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**Testimony of Douglas Laube, MD, MEd
Board Chair, Physicians for Reproductive Choice and Health**

Submitted to the House Energy and Commerce Committee

Subcommittee on Health

November 2, 2011

Physicians for Reproductive Choice and Health (PRCH) is a doctor-led national advocacy organization that relies upon evidence-based medicine to promote sound reproductive health policies. PRCH welcomes the opportunity to submit testimony to the House Energy and Commerce Subcommittee on Health for the hearing entitled “Do New Health Law Mandates Threaten Conscience Rights and Access to Care?”

PRCH supports the recent recommendation of the Institute of Medicine (IOM) to include contraception in the preventive health benefits¹ for women under the Patient Protection and Affordable Care Act (ACA)² and the decision of the Department of Health and Human Services (HHS) to adopt this recommendation in its draft regulations.³ As physicians, we know that access to contraception is essential to the health and well-being of our patients.

About half of all pregnancies in the United States are unintended.⁴ Regular use of contraception prevents unintended pregnancy and reduces the need for abortion.⁵ Contraception also allows women to determine the timing and spacing of pregnancies, protecting their health and improving the well-being of their children.⁶ Contraceptive use saves money by avoiding the costs of unintended pregnancy and by making pregnancies healthier, saving millions in health care expenses.⁷ Several contraceptives also have non-contraceptive health benefits, such as decreasing the risk of certain cancers and treating

¹ Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps (July 19, 2011).

² Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Mar. 23, 2010) and Health Care and Education Reconciliation Act, Pub. L. 111-152 (Mar. 30, 2011).

³ Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621 (proposed Aug. 3, 2011) (to be codified at 45 CFR Part 147).

⁴ Finer LB, Kost K. “Unintended pregnancy rates at the state level.” Perspectives on Sexual and Reproductive Health 2011;43:78-87.

⁵ Deschner, A., Cohen, S.A. (2003). “Contraceptive Use Is Key to Reducing Abortion Worldwide.” The Guttmacher Report on Public Policy 6(4): 7-10.

⁶ Testimony of the Guttmacher Institute, submitted to the Committee on Preventive Services for Women, Institute of Medicine, 2011, available for download at <http://www.guttmacher.org/pubs/CPSW-testimony.pdf>.

⁷ Gold, R.B. (2011). “Wise Investment: Reducing the Steep Cost to Medicaid of Unintended Pregnancy in the United States.” Guttmacher Policy Review 14(3): 6-10.

debilitating menstrual problems.⁸ Making contraception more affordable is a significant step forward for the health of women and their families.

PRCH appreciates the decision of HHS to include in the draft regulations the coverage of all forms of birth control,⁹ allowing patients to access to the method that best meets their needs. Contraceptive methods vary and women with their health care providers need to be free to select from the full range of FDA-approved contraceptives. Not all contraceptives are clinically appropriate for every woman.¹⁰ We also know that women and couples are more likely to use contraception successfully when they are given their contraceptive method of choice, be it a birth control pill, a vaginal ring, or an intrauterine device (IUD).¹¹ The draft regulations hold the promise of making contraception more affordable and easier to access for millions of women.

While we strongly support the inclusion of contraception as preventive care, we are deeply troubled by the provisions that exempt certain employers from compliance. The draft regulations threaten to compromise the very important protections they would put in place. As physicians who care for patients who may be deprived of the affordable contraceptive coverage that all women deserve, we outline our concerns in the comments below.

I. Women employed by religious employers should be ensured the same preventive reproductive health care coverage as all other women.

The draft regulations allow certain religious employers to refuse to provide access to essential reproductive health care coverage for contraception.¹² That means that some women, because they work for religious employers that fail to allow this benefit, will be denied access to affordable birth control coverage. That is grossly unfair to these women, and from a medical perspective would constitute indefensible health policy. All women deserve access to affordable birth control—an important component of preventive health care, as the Department and the IOM have recognized—no matter where they work.

⁸ Burkman, R., Schlesselman, J.J., Ziemann, M (2004). “Safety concerns and health benefits associated with oral contraception.” American Journal of Obstetrics and Gynecology 190(4): S5-22.

