



The Contraception Controversy: A Comprehensive Reply

Introduction

The Obama Administration's recently announced policy to require insurers to cover contraception as women's preventive health care has prompted many over-heated [op-eds](#), [editorials](#) on [both sides](#) and even a thoroughly [one-sided Congressional hearing](#). The controversy is unlikely to end anytime soon: [pending federal legislation](#) and [proposed amendments](#) would massively enlarge the scope of insurers' and business owners' ability to restrict any type of insurance benefit on either "moral" or "religious" grounds, undermining the very purpose of insurance.

Below, we take a closer look at the arguments by opponents of the contraception requirement, unpack the legal issues and public health debate, and respond to many erroneous assertions.

First, however, we note what is at stake. Last August, recommendations for women's preventive care from an Institute of Medicine panel of medical experts made a compelling case for transformative improvements in the availability of contraception that will lead, at last, to measurable improvements in the [sky-high rates of unplanned pregnancy](#) in the United States, and will, happily, increase the proportion of planned pregnancies among American women.¹

By ensuring access to contraception, the policy

will [improve maternal and child health and reduce health care costs](#). These goals are recognized by both [the public](#) and [the courts](#) as a compelling interest essential to the well-being, autonomy, and privacy of women and families. As *The Salt Lake Tribune* [notes](#), "[t]here is no rational objection to the idea that universal access to contraception improves women's health and lives, is key to reducing poverty, is cheaper than childbirth and belongs in any health care plan worthy of the name."

The vast majority of Americans already use contraception, albeit inconsistently. Too many today find the [most highly effective, long-acting forms of contraception out-of-reach for cost reasons](#). The significance of the contraceptive-coverage requirement cannot be overstated: it will allow millions of women who today [cannot afford regular access to contraception](#) the ability to take better control of their health and the direction of their lives. Perhaps this is the reason that the policy is receiving such [high levels of public support](#), even among self-professed Catholics (61 percent of whom support it in [one recent poll](#), at the same rate as the general public).

The policy's wide reach will particularly assist women with fewer resources, [many of whom admit to](#) sometimes using contraception inconsistently in order to save money. Such a [transformative change](#) cannot happen, and will not happen, if the rule is

permitted to be punched full of holes in order to prioritize religious institutions' views *over* the needs and wishes of the women and families employed by them.

The nature of insurance coverage as a service is that it asks nothing of those who may not need, want, or use the full scope of coverage. Millions of women are employed by religiously affiliated hospitals and social-service organizations. The health needs of these women and their families are [identical to those of the general population](#), and they [want and need coverage for contraception](#).

The outlines of the issue are by now clear. [Citing cost disparities that fall heavily on women in the healthcare insurance market](#), Congress enacted a new women's preventive services coverage requirement as part of the Affordable Care Act. Following a year-long review by medical experts, the prestigious Institute of Medicine (IOM) [recommended a host of health measures](#) to be covered without co-pay in insurance, including "the full range of Food and Drug Administration-approved contraceptives." The Department of Health and Human Services (HHS) published an [interim final rule](#) last year that adopted the IOM recommendations, but proposed an exemption for houses of worship, including churches and integrated auxiliaries of churches, on the grounds that these institutions exist to instill religious values and primarily employ and serve people of the same faith.

In January, HHS announced that this rule would be finalized with an additional one-year grace period to permit a broader range of religiously-objecting organizations, such as hospitals and universities, to comply. Subsequently, in response to a vigorous public debate, on February 10, 2012, President Obama took steps to accommodate the concerns of these groups with a modified implementation plan.

Under the [new policy](#), formally memorialized in the [Federal Register](#), objecting employers may opt out of paying for, and communicating about, contraception coverage. Instead, insurance companies will be required to offer the coverage directly to employees. At the same time, HHS also issued [a bulletin](#) regarding the temporary enforcement safe harbor.

This workable and balanced approach [has the approval of a majority of Americans](#), including a majority of Catholics, and quickly garnered the support of many large Catholic organizations, such as the [Catholic Health Association](#), the [Association of Jesuit Colleges and Universities](#), the [Sisters of Mercy of the Americas](#), and [Catholic Charities](#), as well as other [religious denominations](#) and religious [leaders](#).

Yet the United States Conference of Catholic Bishops (USCCB) and some other religious leaders have [vociferously objected](#) to the policy, claiming it would violate religious liberty. Instead, [they urged support](#) for [highly unpopular](#) legislation to allow any employer, including anyone who runs "[a Taco Bell](#)," to refuse to provide coverage for *any* services on *any* moral or religious grounds.

The following rebuts the most common arguments against the accommodation. Specifically, we suggest that:

1) Religious liberty and the right of an individual to live according to his or her own religious conscience are supported, not threatened, by this policy.

The issue raised in this debate is not whether religious liberty should be protected, but *whose* religious liberty the law should protect. Conscience rights belong to individuals, not institutions. The new policy accommodation responds to the concerns of religiously-objecting institutions without sacrificing individual workers' rights, religious liberty or consciences.

2) Both the original policy and the accommodation are legally and constitutionally sound.

Neither the Administration's accommodation nor the original policy violates constitutional principles or federal law. Opponents of the contraceptive-coverage requirement lack a robust legal basis for challenging the policy, and they would not be supported in their claims even by conservative justices on the Supreme Court.

3) The Administration's policy accommodation fairly balances the interests of employers and employees and is based on the economic realities of the insurance marketplace.

Once paid to the insurer, the funds of an objecting religious employer lose their identity and become those of the insurer. The employer may not direct how the insurer invests, spends or otherwise uses those dollars. The Bishops' continuing opposition reveals how they have shifted the goalposts over the course of this debate – now it is not only paying for contraceptive coverage that is objectionable, but the very knowledge that an employee might independently obtain a service despite the disapproval of her employer.

