

Contraceptive Coverage at the U.S. Supreme Court: Countering the Rhetoric with Evidence

By Adam Sonfield

After years of controversy, the federal contraceptive coverage guarantee under the Affordable Care Act (ACA)—which requires most private health plans to cover the full range of women’s contraceptive methods and services, without out-of-pocket costs for the patient—is heading toward an important showdown this spring. The U.S. Supreme Court will hear arguments on March 25 on two challenges: *Sebelius v. Hobby Lobby Stores*, in which the Tenth Circuit Court of Appeals sided with an Oklahoma-based craft supply chain store against the federal policy, and *Conestoga Wood Specialties v. Sebelius*, in which the Third Circuit ruled against a Pennsylvania-based furniture manufacturer in support of the policy. A final ruling on the cases is likely to be announced in June.

At the core of these cases is a conflict between religiously motivated objections by employers and the rights, beliefs and health care needs of employees and their dependents. Broadly, opponents of the policy argue that it violates the religious rights of employers by requiring them to be involved in covering contraception in the health plans they offer to employees and their dependents, and demand that it be repealed entirely or that it exempt all companies that assert a religious or moral objection. Supporters, on the other hand, argue that the requirement is needed to protect women’s health and equal rights, and that the Obama administration has already gone well beyond what is necessary by providing an exemption for houses of worship and an accommodation for other religiously affiliated nonprofit organizations, such as universities, hospitals and social relief agencies (see “Implementing

the Federal Contraceptive Coverage Guarantee: Progress and Prospects,” Fall 2013).

The two cases before the Supreme Court entail more specific objections by specific employers. In both cases, the businesses are for-profit corporations owned privately by members of a single family, and both the owners and the corporations themselves are plaintiffs. In both cases, the plaintiffs object not to coverage of all contraceptive methods and services, but to coverage of and counseling and education about specific methods that they deem abortifacients: both types of emergency contraceptive pills (known best by the brand names Plan B and ella) and both copper and hormonal IUDs.

In part because of these specifics, it is likely that the Court’s ruling in the pending cases will not be the last word, and that many of the roughly 75 other active cases might still have to be litigated to address further objections.¹ Many of those cases involve nonprofit organizations challenging the administration’s accommodation. They argue that by filling out a form expressing their objections and transmitting it to their insurance company—which is all a religiously affiliated nonprofit must do to take advantage of the accommodation and be free of having to pay for, arrange for or even talk about coverage of contraception—they would be complicit in a process that results in their employees obtaining coverage for contraception.

All of these cases involve various legal claims and complexities, including challenges under the First Amendment’s protection for religious

exercise and under a 1993 federal law called the Religious Freedom Restoration Act. However, the cases also revolve around several important questions of fact that have been subject to misinterpretation and obfuscation by opponents of the contraceptive coverage guarantee—facts for which the record must be set straight.

Contraception Is Not Abortion

One of the key assertions of fact in the two cases before the Supreme Court is that certain methods of contraception are actually methods of abortion. That assertion is important legally: The ACA explicitly requires coverage of the full range of contraceptive methods, while it just as explicitly does not require coverage of abortion. It also matters in the court of public opinion, because some Americans may be more understanding of objections to covering abortion than to contraception.

That assertion, however, contradicts what science says about how pregnancies are established and how contraceptives work. These facts are laid out clearly in an amicus brief submitted to the Supreme Court in October 2013 by numerous medical associations, led by Physicians for Reproductive Health and the American College of Obstetricians and Gynecologists.²

The medical groups' brief describes the process of establishing a pregnancy, including ovulation (the release of an egg from the ovary), fertilization (the fusion of a viable egg with a viable sperm) and implantation (the implantation of a fertilized egg into the uterine lining). A contraceptive method, by definition, prevents pregnancy by interfering with ovulation, fertilization or implantation. Abortion ends an established pregnancy, after implantation. This scientific definition of pregnancy is also the legal definition, and has long been accepted by federal agencies (during administrations both supportive of and opposed to abortion rights) and by U.S. and international medical associations.

In addition, the brief describes the most up-to-date evidence about how the four methods in question function and reports that none of them have been shown to disrupt an existing preg-

nancy. Thus, none of them can be accurately described as an abortifacient. Moreover, only one—the copper IUD—appears capable of even preventing implantation, which is the specific line the plaintiffs object to crossing. Rather, both Plan B and ella work primarily by preventing ovulation; they can work for up to five days after sex, because sperm can survive in a woman's body for that long. Both the hormonal and copper IUDs work primarily by preventing sperm from reaching and fertilizing the egg.

