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Commentary

The Trump Administration's Final Regulations Limit Insurance Coverage of Contraception

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Two recently issued federal regulations will permit employers to limit employees' access to insurance coverage of contraceptives owing to religious or moral objections, effective mid-January 2019 (U.S. Departments of Treasury, Labor and Health and Human Services, 2018a, 2018b). Under the new regulations, any private or nonprofit employer, including private educational institutions, may refuse to provide insurance coverage of contraception owing to religious objections. Nonprofit and "closely held" private employers, those in which a small number of individuals own most of the stock and control the policies, may also deny coverage owing to moral objections. One source notes that 90 percent of U.S. businesses are closely held (Inc., 2018); thus, the new rules apply to a large number of employers. Under the new rules, employers with religious or moral objections may either use "accommodations," under which the insurer still covers contraception, but the employer does not pay for it, or "exemptions," in which the firms' employees and their dependents have no insurance coverage for contraception. Employers could also refuse to cover some types of contraceptives, in contrast with prior policies that required coverage of the broad range of contraceptives approved by the U.S. Food and Drug Administration.

With almost one-half of pregnancies in the United States unintended (Finer & Zolna, 2016), the administration's expansions to exemptions from contraception coverage and their potential impact on women's health should deeply trouble the public health and medical communities. Further, the rules' prioritization of employers' rights over those of employees and dependents is cause for great concern.

A Brief History

The Affordable Care Act (ACA) required private insurance to cover certain preventive services without cost sharing, specifying that the Health Resources and Services Administration would determine which women's preventive health services to include. Following the Institute of Medicine's recommendations (2011), the Health Resources and Services Administration required coverage of contraceptive methods and counseling, because they were determined to be essential preventive services (U.S. Health Resources and Services Administration, 2017). The resulting policy effectively established the right of privately insured women, both employees and dependents, to have access to no-cost contraceptive services.

Originally, in acknowledgment of certain beliefs held by religious institutions, the Obama Administration offered exemptions to the contraceptive mandate for "houses of worship" and grandfathered plans (purchased before 2010). It then extended an accommodation to religiously affiliated nonprofits, such as charities or private universities. With such accommodations, workers would still receive no-cost contraceptive coverage.

In the 2014 Supreme Court case *Burwell v. Hobby Lobby Stores* (134 S. Ct. 2751), the court found that closely held private corporations with religious objections could also receive accommodations to the contraceptive mandate. The Religious Freedom Restoration Act, which protects a "person's exercise of religion," formed the basis of their five-to-four decision that extended the religious rights of "persons" to closely held corporations as well. A related case was brought by nonprofit organizations (*Zubik v. Burwell*, 136 S. Ct. 1557), but was remanded to lower courts and never fully resolved.

The Trump Administration's final rules go well beyond prior court decisions in expanding the ability of employers to exclude employees and dependents from access to contraceptive coverage. Under the new regulations, a much broader set of employers are eligible for exemptions and accommodations,

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including for moral objections rather than just religious beliefs. Further, eligible employers citing religious or moral objections are not required to offer accommodations, and objecting employers may limit the range of contraceptives covered by insurance.

The new policies resurrect debates regarding the rights of individual employees and their dependents versus their employers. Despite two federal courts' issuing injunctions that blocked the 2017 interim final regulations (Bagley, 2018; Keith, 2018), the administration has chosen to publish the final rules without extensive changes. States objecting to the final regulations have asked the courts to enjoin the final regulations as well (Keith, 2019).

Potential Scope

It is unclear how many women could lose contraceptive coverage if the new rules are implemented. In a fact sheet (2018) accompanying the rules, the Department of Health and Human Services states that between 6,400 and 127,000 women nationwide could be affected. The administration based these estimates on firms that previously brought suits against the ACA mandate. However, the new rules broaden the potential for firms to exclude contraception; any private or nonprofit organization could claim a religious exemption and any religious, nonprofit, or closely held for-profit firm could claim a moral exemption. It is likely that these numbers underestimate the impact of the new rules, especially because they do not seem to fully take the number of potentially affected dependents into account.

A poll by the Pew Research Center (2016) found that 4% percent of Americans believe contraception is "morally wrong," whereas 36% say it is morally acceptable and 43% state it is not a moral issue at all. If 4% of employers, or even one-half that number, seek a moral exemption, in addition to others that could claim religious exemptions, the number of women affected will be much greater. Approximately 40 million American women 15–44 years old have employment-based insurance coverage based on the 2018 Current Population Survey (authors' calculations) and, as noted, most U.S. businesses may be considered "closely held" firms that could raise either religious or moral objections under the final regulations.

The rules downplay women's risks of losing access, arguing that employers with religious or moral objections generally employ like-minded staff who are unlikely to use contraceptives. However, even those with similar religious beliefs may differ in their beliefs regarding contraception. Data show that very few (3%–8%) Roman Catholics and Protestants, including evangelicals, believe contraception is morally wrong (Pew Research Center, 2016), and sexually active women belonging to all religious denominations surveyed overwhelmingly (89%) choose to use contraceptives (Jones & Dreweke, 2012). Further, there is a lack of evidence showing that employees who work for firms that are not religiously affiliated will share their employers' moral convictions. Even if some employees do agree with their employers' objections, there is little reason to believe that the employees' dependents are in accord.

