* N.Y. St. Conference of Blue Cross & Blue Shield Plans v. Travelers, 514 U.S. 645 (1995).

79. *See* ERISA, *supra* note 75, at § 514.

The self-funded/insured plan difference is important, as all previous laws mandating coverage had been passed by state legislatures, meaning that self-insured plans had been able to escape the requirement. To take advantage of ERISA preemption and avoid covering contraceptives, many religious entities converted to self-insured plans. It was not until the passage of ACA that these plans could also be brought into the fold and be required (unless there is a strict religious exemption or they are a grandfathered⁸⁰ plan) to provide contraceptive coverage.⁸¹ Religious entities have also tried to escape mandatory coverage through First Amendment litigation brought on behalf of entities that could not satisfy the definition of a religious employer in their respective state statute.⁸²

Since 1999, almost all Federal Employee Health Benefit (FEHB) program plans are required to cover all approved contraceptive supplies and devices, and many federal programs offer coverage or provide incentives (Medicaid) to entice states to do so.⁸³ The FEHB program purchases health insurance coverage through private plans for federal workers and their dependents.⁸⁴ The preventive services covered, provider networks, and out-of-pocket spending responsibilities for these private plans vary by state, which will change under the new ACA rules. In 2009, about 850,000 disabled women under 45 years old were enrolled in Medicare,⁸⁵ but coverage of contraceptives under Medicare only applies to Part D coverage, a voluntary program.⁸⁶ The extent of their out-of-pocket costs and the scope of coverage for prescriptions were largely dependent on the type of Part D drug plan that they selected.⁸⁷ Since 1972, the various Medicaid programs have been required to cover “family planning services and supplies furnished to individuals of childbearing age

80. See Interim final rules for group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726–41756 (2010). Plans which are grandfathered do not have to offer the expanded benefits unless they lose this status. Plans will lose their “grandfather” status if, compared to March 23, 2010, they significantly cut or reduce benefits, raise co-insurance charges or significantly raise co-payment charges or deductibles, significantly reduce employer contributions, tighten annual limits on what insurers will pay, or change insurers. Plans that make any of these changes can be deemed to lose their grandfather status and will be required to follow the ACA preventive benefit coverage rules. *Id.*

81. *Id.*

82. Stabile, *supra* note 16, at 741–43.

83. IOM Report, *supra* note 26, at 57–58.

84. *Id.*

85. *Id.* at 59.

86. *Id.* at 58.

87. *Id.*

(including sexually active minors), who are eligible under the state's plan, and who desire such services and supplies," and these services must be provided without cost sharing.⁸⁸ In return for covering such drugs, states received a 90% federal match on the funds that they spent on these services, and as such, all states provided such coverage.⁸⁹ TRICARE⁹⁰ and the Peace Corps cover without cost formulary contraceptives purchased at approved treatment facilities or medical units.⁹¹

B. Early Attempts to Secure a National Coverage Mandate

While there has been no express federal requirement mandating coverage of contraceptive methods until 2011 HHS decision, there have been a number of previous actions that many groups have interpreted as a de jure requirement of coverage and a number of legislative attempts to install a national mandate.⁹² No such previous attempt has been victorious.⁹³ One of the strongest arguments for mandatory coverage came from the evolution of the Pregnancy Discrimination Act (PDA), which amended Title VII of the Civil Rights Act of 1964 that sought to end "discrimination in employment and to place all men and women, regardless of race, color, religion, or national origin, on equal footing in how they were treated in the [workforce],"⁹⁴ and mandated that "[i]t shall be an unlawful employment practice for an employer . . . to discriminate against any individual . . . because of such individual's . . . sex."⁹⁵ The PDA was passed to reverse the holding of the U.S. Supreme Court in *General Elec. Co. v. Gilbert*, where the Court held that an employer's selective exclusion of benefits for pregnancy-related disabilities did not constitute sex discrimination under Title VII.⁹⁶

88. See USHA RANJI ET AL., STATE MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: SUMMARY OF STATE SURVEY FINDINGS (2009), available at <http://www.kff.org/womenshealth/upload/8015.pdf>. See also IOM Report, *supra* note 26, at 61.

89. *Id.*

90. TRICARE is the health plan which is available for currently serving members of the military and their families. *What is Tricare?*, TRICARE.MIL (March 6, 2012), <http://tricare.mil/mybenefit/home/overview/WhatIsTRICARE>.

91. IOM Report, *supra* note 26, at 63.

92. See *infra* notes 105–07 and accompanying text.

93. *Id.*

94. See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1269 (W.D. Wash. 2001).

95. 42 U.S.C. § 2000e–2(a) (2006).

96. *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 145–46 (1976).

