

TESTIMONY BEFORE THE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

**FOR THE HEARING ENTITLED “DO NEW HEALTH LAW MANDATES THREATEN CONSCIENCE RIGHTS
AND ACCESS TO CARE?”**

NOVEMBER 2, 2011

BY THE

NATIONAL HEALTH LAW PROGRAM

The National Health Law Program (“NHeLP”) submits this testimony to the Energy and Commerce Committee’s Subcommittee on Health. NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers, and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. In a just society, every woman must be able to make her own decisions about whether or when to have children based on her own beliefs and needs. The Patient Protection and Affordable Care Act (“the ACA”) recognizes that preventive health services are critical to individual and community health, and that cost is often a barrier to accessing the preventive services we need. Moreover, it acknowledges the critical role that a woman’s health plays in her family and her community by explicitly requiring that women’s preventive health services be covered without cost-sharing.

NHeLP’s testimony addresses issues raised by the Majority staff’s Internal Hearing Memorandum dated October 28, 2011, and circulated to Members of the Subcommittee on Health. NHeLP strongly supports the decision by the U.S. Department of Health and Human Services Secretary, Kathleen Sebelius, to adopt the recommendations from the Institute of Medicine (“IOM”) to require insurance coverage of women’s preventive health services, including contraception, without cost-sharing. NHeLP strongly opposes efforts to undermine the health and autonomy of women, and the Majority staff’s Memorandum presents two such threats: (1) HRSA’s proposed exemption from the contraceptive requirement for certain religious employers; and (2) H.R. 1179, an expansive bill that undermines health reform by permitting insurers to opt-out of providing insurance coverage.

These efforts disregard accepted “standards of care,” practices that are medically necessary and services that any practitioner under the circumstances should be expected to render. Every person who enters a doctor’s office or hospital expects that the care he or she gets will be based on the best medical evidence and will meet accepted medical guidelines – in other words, that care will comport with medical standards of care. Refusal clauses and denials of care

violate these standards. They undermine standards of care by allowing or requiring health care professionals and institutions to abrogate their responsibility to deliver services and information that would otherwise be required by generally accepted practice guidelines. Ultimately, refusal clauses and institutional denials of care conflict with professionally developed and accepted medical standards of care and have adverse health consequences for patients.

A. THE REQUIREMENT TO COVER CONTRACEPTIVES AS A COMPONENT OF PREVENTIVE CARE IS EVIDENCE-BASED.

The ACA requires group health plans and health insurance issuers to cover certain preventive services without cost-sharing.¹ Among other things, the ACA requires new group health plans and health insurance issuers to cover such additional women's health preventive care and screenings as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA").² By doing so, the ACA recognizes that women have unique reproductive and gender specific health needs, disproportionately lower incomes, and disproportionately higher out-of-pocket health care expenses. HRSA commissioned the independent IOM to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep women healthy. The IOM developed eight recommendations based on scientific evidence, including the input of independent physicians, nurses, scientists, and other experts. HRSA recently adopted eight recommendations submitted by the Institute of Medicine ("IOM"), which include the recommendation that women receive coverage for all FDA-approved methods of contraception free of cost-sharing.³ Requiring coverage of all eight preventive services recommended by the IOM, including coverage of all-FDA approved methods of contraception, is good medical and economic policy.

HRSA charged the IOM with convening a committee to determine the preventive services necessary to ensure women's health and well-being.⁴ To this end, the IOM convened a committee of 16 eminent researchers and practitioners to serve on the Committee on Preventive Services for Women.⁵ The Committee met five times in six months.⁶ The Committee reviewed existing guidelines, gathered and reviewed evidence and literature, and considered public comments.⁷ With respect to women, the IOM identified gaps in the coverage for preventive services not already addressed by the ACA, including services recommended by the United States Preventive Services Task Force, the Bright Futures recommendations for adolescents from the American Academy of Pediatrics, and vaccinations specified by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The IOM

¹ Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 2713(a), 42 U.S.C. § 300gg-13.