⁹ The draft regulations properly include forms of emergency contraception in the birth control coverage provisions. Some groups have claimed this is a violation of federal law, arguing that emergency contraception is an abortifacient. This is medically inaccurate. Emergency Contraception. Practice Bulletin No. 112. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;115:1100–9.

¹⁰ Bonnema, R.A., McNamara, M.C., Spencer, A.L. (2010). “Contraception choices in women with underlying medical conditions.” American Academy of Family Physicians 82(6): 612-8.

¹¹ Frost, J. J. and J. E. Darroch (2008). “Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004.” Perspectives on Sexual & Reproductive Health 40(2): 94-104.

¹² The Interim Final Rules define an employer that can invoke the exemption as 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 6033(a)(3)(A)(i) or (iii) of the Code. 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.

Some of the most vocal opposition to the inclusion of birth control as a preventive service comes from the United States Conference of Catholic Bishops (USCCB).¹³ It is worth noting that virtually all women, including 98 percent of Catholic women, use contraception at some point during their lifetimes.¹⁴ Moreover, the decision to use birth control should be left to the *individual*. Employers should not have the power to interfere in private health care decisions by withholding coverage for care. A key promise of the ACA is that women will no longer be subjected to extra charges for necessary preventive prescriptions and treatments. Birth control should not be treated any differently. Employers should remain entirely free to express their opposition to birth control, but that opposition should never translate into substandard preventive medical care coverage.

One of our physicians had a patient we will call Susan.¹⁵ Susan worked in administration at a Catholic Archdiocese and her employer provided health insurance that did not cover contraception because of the employer's belief that birth control is immoral. Susan was in a relationship and did not want to become pregnant. Her partner refused to use condoms and the burden to prevent pregnancy fell on her. Because of her high blood pressure, Susan could not take birth control pills, and she and her doctor decided that an IUD was her best preventive health care option. But Susan could not afford the hundreds of dollars for the device and insertion. She went without any birth control, became pregnant and then had an abortion that should have never become necessary.

Susan was a victim of second-class preventive medical care. Susan and women in similar employment situations deserve access to affordable contraception. As physicians, we believe that medical evidence should govern healthcare and that every one of our patients should have access to high quality preventive reproductive health services.

II. Women employed by organizations affiliated with religious institutions should be assured access to the same preventive reproductive health care coverage as all other women.

Opponents of contraceptive coverage without co-pays have argued for an expansion of employers who could refuse to provide coverage.¹⁶ In their view, hospitals and social service agencies should have the ability to deny preventive reproductive health care coverage for their employees. These exclusions of care translate into significant hardships for our patients. Broadening the definition of a religious employer would make an already medically unsound policy even worse, depriving more women of essential preventive coverage.

¹³ "HHS Mandate for Contraceptive and Abortifacient Drugs Violates Conscience Rights," USCCB press release, August 1, 2011. [See also](#), comments from USCCB submitted to the Centers for Medicare & Medicaid Services, August 31, 2011.

¹⁴ Jones, R.K. and Joerg Dreweke, "Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use," Guttmacher Institute, April 2011. Among all women who have had sex, 99% have used a contraceptive method other than natural family planning.

¹⁵ Names of patients have been changed to protect privacy.

¹⁶ In their August 1 press release, [supra](#), note 13, USCCB noted their displeasure with the interim rules stating "Although this new rule gives the agency the discretion to authorize a 'religious' exemption, it is so narrow as to exclude most Catholic social service agencies and health care providers."

One of our physicians has a patient we will call Melanie. Melanie has worked for many years as an emergency room nurse at a Catholic hospital. She wanted a long-acting, reversible contraceptive, specifically an IUD. But the hospital's health insurance did not cover birth control. Melanie paid for birth control pills out-of-pocket, but she had experienced an unintended pregnancy while on the pill and knew that an IUD would be more effective. However, Melanie could not afford the nearly one thousand dollars for the IUD and its insertion. Instead, Melanie obtained an IUD from a nearby study of a new, experimental type of IUD. Her need for an IUD plainly outweighed her worries about using a contraceptive without FDA approval.