In the 1990s, spurred by the coverage of male-oriented drugs such as Viagra, women's groups began to question whether the PDA did, in fact, actually require the coverage of contraceptives.⁹⁷ Their answer did not come until 2000 when a ruling by the Equal Employment Opportunity Commission (EEOC) found that employers offering plans that provided coverage for drugs, devices, and preventive care, but not including coverage for preventive contraceptives, were in violation of the Pregnancy Discrimination Act.⁹⁸ While not binding on the courts of law, the EEOC decision does carry significant weight and influence given that it is the agency charged with administering Title VII.⁹⁹ This decision was not without challenge, and although it was upheld by a federal district court in the state of Washington one year after it was delivered,¹⁰⁰ the U.S. Court of Appeals for the Eighth Circuit ruled in a 2-to-1 decision that an employer may exclude contraception coverage from its health plan without violating the Pregnancy Discrimination Act because the employer also failed to cover condoms and vasectomies that affect men.¹⁰¹ The court in *Erickson v. Bartell Drug Co.* concluded that when an employer decides to selectively exclude drugs from an otherwise comprehensive prescription drug plan, "it has a legal obligation to make sure that the resulting plan does not discriminate based on sex-based characteristics and that it provides equally comprehensive coverage for both sexes."¹⁰² However, even in this narrow exception, the EEOC decision still controls, and therefore creates the connection between Title VII and mandatory contraception coverage. As such, opponents have continued to attack that decision and to broaden the Eighth Circuit opinion in *In re Union Pac. R.R. Emp't Practices Litig.*, but to no avail. With the 2011 HHS coverage mandate and its federal

97. See, e.g., Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 373 (1998).

98. *Decision on Coverage Of Contraception*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N (Dec. 14, 2000), available at <http://www.eeoc.gov/policy/docs/decision-contraception.html>.

99. See, e.g., *Bragdon v. Abbott*, 524 U.S. 624, 642 (1998) ("[T]he well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944))); *In re Union Pac. R.R. Emp't Practices Litig.*, 378 F. Supp.2d 1139, 1143 (D. Neb. 2005) ("The EEOC's policy is not binding on this Court, but is entitled to some deference, because the EEOC is the administrative body responsible for enforcement of Title VII and the PDA.")

100. *Erickson*, 141 F. Supp. 2d at 1276.

101. *In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 944 (8th Cir. 2007).

102. *Erickson*, 141 F. Supp. 2d at 1272.

law applicability, there will likely be federal challenges to the decision instead of primarily state actions.¹⁰³

In an attempt to give the EEOC decision a more established legal footing, Democrats in the U.S. Congress attempted to institute a national contraceptive mandate in 2007 through the Equity in Prescription Insurance and Contraception Act by way of reintroducing the failed Putting Prevention First Act of 2004.¹⁰⁴ The 2007 act was introduced simultaneously by Senate Majority Leader Harry Reid (D–NV), and Rep. Louise McIntosh Slaughter (D–NY). However, its eleven cosponsors in the Senate and 130 cosponsors in the House were not successful in gaining passage. While the main goal of the bill was to lower the levels of unintended pregnancies, a driving force behind the bill concerned the fact that women of lower socioeconomic status generally cannot afford to pay for contraception and reproductive health services.¹⁰⁵ To combat this concern, the 2007 Act mandated full coverage of contraceptive methods without cost sharing and did not include any exemptions, religious or otherwise.¹⁰⁶

III. ACA AND THE EXTENDING COVERAGE: THE IOM REPORT AND THE HHS DECISION

For the first time, federal rules stipulate that women's preventive services must be covered while also prohibiting out-of-pocket payments for individuals who obtain these covered services from in-network providers.¹⁰⁷ The PPACA and the subsequent HHS approval of the Institute of Medicine (IOM) recommendations with

103. See *infra* Part IV.

104. See Putting Prevention First Act of 2004, H.R. 4192, 108th Cong. (2nd Sess. 2004); Putting Prevention First Act of 2004, S. 2336, 108th Cong. (2nd Sess. 2004); see also, Equity in Prescription Insurance and Contraceptive Coverage Act of 2007, H.R. 2412, 110th Cong. (1st Sess. 2007). The 2007 version of the 2004 bill was introduced under the name Equity in Prescription Insurance and Contraceptive Coverage Act of 2007.