² ACA § 2713(a)(4), 42 U.S.C. § 300gg-13.

³ U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, <http://www.hrsa.gov/womensguidelines>.

⁴ Institute of Medicine of the National Academies, *supra* note 3, at 1.

⁵ *Id.* at 2.

⁶ *Id.*

⁷ *Id.*

recommended that, among other things, women receive coverage for all United States Food and Drug Administration (“FDA”)-approved methods of contraception free of cost-sharing because: (1) pregnancy affects a broad population; (2) pregnancy prevention has a large potential impact on health and well-being; and (3) the quality and strength of the evidence is supportive of the recommendation to provide contraceptive coverage free of cost-sharing.⁸

B. CONTRACEPTION EFFECTIVELY PREVENTS UNINTENDED PREGNANCIES, AND WOMEN NEED TO BE ABLE TO SELECT THE METHOD THAT IS MOST APPROPRIATE.

Family planning is an essential preventative service for the health of women and families. In 2008, there were 66 million United States women of reproductive age (ages 13-44).⁹ Over half of these women—36 million—were in need of contraceptive services and supplies because they were sexually active with a male, capable of becoming pregnant, and neither pregnant nor seeking to become pregnant.¹⁰ Each year, nearly half of the pregnancies in the United States are unintended—meaning they were either unwanted or mistimed.¹¹ Forty-two percent of unintended pregnancies end in abortion.¹² By age 45, more than half of all women in the United States will have experienced an unintended pregnancy, and four in ten will have had an abortion.¹³ Increased access to, and use of, contraceptive information and services could reduce the rate of these unwanted pregnancies.

The IOM report recognized that not all contraceptive methods are right for every woman, and access to the full range of pregnancy prevention options allows a woman to choose the most effective method for her lifestyle and health status. Current methods for preventing pregnancy include hormonal contraceptives (such as pills, patches, rings, injectables, implants, and emergency contraception), barrier methods (such as male and female condoms, cervical caps, contraceptive sponges, and diaphragms), intrauterine contraception, and male and female sterilization. As the IOM reported, female sterilization, intrauterine contraception, and contraceptive implants have failure rates of less than one percent.¹⁴ Injectable and oral contraceptives have failure rates of seven and nine percent, largely due to misuse.¹⁵ Failure rates for barrier methods are higher.¹⁶ A woman has an 85 percent chance of an unintended pregnancy

⁸ *Id.* at 6, 151.

⁹ Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Institute, *Contraceptive Needs and Services: National and State Data, 2008 Update* 3 (2010), <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.

¹⁰ *Id.*

¹¹ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, *Perspectives on Sexual & Reprod. Health* 90, 92 (2006), <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>; Guttmacher Institute, *Facts on Induced Abortion in the United States* (Aug. 2011), www.guttmacher.org/pubs/fb_induced_abortion.html.

¹² Institute of Medicine of the National Academies, *supra* note 3, at 102.

¹³ Guttmacher Institute, *Fact Sheet: Facts on Induced Abortion in the United States* (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

¹⁴ Institute of Medicine of the National Academies, *supra* note 3, at 104-05.

¹⁵ *Id.*

¹⁶ *Id.*

if she uses no method of contraception.¹⁷ Approximately 50 percent of unintended pregnancies in the United States occur among the eleven percent of women using no contraceptive method.¹⁸ According to the Guttmacher Institute, in the United States, publicly funded family planning services and supplies alone help women avoid approximately 1.5 million unintended pregnancies each year.¹⁹ If these services were not provided in 2008, unintended pregnancy rates would have been 47 percent higher, and the abortion rate would have been 50 percent higher.²⁰