Not only is contraception distinct from abortion, but by preventing unintended pregnancies, effective contraceptive use dramatically reduces the need for abortion. That should be obvious, yet the most vehement opponents of contraception falsely claim that the existence of contraception actually leads to more abortions by promoting promiscuity and nonmarital pregnancy. In reality, contraceptives are extremely effective: The two-thirds of women at risk of unplanned pregnancy who use contraceptives consistently and correctly account for only 5% of unintended pregnancies.³

The starkest evidence demonstrating that the increased use of modern contraceptives is associated with a drop in abortion rates comes from eastern Europe, where access to modern contraception came relatively recently and where contraception quickly began to replace reliance on abortion as the primary means of fertility control.^{4,5} Those findings are echoed domestically: Guttmacher research released in February 2014 found that the U.S. abortion rate in 2011 reached its lowest level since 1973.⁶ This historically low abortion rate coincided with record low birthrates in 2011, indicating that overall declines in pregnancy are likely the primary cause of the decline in abortions. The researchers point to improvements in contraceptive use among U.S. women—specifically, the rising uptake of long-acting reversible contraceptives (LARCs) like the IUD and implant—as important factors likely contributing to the decline in abortions.

Other evidence further bolsters the claim that more effective contraceptive use reduces the need for abortion: For example, the abortion

rates among women offered the choice of any contraceptive method at no cost as part of a large pilot program in St. Louis (the CHOICE Project) were less than half those for women overall in the region and in the country.⁷ Moreover, the U.S. publicly funded family planning effort helped women prevent 760,000 abortions in 2010 alone; without such services, the U.S. abortion rate would have been two-thirds higher.⁸

Contraceptive Use Benefits Women and Families

A second key premise of the cases before the Supreme Court—and of objections to the contraceptive coverage guarantee more broadly—is that there is no good reason for the government to be promoting contraceptive use. Opponents argue that modern contraception has no legitimate health benefits (repeating the mantra that “pregnancy is not a disease”) and that it actually harms women, families and society. These claims are belied by decades of scientific evidence and the life experiences of millions of women in the United States and around the world.

First, as summarized in a 2013 Guttmacher Institute review of dozens of studies, access to contraception is important in enabling women to prevent unintended pregnancies, and to plan and space wanted pregnancies.⁹ And, by reducing unintended pregnancies, contraceptive use decreases pregnancy-related illness, injury and death, especially for women who are near the end of their reproductive years and those who have medical conditions that may be exacerbated by pregnancy. Moreover, appropriate spacing of pregnancies is associated with improved birth outcomes, including reductions in the number of babies born premature, low-birth-weight or small for their gestational age. In addition, planned pregnancy is linked to earlier initiation of prenatal care and more prenatal visits, along with increased likelihood and longer duration of breast-feeding.

Second, by helping women reliably determine whether and when to have children, contraceptive use has contributed substantially toward the goals of women’s equality and social justice—a fact that women themselves recognize (see

“What Women Already Know: Documenting the Social and Economic Benefits of Family Planning,” Winter 2013). In a 2011 survey of more than 2,000 women seeking contraceptive services at U.S. reproductive health–focused providers, most said that access to contraception had enabled them to take better care of themselves or their families (63%), support themselves financially (56%), complete their education (51%), or get or keep a job (50%).¹⁰

These beliefs have been confirmed by a wide array of studies from the past three decades, as summarized in a second 2013 Guttmacher literature review.¹¹ States’ granting legal access to contraception to young women was a major factor contributing to the substantial increases over the final decades of the 20th century in women’s pursuit of college education and advanced professional degrees, and to the trend of more women pursuing full-time jobs outside the home and careers with higher pay and prestige. As women have had more opportunity to invest in their own education and careers, access to contraception has helped increase their earning power and narrow the gender gap in pay.

This body of research also demonstrates the benefits of contraceptive use and pregnancy planning in establishing and maintaining healthy relationships and in supporting mental health and happiness. Finally, contraceptive use gives women and couples time to prepare for parenthood, and for the emotional and economic investments needed to help their children succeed; this, in turn, may positively influence their children’s mental and behavioral development, and educational achievement.

Comprehensive Contraceptive Coverage Improves Use

A related assertion in many of the challenges to the contraceptive coverage guarantee is that there is no legitimate reason for the government to require this coverage. Essentially, opponents argue that contraception is so ubiquitous and inexpensive—citing, for example, condoms for sale in drug stores—that insurance coverage will do nothing to improve use.

Often cited as supposed evidence for this assertion is the fact that virtually all U.S. women of reproductive age—more than 99% of those who have had sex with a man—have used some form of contraception in their lifetime.¹² However, because those numbers are essentially identical across religions, they underscore the inconvenient fact that employees and their dependents often disagree with their employers' objections to contraception.