105. See generally, 153 CONG. REC. 3130–31 (2007) (Statement of Rep. Louise Slaughter on the Prevention First Act).

106. Equity in Prescription Insurance and Contraceptive Coverage Act of 2007, H.R. 2412, 110th Cong. (1st Sess. 2007).

107. See Interim Final Rules For Group Health Plans And Health Insurance Issuers Relating To Coverage Of Women's Preventive Services Under The Patient Protection And Affordable Care Act, 75 Fed. Reg. 41731 (proposed July 19, 2010) (to be codified at 45 C.F.R. pt. 147) (Section 2713 of the PHS Act, as added by the Affordable Care Act and incorporated under section 715(a)(1) of ERISA and section 9815(a)(1) of the Internal Revenue Service Code, states that a group health plan and a health insurance issuer which offers group or individual health insurance coverage must provide benefits for and prohibit the imposition of cost-sharing with respect to a number of these preventative measures); See also, Marks, *supra* note 27, at 486.

respect to women's preventative health measures are aimed at ensuring that all women have access to preventative care, minimizing problems with access to family planning and contraceptives.¹⁰⁸ For non-grandfathered private plans,¹⁰⁹ this will be achieved through the elimination of cost sharing for not only the product, but the corresponding visit as well.¹¹⁰ In addition to private plans, plans that are offered under the FEHB (Federal Employee Health Benefit) program either are or will be required to offer coverage of all services that are recommended by the USPSTF, the ACIP, and Bright Futures, including contraceptives.¹¹¹ The plans offered under the FEHB program either are or will be required to offer coverage for preventive services for women without cost sharing if the services are obtained from an in-network provider.¹¹²

However, the coverage of preventative care for women almost did not happen. Coverage of women's preventative care and screenings was not included in the original drafting of the Affordable Care Act as it was originally written.¹¹³ In 2009, the U.S. Preventive Services Task Force (USPSTF),¹¹⁴ the body in charge of reviewing and making recommendations for both frequency and type of preventative care which individuals should receive, issued a recommendation that worried many women's health proponents—

108. Press Release, U.S. Dep't of Health & Human Services, Affordable Care Act Ensures Women Receive Preventive Services at No Additional Cost (August 1, 2011), available at <http://www.hhs.gov/news/press/2011pres/08/20110801b.html> [hereinafter U.S. Health and Human Services]

109. See *Fact Sheet*, *supra* note 11.

110. See Amendments to Interim Final Rules for Group Health Plan Coverage, 76 Fed. Reg. 46623 (proposed Aug. 3, 2011) (to be codified at 45 C.F.R. pt. 147).

111. This extends only the no cost sharing requirement to federal employee health plans given that these plans have covered access to contraceptives since 1997. IOM Report, *supra* note 26, at 58.

112. *Id.* at 57–58.

113. Adam Sonfield, *Contraception: An Integral Component of Preventative Care for Women*, GUTTMACHER INSTITUTE (2010), <http://www.guttmacher.org/pubs/gpr/13/2/gpr130202.html>.

114. The U.S. Preventive Services Task Force (USPSTF), first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the Agency for Healthcare Research and Quality (AHRQ), is the leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Its recommendations are considered the "gold standard" for clinical preventive services. The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for clinical preventive care. IOM Report, *supra* note 26.

pushing back the recommended first mammogram to age fifty (from age forty) and every two years (instead of every year).¹¹⁵ To counter the conservative allegations that this decision was evidence that federal healthcare reform would lead to care rationing and to ensure that access to women's health screenings was increased, liberal proponents of the legislation, led by Sen. Barbara Mikulski (D-MD) sought to write mandatory coverage for women's preventative health and care into the landmark health legislation.¹¹⁶ Representing the first major Senate amendment to what would become the ACA, Sen. Mikulski's Women's Health Amendment was passed on December 3, 2009 by a vote of 61–39 in the Senate,¹¹⁷ and it added women's preventive care and screenings as a fourth category of mandated preventive services.¹¹⁸ The amendment stated that all new insurance plans to which the ACA is applicable must cover preventive services (including counseling, screenings, and interventions) that are backed by scientific evidence and included in the comprehensive guidelines from HRSA (in addition to services already recommended by the USPSTF which received an "A" or "B" rating¹¹⁹).¹²⁰ By

115. Sonfield, *supra* note 113, at 3.

116. Meredith Cohn & Kelly Brewington, *In Battle Over Mammograms, MD. Leaders Race to Front Lines; Politicians, Activists Quickly Oppose Relaxed Guidelines*, *BALT. SUN*, Nov. 22, 2009, at 1A; *see also*, H.R. 3590, 111th Cong. (1st Sess. 2009).

117. David M. Herszenhorn & Robert Pear, *Senate Backs Preventative Healthcare for Women*, *N.Y. TIMES*, Dec. 3, 2009, at 21 (The vote was 61 to 39, with three Republicans joining 56 Democrats and the two independents in favor).

118. Marks, *supra* note 27, at 488–89 (“Regarding preventive care, section 1001 of the PPACA adds section 2713 to the Public Health Service Act (“PHSA”) and reads in part: A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for: (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; [and] (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.”).