The federal rules imply that women who are unable to obtain employer-based contraceptive coverage may use governmental family planning programs. They state the new policies "do not alter multiple other federal programs that provide free or subsidized contraceptives or related education and counseling" (U.S. Departments of Treasury, Labor and Health and Human Services, 2018a, 2018b). However, these programs are often stretched thin (Gold & Hasstedt, 2017) and are not available in all areas. They typically charge sliding scale fees to patients whose incomes are above the poverty line. An out-of-pocket cost of as little as $6 increases the likelihood that women with private insurance will discontinue their contraception (Pace, Dusetzina, & Keating, 2016), so financial barriers will still exist. Moreover, the administration has separately proposed rules limiting the scope of Title X, a major federal funding program established to provide the aforementioned free or subsidized contraception. The revisions are expected to restrict the number of clinics eligible to receive federal funding for family planning (Hasstedt, 2018). Thus, access from these safety net clinics is not nearly as robust as a guarantee of contraceptive coverage without cost sharing.

The Benefits of No-Cost Contraceptive Coverage

The public and individual health benefits of contraception are well-known and serve as the basis for the Institute of Medicine's determination that contraception is an essential preventive health service. Unintended pregnancies are associated with a lower likelihood of initiating timely prenatal care and completing the recommended number of prenatal visits, a higher likelihood of smoking prenatally and postpartum, higher rates of preterm and low-birth-weight infants, and an increased risk of postpartum depression (Cheng, Schwarz, Douglas, & Horon, 2009; Finer & Zolna, 2016). Women with unintended pregnancies are also more than twice as likely to consume inadequate folic acid before pregnancy as those with intended pregnancies, which may lead to poorer infant health (Cheng et al., 2009). Contraception is especially important for the growing population of reproductive-aged women with chronic diseases such as obesity, diabetes, and hypertension, because planning for pregnancy can help to decrease the risk of pregnancy complications associated with such conditions.

Contraceptive coverage has been shown to improve use of the most effective contraceptive methods and could enhance consistency of use of short-acting methods. Long-acting reversible contraceptive methods (LARC), such as intrauterine devices (IUDs) and implants, are the most effective methods of contraception. Because they do not require user involvement, unlike short-acting methods, their effectiveness is equal to that predicted with perfect use and on par with permanent sterilization. LARCs are associated with higher continuity of contraceptive use, enabling women to better control pregnancy timing and spacing (Wu, Moniz, & Ursu, 2018). However, LARC methods are more costly up front, creating financial barriers even to insured women before the ACA (Dusetzina et al., 2013). An IUD itself can cost around $500 to $800 without insurance, excluding the costs of contraceptive counseling and the device's placement and removal. Despite their initial cost, IUDs and implants are the most cost-effective forms of reversible birth control when taking into account the economic burden of abortions, pregnancies, and births (Trussell et al., 2009). However, all contraceptives are more cost effective than "no method."

The ACA's contraception mandate was estimated to save privately insured women $248 per year for IUD users and $255 for those taking contraceptive pills (Becker & Polsky, 2015; Trussell et al., 2009). Reduced cost sharing is associated with

increased use of more effective LARC methods, as well as more consistent use of short-acting contraceptive methods (Pace, Dusetzina, Fendrick, Keating, & Dalton, 2013; Pace et al., 2016; Snyder, Weisman, Liu, Leslie, & Chuang, 2018).

Efforts to increase access to highly effective contraception by providing counseling and contraceptive methods free of cost have decreased the rates of unintended pregnancy. In the multiyear Contraceptive CHOICE Project, which provided almost 10,000 women in the St. Louis area with contraceptive counseling and the cost-free method of their choosing, 75% of women initially chose LARC methods, in contrast with the 14.3% of women using contraception in the general population who choose LARC. Rates of unintended pregnancy and abortion were far lower than the national average rates and rates in a city of comparable size (McNicholas, Madden, Secura, & Peipert, 2014). A program in Colorado geared toward teenagers offered no-cost LARC and reduced teen births and abortions by 50% (Colorado Department of Public Health and Environment, 2017). In a recent survey, 80% of women reported that eliminating cost sharing helped them to afford and use contraception and 60% said that its elimination helped them choose a better method of contraception (Bearak & Jones, 2017). Decreasing out-of-pocket costs for birth control thus seems to be an important strategy for reducing unintended pregnancy.

Because reduced contraceptive coverage would be more burdensome for privately insured women with lower incomes, the new contraceptive rules have the potential to increase socioeconomic and racial or ethnic disparities in health outcomes. Unintended pregnancies are more common in women who have low incomes or are racial or ethnic minorities (Kim, Dagger & Chen, 2016). Reduced contraceptive access will disproportionately affect populations who are already at higher risk for maternal and infant morbidity and death (MacDorman, Declerq, & Thoma, 2017).

Conclusions

The public health rationale for universal access to affordable contraception is compelling. The new final regulations that permit corporate objections to preempt the rights of individual women in such personal and private health matters are deeply problematic. Although the new policies were issued as final regulations, new legal challenges have already been issued (Keith, 2019). In 2012, Congress defeated a bill intended to allow employers to avoid the contraceptive mandate owing to moral objections (Aizenman & Helderman, 2012). Further, federal courts have already raised issues with the interim rules' legality, issuing injunctions that blocked their implementation. Although the U.S. Department of Health and Human Services (2018) states that more than 100,000 public comments were received and analyzed, the final regulations are largely the same as the rules that were blocked.

Given the new political math, in which Democrats have a majority in the House of Representatives, the administration must choose whether to take a more bipartisan approach to policies or double down on the use of executive authority. If it chooses the latter option, then the third arm of government—the courts—will become increasingly important in determining which rules are lawful. Public health, medical, and social scholars have a vital role in producing and interpreting scientific evidence to advance population health and public policy, and it is now especially important to consider that evidence in a legal and judicial context.

In light of the public health and social importance of preventive services, we believe that religious or moral decisions, especially when they pertain to personal and private health care decisions about contraception, should be made by women themselves, not by their employers. It is critical to continue making the case for affordable access to safe and effective contraception and to explain why these choices are best made by individuals in consultation with their health care providers. Clinicians and researchers play a key role in communicating this message.

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