C. CONTRACEPTIVES ARE WIDELY USED IN THE UNITED STATES.

Most sexually active women in the United States use contraception to prevent pregnancy. Contraceptive use is nearly universal in women who are sexually active with a male partner: more than 99 percent of women 15–44 years of age who have ever had sexual intercourse with a male have used at least one contraceptive method.²¹ This is true for nearly all women, of all religious denominations.²² Indeed, the overwhelming majority of sexually active women of all denominations who do not want to become pregnant are using a contraceptive method.²³ Approximately 98 percent of sexually active Catholic women have used contraceptive methods banned by the Catholic Church.²⁴ Even among those Catholic women who attend church once a month or more, only two percent rely on the natural family planning method to prevent unintended pregnancy.²⁵

D. COST PREVENTS WOMEN FROM ACCESSING CONTRACEPTIVE INFORMATION AND SERVICES.

Financial barriers impede women's access to contraceptive information and services. Cost-sharing can pose barriers to accessing health care services, particularly for low-income women. Indeed, one of the major barriers to universal contraceptive access is the high out-of-pocket cost for women—who are also disproportionately low-income—whose health plans do not cover contraception. Low-income women have higher rates of unintended pregnancy, as compared to higher-income women.²⁶ Low-income women are the least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.²⁷

¹⁷ *Id.* at 105.

¹⁸ Guttmacher Institute, *supra* note 14.

¹⁹ Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Institute, *Contraceptive Needs and Services: National and State Data, 2008 Update* 5 (2010), <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.

²⁰ *Id.*

²¹ Williams D. Mosher & Jo Jones, *Use of Contraception in the United States: 1982–2008*, Nat'l Ctr. for Health Statistics, 23 *Vital and Health Statistics*, no. 29, 2010, at 5.

²² Rachel K. Jones & Joerg Dreweke, Guttmacher Institute, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use* 4-5 (2011), <http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf>.

²³ *Id.*

²⁴ *Id.* at 4.

²⁵ *Id.* at 5.

²⁶ Lawrence B. Finer & Stanley K. Henshaw, *supra* note 12.

²⁷ Sheila D. Rustgi, Michelle M. Doty & Sara R. Collins, The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* 3-4 (2009),

Increased use of longer-acting, reversible contraceptive methods, which have lower failure rates, could further help reduce unintended pregnancy rates. These more effective methods of contraception, however, also have the most up-front costs, which put them outside of the reach of many women.²⁸ In 2008, for example, only 5.5 percent of women using contraception chose the more effective and longer-term methods.²⁹ As the IOM recognized, the “elimination of cost sharing for contraception . . . could greatly increase its use, including use of the more effective and longer-acting methods, especially among poor and low-income women most at risk for unintended pregnancy.”³⁰ In this regard, the California Kaiser Foundation Health Plan’s experience is informative. The California Kaiser Foundation Health Plan eliminated copayments for the most effective contraceptive methods in 2002.³¹ Prior to the change, users paid up to \$300 for 5 years of use; after elimination of the co-payment, use of these methods increased by 137 percent.³²

E. PREVAILING STANDARDS OF CARE REQUIRE THAT WOMEN HAVE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES.

The government should make health care decisions based on scientific evidence and good economic policy, not on the religious and moral beliefs of some institutions. Health care refusals and denials of care, also known as “conscience” clauses, are based on ideological and political justifications that have no basis in scientific evidence, good medical practice, or patient needs. These policies violate the essential principles of modern health care delivery: evidence-based practice, patient centeredness, and prevention. “Standards of care” are practices that are medically necessary and the services that any practitioner under the circumstances should be expected to render. Refusal clauses and denials of care undermine standards of care by allowing or requiring health care professionals and/or institutions to abrogate their responsibility to provide services and information that would otherwise be required by generally accepted practice guidelines.

Although there is near universal agreement in medical practice guidelines that women should be given information about and access to contraceptives to prevent pregnancy, women face many barriers to contraceptive use, including institutional restrictions, physicians’ denials of care, and pharmacists’ refusals to fill prescriptions. Women consider a number of factors in determining whether to become or remain pregnant, including: age, educational goals, economic situation, the presence of a partner, medical condition, mental health, and whether they are taking medications that are contra-indicated for pregnancy. For example, a number of commonly

http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf .

²⁸ Institute of Medicine, *supra* note 3, at 108.

²⁹ Kelly Cleland, et al., *Family Planning as Cost-Saving Preventive Health Service*, *New Eng. J. Med* 1 (2011), <http://healthpolicyandreform.nejm.org/?p=14266>.

³⁰ Institute of Medicine of the National Academies, *supra* note 3, at 109.

³¹ Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use*, 40 *Sexual & Reprod. Health* 94 (2008).

³² *Id.*

prescribed pharmaceuticals are known to cause impairments in the developing fetus or to create adverse health conditions if a woman becomes pregnant while taking them. Approximately 11.7 million prescriptions for drugs the FDA has categorized as Pregnancy Classes D (there is evidence of fetal harm, but the potential may be acceptable despite the harm) or X (contraindicated in women who are or may become pregnant) are filled by significant numbers of women of reproductive age each year.³³ Pregnancy for women taking these drugs carries risk for maternal health and/or fetal health.³⁴ Women taking these drugs who might be at risk for pregnancy are advised to use a reliable form of contraception to prevent pregnancy.³⁵

Unwanted pregnancy is associated with maternal morbidity and risky health behaviors. The World Health Organization recommends that pregnancies should be spaced at least two years apart.³⁶ Pregnancy spacing allows the woman's body to recover from the pregnancy. Further, if a woman becomes pregnant while breastfeeding, the health of both her baby and fetus may be compromised as her body shares nutrients between them. According to the American College of Obstetricians and Gynecologists, women who become pregnant less than six months after their previous pregnancy are 70 percent more likely to have membranes rupture prematurely, and are at a significantly higher risk of other complications.³⁷ Family planning is a focus area of the Healthy People 2010 health promotion objectives set out by the United States Department of Health and Human Services. Goal 9 of Healthy People 2010 is, "Improve pregnancy planning and spacing and prevent unintended pregnancy."³⁸ Specific indicators include increasing intended pregnancies from 51 percent to 70 percent; increasing pregnancy spacing to 24 months; increasing the proportion of women at risk for unintended pregnancy who use contraceptives to 100 percent, and increasing the proportion of teens that use contraceptive methods that both prevent pregnancy and prevent sexually transmitted disease.³⁹

Further, millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services does not comport with medical standards that recommend pregnancy prevention for these medical conditions. Refusal clauses impose significant burdens on the health and well-being of affected women and their families. These are burdens that fall disproportionately and most harshly on low-income women, severely impacting their health outcomes and their ability to give informed consent for medical care. Low income women, and low income women of color already experience severe health disparities in reproductive health, maternal health outcomes, and birth outcomes. Cardiovascular disease, lupus, and diabetes, for

³³ *Id.*

³⁴ David L. Eisenberg, et al., *Providing Contraception for Women Taking Potentially Teratogenic Medications: A Survey of Internal Medicine Physicians' Knowledge, Attitudes and Barriers*, 25 J. Gen. Internal Med. 291, 291 (2010).

³⁵ *Id.* at 291-92.

³⁶ Cicley Marston, *Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (June 13-15, 2005).

³⁷ Am. Coll. of Obstetricians & Gynecologists, *Statement of the Am. Coll. of Obstetricians & Gynecologists to the U.S. Senate, Comm. on Health, Educ., Labor & Pensions, Pub. Health Subcomm. on Safe Motherhood* (April 25, 2002).

³⁸ U.S. Dep't of Health & Human Servs., *Healthy People 2010: Understanding and Improving Health* (Nov. 2000).

³⁹ *Id.*

example, are chronic diseases that disproportionately impact women of color. The incidence rate for lupus is three times higher for African American women than for Caucasian women.⁴⁰ Similarly, although an estimated 7.8 percent of Americans have diabetes, the prevalence rate (the number of cases in a population at a specific time) is higher for women of color in all age groups, with obesity and family history being significant risk factors for Type II diabetes.⁴¹ Women who are poor also have unintended pregnancy rates that are more than five times the rate for women in the highest income level.⁴² Nearly one out of ten African American women and one in fourteen Latinas of reproductive age experience an unintended pregnancy each year.⁴³ Inaccessible and unaffordable contraceptive counseling and services contribute to these disparities.