119. *Id.* at 489–90 (“In accordance with section 2713, the U.S. Preventive Services Task Force (“USPSTF”) has a significant role in determining which preventive services are covered. The USPSTF reviews scientific evidence related to the effectiveness and appropriateness of clinical preventive services for the purpose of developing recommendations. The USPSTF is composed of a panel of non-federal experts in prevention and evidence-based medicine. The panel of experts includes: internists, pediatricians, family physicians, gynecologists, obstetricians, nurses, and health behavior specialists. With regard to the new legislation, this panel is tasked with rating preventive services based on the strength of scientific evidence documenting their benefits. Those services that are graded as 'A' or 'B' are designated as

creating coverage for services above and beyond those recommended by USPTF, the amendment successfully countered the Republican attacks that health reform would lead to decreased care, and that the amendment failed to guarantee coverage for the very concerns (mammogram coverage) which led to its drafting. In an HHS rule published in the federal register on July 19, 2010, insurance companies were required to provide coverage for women's preventative care as defined by forthcoming HRSA guidelines that expanded upon the previous USPSTF recommendations.¹²¹

However, there was debate over what types of preventative care were intended to be covered by the broadly worded amendment, most specifically concerning contraceptive coverage. HRSA was challenged to decide if the legislative record concerning the amendment showed a clear intent by the Senate to include family planning coverage along with the more commonly covered women's preventative services, such as mammograms.¹²² While much of the debate in the Senate over the Mikulski Amendment concerned mammography, there was an intention by its drafters and sponsors that it would guarantee coverage without cost-sharing for a far broader group of preventive services, including family planning.¹²³ During the debate, at least six senators joined with Sen. Mikulski in praising the amendment's inclusion of family planning services.¹²⁴ On the floor, Sen. Al Franken (D-MN) stated, "several crucial women's health services are omitted [from the USPSTF recommendations, but] Sen. Mikulski's amendment closes this gap [by including] . . . well woman visit, prenatal care, and family planning."¹²⁵ Sen. Barbara Boxer (D-

sufficiently evidence-based, and are thus covered under the new regulations."); *see also* IOM Report, *supra* note 26, at 30-33 (for a complete methodology of their decision making process).

120. NATIONAL WOMEN'S LAW CENTER, DENYING COVERAGE OF CONTRACEPTIVES HARMS WOMEN 1-3 (2011), *available at* http://www.nwlc.org/sites/default/files/pdfs/fs_on_the_relig_exempt_to_cc_without_cost-sharing_november_2011.pdf.

121. Interim Final Rules For Group Health Plans And Health Insurance Issuers Relating To Coverage Of Women's Preventive Services Under The Patient Protection And Affordable Care Act, 75 Fed. Reg. 41731 (proposed July 19, 2010) (to be codified at 45 C.F.R. pt. 147).

122. Donna Crane, Policy Director for NARAL Pro-Choice America, Comments to IOM: The Women's Health Amendment: Ensuring Access to Comprehensive Preventative-Health Care, (Nov. 16, 2010), *available at* http://www.prochoiceamerica.org/assets/iom_panel.pdf.

123. Press Release, Senator Barbara A. Mikulski, Mikulski Puts Women First in Health Care Reform Debate (Nov. 30, 2009), *available at* <http://www.mikulski.senate.gov/media/pressrelease/11-30-2009-2.cfm>

124. Sonfield, *supra* note 113, at 3.

125. *Id.* at 3-4.

CA) seemed to elaborate on just what might be covered when she said that “these healthcare services include annual mammograms for women at age 40, pregnancy and postpartum depression screenings, screenings for domestic violence, annual women’s health screenings, and family planning services.”¹²⁶ Further, Sen. Diane Feinstein (D–CA) included family planning services when describing the scope of the amendment and stated that the basic services covered would be those needed throughout a woman’s life.¹²⁷ Sen. Ben Nelson (D–NE), who voted against the amendment because of a claim that it could lead to mandated coverage of abortion, said that he opposed the amendment “with regret because I strongly support the underlying goal of furthering preventive care for women, including mammograms, screenings, and family planning.”¹²⁸

While there was a general acknowledgement that family planning coverage was intended and should find a strong place in the mandated preventative services, the job of fleshing out the bare bones authorization for women’s preventative care measures given to HRSA was left ultimately to the IOM, acting as the scientific resource for HHS’s final coverage rule.¹²⁹ The IOM was tasked by HRSA to make recommendations on just what preventative services should be offered as part of the women’s preventative care package.¹³⁰ The IOM met extensively with interest groups and women’s health organizations, and it held public forums with public comments to supplement and amend their own care recommendations.¹³¹ Because the committee was charged to recommend coverage for services that were outside of those already recommended under the USPTF and other like federal bodies, the IOM committee conducted a review of the currently recommended services, and made note of the coverage gaps they felt ought to be filled.¹³² With the coverage gaps in mind, the committee sought to expand the number of services that they felt ought to be offered without cost sharing as part of a complete preventative care package, including those concerning prevention of unintended pregnancies.¹³³ Finding that contraception and contraceptive counseling were not currently among those preventive services

126. *Id.* at 4.