More importantly, the fact that half of U.S. pregnancies are unplanned¹³ demonstrates that effective contraceptive use is a significant challenge for many women over their lifetime. The typical woman spends less than three years pregnant or trying to become pregnant, and more than 30 years trying to prevent pregnancy.³ It is not enough that women have access to some contraceptive methods. They need access to and complete information about the full range of available options to help them choose a method at each stage in their life that they can use most effectively.

Some methods are, on average, far more effective than others in practice, largely because of the relative opportunities for mistakes: For example, compared with a couple relying on the hormonal IUD, a couple relying on oral contraceptives is 45 times as likely and a couple relying on condoms is 90 times as likely to have an unintended pregnancy in one year, because women may skip pills and couples may use condoms inconsistently or incorrectly.¹⁴ Beyond those averages, however, women's contraceptive needs and choices are influenced by concerns about side effects and drug interactions, how frequently they expect to have sex, their perceived risk of STIs and a host of other factors. Indeed, most women use four or more contraceptive methods in their lifetime.¹² A method's effectiveness depends, in part, on its user's satisfaction, because women who are not completely satisfied with their choice of a method are particularly likely to use it inconsistently or incorrectly, or to experience gaps in use.¹⁵

That the plaintiffs in the cases before the Supreme Court object not only to specific contraceptive methods but also to counseling and

education involving those methods is especially problematic. Put into practice, that objection might mean a partial gag rule: a prohibition against health care providers discussing specific methods with their patients, if the office visit is to receive any insurance reimbursement. That would have serious repercussions for the provider-patient relationship and for women's ability to give informed consent for their care. Alternatively, this objection to discussing specific methods could become, in practice, a complete gag rule, which would entirely bar contraceptive counseling and education about any method at a plan-covered visit.

As summarized in the Guttmacher Institute's January 2011 testimony before the Institute of Medicine's panel on women's preventive health services, financial costs are one of the serious barriers to method choice and to consistent and effective use that must be knocked down.¹⁶ The most effective contraceptive methods—such as IUDs, implants and sterilization—are ultimately cost-effective, but can all entail hundreds of dollars or more in up-front costs. The cost for other methods can also be daunting over many years: One national study found that uninsured women on average pay \$370 for a full year's worth of pills, which amounts to 68% of their annual out-of-pocket expenditures for all health services.¹⁷ What may seem to some Americans to be a modest cost barrier is also the equivalent of 51 hours of work for someone making the federal minimum wage of \$7.25.

It should not be surprising, therefore, that cost concerns are an important factor in contraceptive method choice and use. For example, one-third of women would switch methods if they did not have to worry about cost, and women with cost concerns are twice as likely as other women to rely on condoms or other less-effective methods.¹⁸ More broadly, numerous studies have found that even seemingly small cost-sharing requirements in health insurance can reduce the use of preventive care, especially for low-income individuals.¹⁹ Removing those costs can dramatically affect women's choices: Three-quarters of women in the CHOICE Project chose LARCs, a far higher level than in the general population.⁷

Insurance coverage is designed to help people afford the health care they need, and there is ample evidence it does so, particularly for contraceptive use. Indeed, women with health insurance are substantially more likely than uninsured women to use sexual or reproductive health services, including contraceptive care.²⁰⁻²³ And privately insured women are more likely to practice contraception consistently in states that require insurers to cover contraceptives than in states that do not.²⁴ Twenty-eight states require private insurers that cover prescription drugs to provide coverage of the full or nearly the full range of FDA-approved contraceptive drugs and devices.²⁵ Although these state policies reduced women's up-front costs, eliminating out-of-pocket costs entirely—as the new federal policy does—has even greater potential to increase effective contraceptive use.

Contraceptive Coverage Is Not a Financial Burden

Another important premise upon which the legal challenges rest is that requiring private health plans to cover contraceptive services, supplies and counseling is somehow a burden on employers. Much of that discussion involves questions of religious exercise and free speech, questions outside the realm of scientific fact. Yet, one piece of that discussion—whether requiring contraceptive coverage in private health plans imposes a financial burden on employers—can be addressed with facts.