Heart disease, for example, is the number one cause of death for women in the United States.⁴⁴ The American College of Cardiology and the American Heart Association Task Force on Practice Guidelines issued specific recommendations for management of women with valvular heart disease.⁴⁵ They conclude that individualized preconception management should provide the patient with information about contraception as well as material and fetal risks of pregnancy.⁴⁶ Some cardiac conditions in which the physiological changes brought about in pregnancy are poorly tolerated include valvular heart lesions such as severe aortic stenosis, aortic regurgitation, mitral stenosis, and mitral regurgitation all with III-IV symptoms, aortic or mitral valve disease, mechanical prosthetic valve requiring anticoagulation and aortic regurgitation in Marfan syndrome.⁴⁷

The American College of Obstetricians and Gynecologists and the American Diabetes Association have developed practice guidelines for the preconception care for women with pregestational diabetes. According to the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Their recommendations for diabetic women with childbearing potential include: (1) use of effective contraception at all times, unless the patient is in good metabolic control and actively trying to conceive; (2) counseling about the risk of fetal impairment associated with unplanned pregnancies and poor metabolic control; and (3) maintain blood glucose levels as close to normal as possible for at least two to three months prior to conception.⁴⁸ The American College of Obstetricians and Gynecologists further recommends

⁴⁰ U.S. Department of Health and Human Services Office on Women's Health, *Lupus: Frequently Asked Questions* 2 (June 13, 2001), <http://www.womenshealth.gov/publications/our-publications/fact-sheet/lupus.pdf>.

⁴¹ U.S. Department of Health and Human Services, National Diabetes Information Clearinghouse, Diabetes Overview, <http://diabetes.niddk.nih.gov/dm/pubs/overview/#scope>; Ann S. Barnes, *The Epidemic of Obesity and Diabetes*, 38 *Tex. Heart Institute J.* 142 (2011).

⁴² Lawrence B. Finer & Stanley K. Henshaw, *supra* note 13, at 94.

⁴³ Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 *Guttmacher Policy Review* 3 (Summer 2008), <http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html>.

⁴⁴ Lori Mosca, et al., *Tracking Women's Awareness of Heart Disease: An American Heart Association National Study*, 109 *J. Am. Heart Ass'n* 573 (Feb. 4, 2004).

⁴⁵ Robert O. Bonow, et al., *Guidelines for the Management of Patients with Valvular Heart Disease*, American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Patients with Valvular Heart Disease), 98 *J. Am. Coll. of Cardiology* 1949-1984 (Nov. 1998).

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ American Diabetes Association, *Standards of medical care in diabetes-2006*, 29 *Diabetes Care* S4, S28 (2006).

that “[a]dequate maternal glucose control should be maintained near physiological levels before conception and throughout pregnancy to decrease the likelihood of spontaneous abortion, fetal malformation, fetal macrosomia [excessive birthweight], intrauterine fetal death, and neonatal morbidity.”⁴⁹

Similarly, contraception plays a critical role in preparing a woman with lupus for pregnancy. Lupus is an auto-immune disorder of unknown etiology which can affect multiple parts of the body such as the skin, joints, blood, and kidneys with multiple end-organ involvement. Often labeled a “woman’s disease,” nine out of ten people with lupus are women.⁵⁰ Women with lupus who become pregnant face particularly increased risks. A large review of United States hospital data found the risk of maternal death for women with lupus is twenty times the risk of non-lupus pregnant women.⁵¹ These women were three to seven times more likely to suffer from thrombosis, thrombocytopenia, infection, renal failure, hypertension, and preeclampsia.⁵² Women who suffer from moderate or severe organ involvement due to lupus are at significantly higher risk for developing complications during pregnancy, and the guidelines discussed above regarding chronic disease apply to women with those co-morbidities.⁵³ This should be taken into consideration in the decision to become pregnant or to carry a pregnancy to term.⁵⁴