127. *Id.*

128. *Id.*

129. IOM Report, *supra* note 26, at 1–2.

130. *Id.*

131. *Id.* at 22–23.

132. *Id.* at 67–74.

133. *Id.* at 102.

available to women under the ACA, the committee recommended coverage of “the full range of Food and Drug Administration–approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.”¹³⁴ However, the IOM recommendations required HRSA approval to be included among the other preventative services then covered through the ACA. Presented with the IOM recommendations, HRSA adopted them in large part on August 1, 2011, including FDA–approved contraception methods and contraceptive counseling.¹³⁵ These recommendations became part of the preventative services offered through the ACA, and all plans subject to the ACA will be required to cover the women’s preventative services without cost sharing by the start of the first plan year after August 1, 2012.¹³⁶

Notably, public commenting leading up to the HRSA decision regarding the IOM recommendations, specifically regarding the mandatory coverage of contraceptives, led the administration to consider coverage exemptions. Many commentators, including religious organizations, recommended that the guidelines include binding coverage of contraceptive services for all women.¹³⁷ However, several commentators asserted it would be a violation of religious freedom to require group health plans sponsored by religious employers to cover contraceptive services that their faith deems contrary to religious tenets, especially when some of these entities do not currently offer such coverage for religious reasons.¹³⁸ These comments prompted HHS and the Obama Administration to issue an amendment to the mandated coverage requirements for plans sponsored by “houses of worship.”¹³⁹

On August 1, 2011, the HHS amendment became effective,¹⁴⁰ allowing HRSA to offer an exemption for plans offered by employers who are deemed by HHS to qualify as a “religious employer” so that they may choose whether or not to cover contraceptives, mirroring the

134. IOM Report, *supra* note 26, at 109–10.

135. U.S. Health and Human Services, *supra* note 108.

136. *Id.*

137. Amendments to Interim Final Rules for Group Health Plan Coverage, 76 Fed. Reg. 46623 (proposed Aug. 3, 2011) (to be codified at 45 C.F.R. pt. 147). Such a decision would close a coverage gap currently in place in many states that mandate coverage, employees of religious employers often are not covered for contraceptive use even if they do not personally subscribe to the religious tenets of their employer. *See supra* Parts I–II.

138. Amendments to Interim Final Rules for Group Health Plan Coverage, *supra* note 137.

139. *Id.*

140. *Id.* at 46621.

policy in place in many states which currently mandate contraceptive coverage.¹⁴¹ However, controversially, HHS did not allow commenting on the amendment, breaking from normal notice and comment rulemaking, as is required by the Administrative Procedure Act (APA) § 553, finding that such a period would be unnecessary as there was already a comment period following the initial rule giving HRSA the power to define the preventative services where many comments regarding a potential religious exemption were received.¹⁴² Even though the wording of the religious exemption makes the exemption applicable only to places of worship, the decision to expand the exemption to other religious organizations was under consideration until January 20, 2012.¹⁴³

The majority of the comments received supported the Obama administration's firm stance on having a narrow exemption. Many women's health advocates decried the administration as giving in too quickly to religious interests.¹⁴⁴ However, because the definition of "religious employer" was narrow enough that its applicability might be limited, the United States Conference of Catholic Bishops (USCCB) voiced its opposition to and disappointment with the HHS rule due to its failure to ensure broader exemptions for religiously aligned organizations.¹⁴⁵ The National Catholic Bioethics Center (NCBC) has

141. The amendment defines a religious employer is 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 non-profit organization under section 6033(a)(1) and section 5033(a)(3)(A)(i) or (iii) of the Code [of Federal Regulations]. Section 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order. *Id.* at 46623.

142. *Id.* at 46624 ("Under the Administrative Procedure Act (APA) (5 U.S.C. 551, et seq.), while a general notice of proposed rulemaking and an opportunity for public comment is generally required before promulgation of regulations, an exception is made when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority to issue interim final rules granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act . . . The Departments have determined that an additional opportunity for public comment would be impractical and contrary to the public interest.").

143. Robert Pear, *Democrats Urge Obama to Protect Contraceptive Coverage in Health Plans*, N.Y. TIMES, Nov. 20, 2011, at 16; Sebelius, *supra* note 14.

