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Religious Freedom and Women's Health - Litigation on Contraception

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Religious Freedom and Women's Health — The Litigation on Contraception

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Health policy experts widely agree that health care should not merely be sickness care; rather, it should actively prevent disease and preserve wellness. Not surprisingly, therefore, the Affordable Care Act (ACA) contains an entire chapter dealing with prevention and public health. The ACA also improves private and public insurance coverage of preventive care. One preventive care requirement, however, has caused a major headache for the Obama administration. Indeed, it has provoked charges that the administration is waging "a war on religion."

The ACA requires private insurers and group health plans (except for "grandfathered" plans, defined as those that existed at the time the ACA became law and have not significantly changed) to cover preventive services without cost sharing by enrollees. This provision does not list the covered services, instead referencing the recommendations of other federal agencies that deal with prevention. It specifically requires coverage of women's preventive care and screening services "provided for in comprehensive guidelines supported by the Health Resources and Services Administration" (HRSA).

At HRSA's request, the Institute of Medicine (IOM) identified women's preventive services that should be covered.[1] On August 1, 2011, HRSA released guidelines based on the IOM's recommendations. Among the services that health plans and insurers must cover are "all Food and Drug Administration–approved contraceptive methods." Coverage must be available for plan years beginning after August 1, 2012.

Requiring contraception coverage is not a radical innovation. Twenty-eight states currently require insurers (with some exceptions) to cover contraceptives.[2] The Equal Employment Opportunity Commission has also concluded that contraception coverage is required by the Pregnancy Discrimination Act, although federal courts have come to contradictory conclusions on this question. But contraception is considered to be a "grave sin" by the Roman Catholic church, and a number of Protestant organizations object specifically to "morning after" contraceptives and intrauterine devices, which they consider to be abortifacients.

In final rules and guidance issued in February 2012, the Department of Health and Human Services (DHHS) recognized these concerns. First, it excused from compliance with the contraception requirement "religious employers," defined to include churches and other nonprofit entities that exist for the inculcation of faith and primarily serve and hire adherents to a particular religious faith. Second, it imposed a moratorium until August 1, 2013, on the application of the requirement to "religious organizations" — nonprofit entities such as universities, hospitals, or charities run by religious groups that do not limit the population they serve and employ to adherents to their religion. In March, the DHHS published an advance notice of proposed rulemaking committing itself to finding an approach that would ensure employees of religious organizations (and students in religious universities) access to contraception without requiring the religious organizations to pay for it. Such organizations might, for example, be excused from paying for contraception coverage while the insurers that offer their group plans covered contraceptives using the savings they accrued from not covering unplanned pregnancies.

This approach was not acceptable to organizations that object to contraception. Forty federal lawsuits have been filed challenging the contraception policy.[3] Most have been filed by religious organizations that do not qualify for the religious-employer exception. A number, however, have been filed by for-profit businesses whose owners have personal religious objections to contraception. The governors of seven states joined one lawsuit supporting the religious-organization plaintiffs.

Although the claims in these lawsuits are fundamentally grounded in the right to religious freedom enshrined in the First Amendment, they are not primarily constitutional claims. The Supreme Court decided more than two decades ago that the First Amendment does not prohibit a "neutral law of general applicability" that burdens religious conduct.[4] Rather, the litigation is based primarily on the Religious Freedom Restoration Act, which Congress adopted in response to that Supreme Court decision. This Act prohibits the federal government from substantially burdening the free exercise of religion

unless it establishes that a requirement "is in furtherance of a compelling governmental interest" and "is the least restrictive means of furthering" that interest.[5]

To date, district courts have issued decisions in 11 cases (see box), with more being decided every week. The courts have dismissed as premature claims brought by religious organizations in 6 cases. These organizations are still protected by the moratorium and have therefore not yet suffered an injury. Because the DHHS has not yet decided how it is going to handle the religious-organization issue, the dispute of these organizations with the agency is not yet timely. They can return to court once the DHHS announces its final rule if they are not satisfied. One court, however, has held that religious organizations are already injured by the rule and can sue.

The cases brought by the secular employers are more problematic. District courts in three of these cases have issued a temporary order prohibiting the federal government from forcing the employer to comply with the contraception requirement while the court considers the case. One other court has dismissed a secular-employer case on the merits, although its decision has been stayed by a federal appellate court. Another court denied a preliminary injunction, holding that the employer was unlikely to succeed on its legal claim.

One issue in the secular-employer cases is whether a private, secular, for-profit corporation can hold protected religious beliefs. The Supreme Court has held that corporations are protected by the First Amendment's freedom-of-speech provisions, but corporations are not protected by other constitutional provisions, such as the Fifth Amendment right against self-incrimination. In one of the contraception cases, the court held that a secular, for-profit corporation cannot hold a religious belief. In other cases, however, the courts have allowed privately held corporations to assert the religious beliefs of their individual owners. These decisions run contrary to the general approach of the law, which refuses to "pierce the corporate veil" separating corporations from their owners.

Another issue is whether the contraception requirement furthers a compelling governmental interest and is the least restrictive means of doing so. The government argues that the requirement promotes a compelling interest in public health, citing the IOM's conclusion that family planning provides health benefits for both women and their children. It also contends that the rule promotes gender equity, freeing women from a significant expense that men do not incur and giving them greater freedom to pursue their life plans. Courts that have enjoined the enforcement of the requirement, however, have asked why, if the interests the law promotes are compelling, it excludes from protection millions of employees who are covered by grandfathered plans or who work for religious employers or for small employers (which are not required to provide health insurance). One court also suggested that the government's goal could be achieved through a public program instead of employer coverage.