Historically, women with lupus were discouraged by the medical community from bearing children. While this is no longer always true, pregnancy for women with lupus is always considered high risk, and should be undertaken when, if at all possible, the disease is under control. The National Institute of Arthritis and Musculoskeletal and Skin Diseases (“NIAMS”) recommends that a woman should have no signs or symptoms of lupus.⁵⁵ In addition, NIAMS directs women as follows: “Do not stop using your method of birth control until you have discussed the possibility of pregnancy with your doctor and he or she has determined that you are healthy enough to become pregnant.”⁵⁶

F. DENYING WOMEN ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES UNDERMINES QUALITY OF CARE FOR WOMEN.

Ideological restrictions occur at three levels: the individual health professional level, the institutional and health system level, and the political level. Refusal clauses are statutory or regulatory “opt out” provisions that impede patient access to necessary and desired health care services and information. At the institutional level, the restrictions that have the greatest impact on access to care are those imposed by institutions controlled by religious entities. In particular,

⁴⁹ The American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 60: Pregestational diabetes mellitus*, 115 *Obstetrics & Gynecology* 675 (2005).

⁵⁰ U.S. Department of Health and Human Services Office on Women’s Health, *supra* note 40, at 2.

⁵¹ Megan E. B. Clowse, et al., *A national study of the complications of lupus in pregnancy*, 199 *Am. J. Obstet. & Gynecol.* 127e. 1, e.3 (Aug. 2008).

⁵² *Id.* at 127e.3-e.4.

⁵³ *Id.*

⁵⁴ National Institute of Arthritis and Musculoskeletal and Skin Diseases, *Lupus: A Patient Care Guide for Nurses and Other Health Professionals* 27-62, Patient Information Sheet 4-5 (3d ed. Sept. 2006).

⁵⁵ *Id.* at 45-46, Patient Information Sheet No. 11.

⁵⁶ *Id.* at Patient Information Sheet No. 4.

the Catholic health system has the broadest religion-based health care restrictions. The U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care Services* for all Catholic medical institutions. The Directives specify a range of services that are prohibited, including contraception. At the political level, legislation enacting refusal clauses impose restrictions unrelated to health and safety on women's ability to access reproductive health care services. These restrictions are driven by political ideology, electoral politics, and other political considerations that have nothing to do with evidence-based medicine.

G. HRSA'S PROPOSED RELIGIOUS EMPLOYER EXEMPTION WOULD UNDERMINE WOMEN'S HEALTH, WELL-BEING, AND AUTONOMY.

Statutory refusal clauses that impede women's access to contraceptive counseling and services jeopardize women's health and well-being, and rob women of their autonomy. HRSA's proposed religious employer exemption, 45 C.F.R. § 147.130(a)(1)(iv)(A)-(B), which allows certain employers to deny women access to effective, necessary, and desired preventive health care, unreasonably impedes the ability of a woman to obtain appropriate and timely medical care, limits the availability of health care services to affected women, and violates standards of care. HRSA's proposed exemption would permit employers to impose their religious doctrines on women who do not share them and at the expense of affected women's health. The clause gives institutions the right to make health care decisions—based on ideology, not science—about and for an individual woman.

Most women are covered by health insurance offered by their employer.⁵⁷ According to a 1998 Guttmacher Institute study, while three-fourths of American women of reproductive age rely on private insurance, the extent to which they have contraceptive coverage can differ dramatically depending on their type of insurance.⁵⁸ The Affordable Care Act recognizes the importance of preventive services to the health and well-being of individuals, their families and their communities. Preventive services are required to be covered without cost-sharing in order to ensure that all foreseeable barriers to access to preventive services are removed. Allowing employers or insurers to erect new barriers in the form of refusal clauses vastly undermines the promise of the ACA to improve the health of the nation.