144. See Editorial, *Women's Rights at Risk*, TAMPA BAY TIMES, Dec. 2, 2011, at 14A; Gail Collins, Op-Ed, *An Early Holiday Hangover*, N.Y. TIMES, Dec. 17, 2011, at 25.

145. See *supra* Part IV; *Bishops Decry HHS Rule, Urge Catholics To Stand Up For Religious Liberty And Conscience Rights In Homilies At Vigil For Life*, U.S. CONFERENCE OF CATHOLIC BISHOPS, Jan. 23, 2012, <http://usccb.org/news/2012/12-015.cfm>.

also strongly opposed this mandate.¹⁴⁶ Until January 20, 2012, religiously affiliated entities were fighting hard for the administration to expand the coverage of the exemption beyond obviously religious entities, such as churches, even though there is broad acceptance of contraception by about three-quarters of Catholic and Republican women.¹⁴⁷ In a 2010 study conducted by Hart Research on behalf of Planned Parenthood, the vast majority of women voters (81%), Republican women voters (72%), and Catholic women voters (77%) said that contraception should be covered under preventative healthcare services.¹⁴⁸ With the comments and the overall support for contraceptive coverage among the vast majority of Americans, HHS refused to expand the exemption beyond plans sponsored by places of worship.¹⁴⁹

Another limitation on the application of this rule is in relation to public plans. Because the preventative services covered under PHSA § 2713 only affects private plans, public government sponsored plans are not subject to its provisions.¹⁵⁰ As such, Medicaid, Medicare, military health plans such as TRICARE,¹⁵¹ and Veteran Affairs and the Indian Health Service (which covers nearly two million American Indians and Alaska natives)¹⁵² are not required to cover the services, nor are they subject to the elimination of cost sharing that PPACA has set into motion.¹⁵³ However, many of these public plans already cover contraceptives, although not without cost sharing for both the visit and the product.¹⁵⁴ For instance, Medicare has its own provisions for the coverage for these services, and Medicaid provides significant

146. Letter from Marie T. Hilliard, Director of Bioethics and Public Policy, National Catholic Bioethics Center, to Kathleen Sebelius, Secretary, Dep't of Health & Human Services (Sept. 27, 2011), *available at* <http://www.ncbcenter.org/www.ncbcenter.org/document.doc?id=209>.

147. Press Release, Planned Parenthood Federation of America, Survey: Nearly Three in Four Voters in America Support Fully Covering Prescription Birth Control (Oct. 12, 2010) *available at* <http://www.plannedparenthood.org/about-us/newsroom/press-releases/survey-nearly-three-four-voters-america-support-fully-covering-prescription-birth-control-33863.htm>.

148. *Id.*

149. Jodi Jacobson, *Obama Administration Does the Right Thing, Finally, on Contraceptive Coverage*, RHREALITYCHECK.COM (Jan. 20, 2012), *available at* <http://www.rhrealitycheck.org/article/2012/01/20/obama-adminstration-does-right-thing-on-contraceptive-coverage>.

150. IOM Report, *supra* note 26, at 58.

151. IOM Report, *supra* note 26, at 63.

152. *IHS Year 2011 Profile*, INDIAN HEALTH SERVICE (Jan. 2011), <http://www.ihs.gov/PublicAffairs/IHSBrochure/Profile2010.asp>

153. IOM Report, *supra* note 26, at 58.

154. *Id.* at 64.

incentives for the coverage of these preventative services without cost sharing.¹⁵⁵ While offering such incentives for inclusion in state Medicaid plans would seem costly, especially given the expansion of public plan participation in the ACA, the cost sharing in many of these public plans is often so low, if anything at all, that there are fewer barriers to participating in preventative care regimens than in other private plans which leads to increased use among the groups most in need of such services.¹⁵⁶

IV. RELIGIOUS ENTITIES AND FUTURE LEGAL CHALLENGES

There is a real threat of litigation on behalf of religiously affiliated entities who did not receive an HHS exemption in the original interim final rule in early August, and whose further pleas were openly cast down by the Obama Administration and HHS. On January 20, 2012, Department of Health and Human Services Secretary Kathleen Sebelius issued a decision to grant one year extensions of contraceptive coverage exemptions to religiously-affiliated schools, universities, hospitals, and institutions, such as Catholic Charities. When the exemptions expire, the institutions are expected to be in compliance with the law.¹⁵⁷ After the expiration of that year, only women who work directly for a religious entity—commonly characterized as a house of worship, such as for a church, synagogue, or mosque itself—will be exempted from the required coverage. Non-profit religious institutions that do not currently cover contraception must do so with no co-pays or deductibles beginning August 2013.¹⁵⁸ The decision prompted Cardinal Daniel DiNardo, Chair of the Bishops' Committee on Pro-Life Activities, to state that "Jesus himself . . . would not qualify as 'religious enough' for the exemption[.]"¹⁵⁹ These same religiously affiliated entities have launched challenges to state contraceptive coverage mandates in the

155. *Id.*

156. See *infra* Section II, discussing the higher rates of unintended pregnancies among those in lower socioeconomic cohorts.