As summarized in Guttmacher's 2011 testimony and a 2012 analysis by the U.S. Department of Health and Human Services, coverage of contraception without patient out-of-pocket costs should not raise insurance costs and is likely cost-saving.^{16,26} The federal government, the nation's largest employer, reported no increase in costs after Congress required coverage of contraceptives for federal employees in 1998.²⁷ Moreover, studies comparing the cost-effectiveness of contraceptives find that all methods save insurers money, after the costs of unintended pregnancies averted are accounted for—with the most effective methods being among the most cost-effective ones.²⁸

More specifically for private employers, both the National Business Group on Health (a membership group for large employers) and Mercer (an employee benefits consulting firm) have published studies recommending contraceptive coverage as a cost-saving option for health plans.^{29,30} A 2007 National Business Group on Health report calls for coverage of the full range of prescription contraceptive services and supplies at “zero cost-sharing...to avoid real or perceived financial barriers, and to increase utilization.”³¹ Relying on actuarial analysis from PricewaterhouseCoopers, the report predicts that savings from this coverage will exceed the costs.

Buttressing this private-sector evidence is a wealth of public-sector data. By helping women avoid unintended pregnancies, public funding for contraceptive services in 2010 resulted in net public savings of \$10.5 billion, or \$5.68 for every dollar spent.⁸ Those savings accrue to Medicaid for costs of pregnancy-related care and infant care. Similarly, a 2010 Brookings Institution review of government programs to reduce unintended pregnancy found that publicly funded family planning efforts have been effective and cost-saving, and “would be even more so if they could increase the use not just of contraceptives, but of long-acting, reversible contraceptive methods.”³²

Shifting Responsibility to the Government Is Not Workable

Finally, those challenging the contraceptive coverage guarantee assert that the federal government could have avoided an imposition on employers claiming a religious objection by instead taking on the burden itself of expanding access to contraception. Even putting aside the political realities that seem to make these approaches impossible under the current Congress—political realities generated by opposition to any form of support for contraception by many of the same organizations and policymakers decrying the contraceptive coverage guarantee itself—these proposals are not workable in practice and would create new hurdles for women.

For example, several alternate proposals would have the federal government assume the cost of insurance coverage of contraception for women otherwise insured through their employers. That could involve a stand-alone government insurance program just for contraception or some type of after-the-fact reimbursement to women, providers or manufacturers.

Under these alternatives, the government would pay for the cost of the contraceptive coverage (estimated by PricewaterhouseCoopers to be about \$40 per person per year),³¹ but the health plan would realize the savings from averted pregnancy-related care. This would create a financial windfall to insurance plans and employers that decide to exclude contraceptive coverage, and could actually be an incentive to employers to opt out of contraceptive coverage for their employees. In addition, proposals to require women to pay up-front for their contraceptive care—even if they receive after-the-fact reimbursement—would have the same problems as not having contraceptive coverage at all for those women who cannot afford it. Thus, they would not be effective approaches to helping women choose a method they can use most effectively.

Another alternative advanced in the legal challenges would shunt some or all privately insured women into the publicly funded family planning system. This alternative would deny many women the ability to obtain contraceptive counseling and services from the same provider and at the same time they receive other primary and preventive care, creating a barrier to effective use.

Moreover, the proposition is simply not realistic given the strains on the system already and the low prospects for substantial new funding. The number of women in need of publicly funded contraception increased from 16.4 million women in 2000 to 19.1 million women in 2010, and the U.S. public effort meets less than half of that need (8.9 million women a year).⁸ And those strains can be expected to increase: Millions of women are gaining coverage under the ACA, and many will be seeking out care at family planning centers. Unfortunately, family planning programs at both the federal and state levels have

sustained economically and ideologically driven budget cuts in recent years, with clear negative ramifications for women's contraceptive access (see "Besieged Family Planning Network Plays Pivotal Role," Winter 2013).

Essentially, because these business owners have a religious objection to certain forms of contraception, they are demanding that contraception be treated as something other than—and less than—health care. As Seventh Circuit Judge Ilana Rovner stated in a November 2013 dissent to another challenge, *Korte v. Sebelius*, "the segregation of this form of healthcare from standard insurance coverage will stigmatize both these services and the employees who wish to access them. This could hardly be more inconsistent with the intent underlying" this policy.

Finally, the contraceptive coverage guarantee is a small part of a broader guarantee for coverage of preventive care, and one of several important coverage guarantees included in the ACA and federal law more broadly. Other employers might have religious objections to coverage—for all employees and dependents, or just for those who are young, unmarried or gay—of HPV vaccination, STI testing, breast-feeding equipment, maternity care, blood transfusions, HIV medication and mental health care. In the words of Judge Rovner, "it is not feasible to expect the government to establish a public insurance option that picks up responsibility for the crazy-quilt of individual services that any individual employer might find incompatible with his individual religious beliefs." www.guttmacher.org

Most of the facts presented in this article are also included in an amicus brief submitted to the Supreme Court in January 2014 by the Guttmacher Institute and one of its board members, George Washington University's Sara Rosenbaum. That brief can be found at <http://www.guttmacher.org/media/guttmacher_scotus_amicus_brief.pdf>.

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