All employers should be required to provide coverage for contraception without cost-sharing. Requiring all employers—including religious employers—to provide contraceptive insurance coverage does not force the employer to use, or even to condone, contraceptive use. Nor does requiring all entities to provide insurance coverage of health care services vital to a woman's health and well-being impinge on the conscience rights of individual providers. Allowing an employer, however, to refuse to cover contraception creates substantial barriers to affected women's ability to prevent pregnancy, and subordinates an affected woman's health needs—and her autonomy—to her employer's ideological beliefs. All women, regardless of where they work, should have access to the care they need. Every woman should be able to

⁵⁷ Usha Ranji & Alina Salganicoff, The Henry J. Kaiser Family Foundation, *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* 10 (2011), <http://www.kff.org/womenshealth/upload/8164.pdf>.

⁵⁸ Rachel B. Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, The Guttmacher Report on Pub. Policy 5-6 (Aug. 1998), <http://www.guttmacher.org/pubs/tgr/01/4/gr010405.pdf>.

make her own decisions about whether or when to prevent pregnancy based on her own beliefs, not the beliefs of her employer.

H. H.R. 1179 WOULD DANGEROUSLY EXPAND RELIGIOUS REFUSALS.

H.R. 1179, misleadingly titled “Respect for Rights of Conscience Act of 2011,” is an extreme and far-reaching refusal provision. H.R. 1179 introduces broad, poorly defined and confusing language, and fails to account for the significant burdens that broad refusals have on patients. These are burdens that fall disproportionately and most harshly on low-income women, severely impacting their health outcomes and their ability to give informed consent for medical care. There are already ample statutory protections for health care providers who object to providing certain services based on their religious or moral beliefs in existing law, which seeks to establish a delicate balance between protecting health care providers and meeting the needs of patients.

H.R. 1179 dangerously expands what a health plan or provider can refuse to do. First, it provides that a health plan could refuse to provide coverage (or, in the case of a sponsor of a group health plan, paying for coverage) “of such specific items or services” based on its “religious beliefs or moral convictions.” Similarly, it requires that an individual be able to purchase a policy that does not contain any “specific items or services” which, are contrary to the “religious beliefs or moral convictions of the purchaser or beneficiary of the coverage.” Under H.R. 1179, a health plan could refuse to provide coverage for virtually *any* service otherwise required by the ACA. Corporations could, for example, refuse to cover screening and counseling for HIV and other sexually transmitted infections. H.R. 1179 would undermine access to essential health services, and create significant and unreasonable barriers for patients seeking access to vital health care.

Second, H.R. 1179 states that the ACA does not obligate an “individual or institutional health care provider, or authorize a health plan to require a provider, to provide, participate in, or refer for a specific item or service contrary to the provider’s religious beliefs or moral convictions.”⁵⁹ The law suggests that virtually any worker, paid or volunteer, in any health care setting can refuse to assist in the performance of any health care service or in any health care program. The law also is unclear as to whether a worker can assert his or her moral belief in refusing to treat a particular patient. Can a technician refuse to participate in dialysis for an alcoholic? Can someone opposed to blood transfusions refuse to change a patient’s hospital gown? Can a health provider refuse to treat a patient who is gay or lesbian? The law is subject to misuse and abuse by creating a health care environment that invites large numbers of workers and health professionals to refuse to participate in the orderly delivery of health care services.

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⁵⁹ H.R. 1179 also states that a health plan has not “failed to provide timely or access to items or services . . . or fulfill any other requirement” under the ACA because it has “respected the rights of conscience” of a “provider.”

Refusal clauses and denials of care should be evaluated using the same measurements used to evaluate quality generally, with the goal of providing care that is evidence-based, patient-centered, and preventative. All women should have access to the health care services they need based on medical evidence, their personal health needs, and their own beliefs. Employers, insurers, and hospital corporations should not be allowed to impose their ideology on women.

For more information or questions, please contact Susan Berke Fogel, Director of Reproductive Health at fogel@healthlaw.org or 818.621.7358.

Thank you.