Perhaps the most interesting question, however, is whether the

Federal Court Cases Challenging the Preventive Services Mandate of the Affordable Care Act.

- Courts have dismissed five cases brought by religious organizations that are covered by the current moratorium because their challenge is premature: *State of Nebraska v. Sebelius* (U.S. District Court for the District of Nebraska, July 17, 2012); *Belmont Abbey College v. Sebelius* (U.S. District Court for the District of Columbia [D.D.C.], July 18, 2012); *Wheaton College v. Sebelius* (D.D.C. August 24, 2012); *Catholic Diocese of Nashville v. Sebelius* (U.S. District Court for the Middle District of Tennessee, November 21, 2012); *Zubik v. Sebelius* (U.S. District Court for the Western District of Pennsylvania, November 27, 2012).
- One court has permitted claims brought by some religious organizations to proceed: *Roman Catholic Archdiocese of New York v. Sebelius* (U.S. District Court for the Eastern District of New York, December 4, 2012).
- One court has dismissed a claim brought by a for-profit employer as not stating a legal claim: *O'Brien v. United States Department of Health and Human Services* (U.S. District Court for the Eastern District of Missouri, September 28, 2012). A federal appeals court has stayed this decision (U.S. Court of Appeals for the Eighth Circuit, November 28, 2012).
- In two cases brought by for-profit employers, the court has granted a preliminary injunction blocking the enforcement of the mandate until the court can give the case full consideration: *Newland v. Sebelius* (U.S. District Court for the District of Colorado, July 27, 2012); and *Tyndale House Publishers v. Sebelius* (D.D.C. November 16, 2012).
- In one other case, the court granted a preliminary injunction to a for-profit employer but denied relief to a religious-organization plaintiff that is protected by the moratorium: *Legatus v. Sebelius* (U.S. District Court for the Eastern District of Michigan, October 31, 2012).
- In one other case, the court denied a for-profit corporation's request for a preliminary injunction, finding that corporations did not have protected rights under the Free Exercise Clause and that the individual plaintiffs did not show a likelihood of success on their legal claim: *Hobby Lobby Stores, Inc. v. Sebelius* (U.S. District Court for the Western District of Oklahoma, November 19, 2012).

requirement substantially burdens the religious beliefs of employers. Two courts have observed that the rule does not require employers to use contraceptives or even to approve of their use. It asks the employer only to make a benefit available, which the employee must then decide whether or not to use. Employers object, however, that they should not have to pay for services that they consider to be morally wrong. The question of whose interests and beliefs — those of the employer or those of the employee — ought to determine access to contraception benefits is one that the courts, and no doubt ultimately the Supreme Court, will have to decide.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Institute of Medicine. Clinical preventive services for women: closing the gaps. Washington, DC: National Academies Press, 2011.
2. Guttmacher Institute. State policies in brief: insurance coverage of contraceptives. New York: Guttmacher Institute, 2012 (http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf)
3. The Becket Fund for Religious Liberty. HHS mandate information central. Washington, DC: The Becket Fund, 2012 (http://www.becketfund.org/hhsinformationcentral)
4. Employment Division, Department of Human Resources of Oregon v. Smith, 494 U.S. 872, 879 (1990).
5. 42 U.S.C. § 2000bb-1(b).

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Shared Decision Making to Improve Care and Reduce Costs

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A sleeper provision of the Affordable Care Act (ACA) encourages greater use of shared decision making in health care. For many health situations in which there's not one clearly superior course of treatment, shared decision making can ensure that medical care better aligns with patients' preferences and values. One way to implement this approach is by using patient decision aids — written materials, videos, or interactive electronic presentations designed to inform patients and their families about care options; each option's outcomes, including benefits and possible side effects; the health care team's skills; and costs. Shared decision making has the potential to provide numerous benefits for patients, clinicians, and the health care system, including increased patient knowledge, less anxiety over the care process, improved health outcomes, reductions in unwarranted variation in care and costs, and greater alignment of care with patients' values.

However, more than 2 years after enactment of the ACA, little has been done to promote shared decision making. We believe that the Centers for Medicare and Medicaid Services (CMS) should begin certifying and implementing patient decision aids, aiming to achieve three important goals: promote an ideal approach to clinician–patient decision making, improve the quality of medical decisions, and reduce costs.

In a 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine recommended redesigning health care processes according to 10 rules, many of which emphasize shared decision making. One rule, for instance, underlines the importance of the patient as the source of control, envisioning a health care system that encourages shared decision making and accommodates patients' preferences.

Unfortunately, this ideal is inconsistently realized today. The care patients receive doesn't always align with their preferences. For example, in a study of more than 1000 office visits in which more than 3500 medical decisions were made, less than 10% of decisions met the minimum standards for informed decision making.[1] Similarly, a study showed that only 41% of Medicare patients believed that their treatment reflected their preference for palliative care over more aggressive interventions.[2]

There's also significant variation in the utilization of procedures, particularly those for preference-sensitive conditions, which suggests that patients may receive care aligned not with their values and preferences, but with their physicians' payment incentives. Among Medicare patients in more than 300 hospital regions, the rate of joint-replacement procedures for chronic hip arthritis varied by as much as a factor of five, and the use of surgery to treat lower back pain varied by nearly a factor of six. Other studies have found wide regional variation in the treatment of early-stage breast and prostate cancers and in the use of cardiac procedures.