Another one of our physicians has a patient we will call Kristen. Kristen worked as a nursing assistant at a Catholic hospital. Like Melanie, her insurance did not cover contraception. Kristen, who is not Catholic, did not know about this policy until after she started working at the hospital. When Kristen first refilled her prescription for birth control pills, she discovered that she would need to pay fifty dollars per month, a new expense for which she had not budgeted as her last employer had covered contraceptives. Kristen was able to afford her prescription for a few months, but could not continue. She later had an unintended pregnancy and needed an abortion.

Yet another one of our physicians takes care of many women who are employees and students at a large, well respected, Catholic college. These women have no objections to birth control—they are either not Catholic, or among the ninety-eight percent of Catholic women who have used birth control. Most have no idea their insurance does not cover birth control pills or any other contraceptive until they begin working or studying there. When they find out, some panic because they cannot afford the full cost.¹⁷ These amounts can be prohibitive for a student or family on a budget. The college educates and employs thousands of women; they should not be denied affordable birth control as a condition of studying or working there.

As illustrated by our colleagues, it is important to the health of patients that affordable preventive reproductive health coverage be available to every woman in the American workforce without regard to the reproductive health position of their employers.

III. All women deserve access to contraceptives prescribed for purposes other than birth control in addition to family planning.

Several states make clear that religious exceptions for contraceptive coverage do not apply to contraceptives that are prescribed for purposes other than birth control. For example, California mandates that employers, including religious employers, cover birth control when prescribed for the purposes of lowering the risk of ovarian cancer, eliminating symptoms of menopause, or for prescription contraception necessary to preserve the life or health¹⁸ of an

¹⁷ For instance, per year, the pill ranges from \$180 to \$600 out of pocket, the vaginal ring from \$180 to \$840. An IUD, which lasts much longer and saves money over time, requires an initial investment of \$500 to \$1,000.

¹⁸ An unintended pregnancy may have significant implications for a woman's health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease. Institute of Medicine, supra note 1.

insured woman.¹⁹ Hormonal birth control, in addition to preventing unintended pregnancies, helps address several menstrual disorders, helps prevent menstrual migraines, treats pelvic pain from endometriosis, and treats bleeding from uterine fibroids.²⁰ Oral contraceptives have been shown to have long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, and short-term benefits in protecting against colorectal cancer.²¹ All women, including women who have religious employers, women in ministerial roles, and women employed by organizations affiliated with religious institutions need insurance coverage that will cover effective treatments, including hormonal contraception, for these conditions. The acceptance of inadequate health care coverage should not be a condition of working for a religious employer or agency.

IV. Conclusion

The Centers for Disease Control and Prevention recognized family planning as one of the singular public health achievements of the twentieth century.²² Yet the proposed "Respect for Rights of Conscience Act of 2011" (H.R. 1179) would allow companies a broad right to deprive women and their families of necessary medical coverage and services such as contraception. It elevates the "consciences" of corporations above the needs of individual patients, allowing a business entity to make personal, private decisions that should be left to women and their families. H.R. 1179 would have extreme consequences – not only allowing the refusal of care, but even coverage to people or groups that a corporation finds objectionable. This is medically unacceptable.

The ACA holds the promise of expanding health care coverage for millions of Americans and ensuring that all of our patients live healthier lives. Allowing religious employers and organizations affiliated with them to interfere with the personal reproductive health care decisions of their employees is poor public health policy that could harm too many American women and families.

¹⁹ Cal. Health & Safety Code §1367.25(b)(2)(c) (enacted 1999): "Nothing in this section shall be construed to exclude coverage for prescription contraceptive supplies ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for prescription contraception that is necessary to preserve the life or health of an enrollee."

²⁰ Burkman, *supra* note 8.

²¹ *Id.*

²² Centers for Disease Control and Prevention, "Achievements in Public Health 1900-199: Family Planning," *MMWR Weekly*, December 03, 1999, 48(47);1073-1080.