157. Sebelius, *supra* note 14 (providing the final ruling notice on the proposal to expand the religious exemption to also include religiously affiliated entities. Secretary Sebelius rejected the extension, holding that only actual places of worship will be exempted).

158. *Id.*

159. Jeremy Kryn, *Cardinal: Not Even Jesus Would Qualify for HHS Contraceptive Mandate Religious Exemption*, LIFESITENEWS.COM (Sept. 29, 2011), <http://www.lifesitenews.com/news/cardinal-not-even-jesus-would-qualify-for-hhs-religious-exemption-on-contral/>.

recent past,¹⁶⁰ however, there is an increased likelihood that the U.S. Supreme Court might seek to weigh in on this reoccurring issue, as there is only state high court precedent in New York and California.

The U.S. Supreme Court has held that neutral, generally applicable laws where the impediment to religious belief or practice is “merely the incidental effect of an otherwise valid provision” do not violate the Free Exercise Clause of the First Amendment.¹⁶¹ In *Employment Div., Dep’t of Human Res. v. Smith*, Justice Antonin Scalia, writing for the majority, expressed the current legal interpretation regarding protection under the Free Exercise Clause when he wrote that free exercise protection only extends to individuals when a law or regulation has the purpose of infringing upon their religious beliefs.¹⁶² Scalia wrote the opinion to avoid the slippery slope that could have arisen under a broader reading of the Free Exercise Clause, which could have served to invalidate many rationally enacted, effective and fair laws that might have the potential to allow effect one’s ability to practice certain religious beliefs.¹⁶³ Further, and most importantly for the coverage exemption question, Justice Scalia wrote that while states may create religious exemptions for certain secular laws, they are not required to do so.¹⁶⁴

As such, the claims of religiously affiliated entities that the HHS contraceptive coverage mandate violates the Free Exercise Clause of the First Amendment are likely to fail “because free exercise protection is only warranted when a law or regulation is aimed at

160. See *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 76–79 (Cal. 2004) (upholding a California law mandating coverage of contraceptives with a narrow religious exemption, finding that the statute did not violate the Free Exercise Clause.) The Court left the question of the proper constitutional standard open, but opined that the statute passed strict scrutiny) *Id.* at 91; See also *Catholic Charities of Albany v. Serio*, 859 N.E.2d 459, 466 (N.Y. 2006) (upholding the application of a state contraceptive coverage mandate over an employer’s free exercise claim because the employer’s primary focus was not the inculcation of religious values, and there was an option to not offer prescription coverage at all).

161. See *Employment Div., Dep’t of Human Res. v. Smith*, 494 U.S. 872, 878 (1990). In *Smith*, the Respondents were denied unemployment benefits after they were fired from their previous jobs for violating an Oregon law that prohibits the use of drugs or hallucinogens. *Id.* at 874. The Respondents had engaged in the use of peyote, a natural hallucinogen, as part of a Native American religious ceremony. *Id.* The Court found that Oregon may deny unemployment compensation for use of the drug. *Id.* at 890.

162. *Smith*, 494 U.S. at 877–78.

163. *Id.* at 888–89.

164. *Id.* at 890.

curtailing the exercise of religious beliefs.”¹⁶⁵ The coverage of contraception is a neutral regulation that applies to all employers; it does not single out any religious entity or practice, and the effects of curtailing unwanted pregnancies is a rational and legitimate government interest, especially with the emphasis this administration has placed on preventative care. Accordingly, guaranteeing contraception coverage does not violate the First Amendment. Further, the mandate should survive attacks which claim that it is a threat to religious liberty, as many religious entities have recently described it, because it does not require contraceptive use, but is concerned with making contraception available to all women without succumbing to the vagaries of where you are employed or your income. Further, following Justice Scalia, the very inclusion of any exemption in this neutral law might not even be necessary.

Even facing this Supreme Court precedent, religiously affiliated organizations have attacked state contraceptive coverage mandates, and there is some threat that they will do so again. The two most prominent cases where state mandates were challenged occurred in New York and California.¹⁶⁶ Both the New York and California statutes that were challenged required all commercial health insurance plans that offered prescription drug coverage to provide coverage of prescription contraceptives.¹⁶⁷ In addition, both statutes also imposed a narrow four-part test for whether an entity qualifies as a religious employer and was to be excluded from the statutory coverage mandates.¹⁶⁸ However, as is the case with the recent HHS final rule, the test was purposely narrow with the idea of excluding from the statute places of worship themselves, but not entities affiliated with or espousing religious ideas or teachings such as religious charities, hospitals, universities or nursing homes.¹⁶⁹ The lower court decision in the California Catholic Charities litigation suggests that the idea behind the statutory definition is that to be excluded from the coverage

165. Jessica Donoghue, Comment, *PeopleV.US v. Obama: An Analysis of Religious Challenges to the Patient Protection and Affordable Care Act*, 12 RUTGERS J. L. & RELIGION 202, 211 (2010).

166. See Serio, 859 N.E.2d at 461; see also *Catholic Charities of Sacramento*, 85 P.3d at 73.

167. CAL. HEALTH & SAFETY CODE § 1367.25(a)(1) (2010); CAL. INS. CODE § 10123.196(a)(1) (2010); N.Y. INS. LAW §§ 3221(16)(A)(1).

168. See Stabile, *supra* note 16, at 748 (“To qualify for the religious employer exclusion, (1) the purpose of the organization must be to inculcate religious values; (2) the organization must primarily employ persons of same faith; (3) the organization must primarily serve persons of same faith; (4) the organization must be organized as a non-profit under Internal Revenue Code section 6033(a)(2)(A)(i) or (iii), rather than section 501(c)(3).”).

169. Stabile, *supra* note 16, at 742–43.

mandate, the entity must only employ persons “who, one reasonably could conclude based on the religious nature of the employment, agree with or willingly defer their personal choices to the religious tenets espoused by their employer.”¹⁷⁰ In these and similar cases, the courts have appeared willing to side with gender equity and women’s health and to find that the legitimate interests in offering the contraceptive services supersede Free Exercise claims.¹⁷¹

While the previous mandatory coverage provisions had been applied to private plans only at the state level, the preventative service requirements in the ACA apply to both PHSA and ERISA plans, and as such have jurisdiction over all plans that are sold on the individual, small and large group markets by insurers as well as those self-funded by employers.¹⁷² When the provisions were applied at the state level, self-insured plans, to which many religious plans had converted in the wake of the court decisions upholding state mandates, escaped the state requirements through the “deemer clause” in ERISA Section 514.¹⁷³ However, since ERISA’s minimum health benefits are amended by the ACA, self-insured plans now must meet the higher coverage requirements that they previously had avoided. This is particularly damaging to the strategies of many religious organizations as the ACA removes the old route of avoiding state mandated coverage by moving to self-insured plan and taking advantage of the “deemer clause.”¹⁷⁴ Thus, newly-amended or newly-created (not grandfathered)¹⁷⁵ plans sponsored by religiously affiliated entities which do not meet HHS’s definition of a religious entity will no longer be able to just convert to self-insured plans and avoid increased benefit coverage, a welcome change for the many women who work at such entities and who are currently denied coverage for family planning services.

170. *Catholic Charities of Sacramento*, 90 Cal. App. 4th at 442.

171. Jennifer Shaw, *The Prevention First Act Examined: An Overview of the State of Contraception Laws as Viewed Through the Lens of Federal Legislation*, 30 WOMEN’S RTS. L. REP. 700, 714 (2009).

172. U.S. Health and Human Services, *supra* note 108.

173. *See supra*, note 78 and accompanying text.

174. *Id.*

175. Since grandfathered plans are exempt from the changes, only newly-created plans or those plans that have changed since the passage of the ACA are affected by these new requirements. *See supra*, note 11 (discussing grandfathered status, its benefits and how it can be lost).

V. CONCLUSION

The January 20, 2012 decision by the HHS to refuse to extend the religious exemption was the correct decision given legal and administrative precedent, and will allow for millions of women who work at religiously-affiliated entities to gain access by 2013 to the contraceptive coverage promised to all women in the ACA.¹⁷⁶ The positive externalities presented by contraceptive use are well documented.¹⁷⁷ The extension of coverage through the ACA will ensure that all women, regardless of socio-economic status, will have access to family planning services that could serve to drastically lower the social problem of unwanted pregnancies. The IOM decision to include contraceptives in its recommendations and the HHS decision to adopt those recommendations will serve to equalize plans nationwide and begin to diminish the myriad regulations that exist between public and private plans. While there is likely to be litigation on behalf of those entities who fail to qualify for the religious exemption established by the HHS in August 2011, *Smith* as well as Justice Scalia's assertion that there is no requirement to offer a religious exemption at all should provide enough legal precedent (when combined with New York and California precedent which is in agreement) to allow the current HHS rule to sustain any legal challenges. Based on the Mikulski Amendment and the tough decisions made by the Obama Administration, millions of women, even religious women, will no longer have to depend on state action or their employers to ensure that they have the means to control their body and when they want to become a mother.

176. *See supra* Part II.

177. *See supra* Part III.