4) Birth control coverage is a mainstream and commonsense aspect of preventive care for women. The coverage requirement is essential to address unconscionably high unintended pregnancy rates in the U.S. and will remedy the cost and consistency problems that currently hamper effective use of contraception.

Respect for life and the experience of pregnancy demands that we take steps to ensure that pregnancies are healthy and wanted. Birth control prevents unintended pregnancy, and the panoply of negative economic, social, and health outcomes that occur for both mother and child when a pregnancy is unintended.

5) Emergency contraception is essential to women’s health and is not an “abortion drug.”

The Bishops’ claim that emergency contraception is abortion-inducing does not reflect scientific reality. Emergency contraception works by inhibiting or delaying ovulation or other *pre*-pregnancy processes. Without a pregnancy, there can be no abortion.

6) Sterilization is a common form of birth control. Denying access, especially when it is medically recommended, can have devastating consequences.

American women increasingly rely on sterilization as a form of contraception as they get older. For many women, a post-partum sterilization is recommended when additional pregnancies are not only undesired but would threaten the woman’s health. Refusing to provide insurance for a sterilization following childbirth in such circumstances may mean denying a patient wanted and needed medical care. It also means that the woman must subject herself to a second, unnecessary surgical procedure and the risks of a second medical intervention.

7) Conclusion

The U.S. has a proud tradition of defending the right of the individual to moral self-determination in both religious and secular matters. The Obama Administration’s healthcare accommodation allows

employers that object to providing coverage for contraception to avoid both paying for and communicating about that coverage, while ensuring that employees of public-facing institutions have the same benefits as everyone else. No one is compelled to use the benefit or pay for contraception under the policy, and no provider is compelled to furnish services. This is a fair and workable balancing of interests and should have ended the controversy.

1) Religious liberty and the right of an individual to live according to his or her own religious conscience are supported, not threatened, by this policy.

At a now-infamous congressional [hearing on February 16](#), the Republican-controlled Committee on Oversight and Government Reform of the House of Representatives assembled a [predominantly male cast of religious leaders](#) to opine on issues of religious freedom ostensibly threatened by the contraceptive coverage requirement. In framing the topic, Chairman Rep. Darrell Issa (R-CA) strained the limits of credulity by [insisting that women’s health and reproductive rights were outside the scope of the hearing](#).

But contrary to Rep. Issa’s assertions, religious liberty, as it has been recognized by courts in constitutional deliberations, does not mean the liberty of employers to abridge their employees’ religious rights, particularly in public-facing institutions. For that reason, women’s health – and the notion of a private zone of decision-making that protects the rights of workers at public-facing institutions – should have been precisely the question considered by Congress. The issue raised in this debate is not whether religious liberty should be protected, but *whose* religious liberty the law should protect.

Despite [misleading assertions](#) by witnesses at the Issa hearing, in a diverse and pluralistic society governed by democratic laws, religious authority is not an absolute. For example, religious organizations cannot control what employees do with their paychecks even if they are the ones paying the salary. They cannot control who moves in next door, even if the neighbors engage in activities that offend. They cannot discriminate when hiring workers for non-ministerial positions, even within a church. They cannot deface billboards, even if the images are directly contrary to their beliefs.

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There are limits, and for this reason, it is essential that one not confuse “[a war on \[\] religion with not always getting everything you want.](#)” Indeed, without such limits, the government’s actions [would violate the First Amendment’s Establishment Clause](#) by supporting, with government action, a particular religious view.

The flip side of the Establishment Clause is the Free Exercise Clause, which ensures that religious individuals retain the freedom to practice their religion. In resolving these sometimes competing interests, the courts have generally sought to strike a balance between respect for the internal decision-making authority of religious institutions and the democratic values reflected in requirements imposed upon public institutions.

This careful balancing act is structured into our Constitution. Interestingly, as noted in a [recent analysis](#) by scholars at the Brookings Institute, the Framers of the Constitution considered – and rejected – specific constitutional protection for conscience rights:

Madison’s original draft of what became the First Amendment would have protected “the full and equal rights of conscience.” By the close of the House debate, the language included protections for both the free exercise of religion and rights of conscience, implying a distinction between them. After moving back and forth between these two formulations, the Senate ultimately selected religious free exercise, which became the language sent to the states for ratification.

So how does the free exercise clause operate in practice? As a first principle, generally applicable laws – even those with an incidental effect on religion – do not violate the First Amendment because they are the *sine qua non* of governing an ordered society.

In the key constitutional case on the question, [Employment Division v. Smith](#), the Supreme Court rejected the claim of Native American Church members whose sacramental use of peyote disqualified them for unemployment benefits. Writing for the Court, Justice Scalia explained that a neutral law of general applicability that happens to burden one’s religious practice does not violate the Constitution because “[t]he government’s ability... to carry out... aspects of public policy, ‘cannot depend on measuring the effects of a governmental action on a religious objector’s spiritual development.’” The alternative is to permit every religious objector to “become a law unto himself” – a result which “contradicts both constitutional tradition and common sense.”

Other cases make clear the balance of interests when religious institutions – rather than individuals –

are involved. Religious organizations, when acting in a religious capacity or deciding matters of internal governance – as is the case with houses of worship – receive considerable deference from the courts. But institutions that voluntarily assume a public role, *including those with religious affiliations*, are, generally, subject to the same laws as everyone else. Those institutions have chosen to primarily employ members of the general public, to primarily serve the general public, and to assign themselves a mission that is not primarily religious in purpose or goal.

Because we do not go to a hospital for a sermon, but rather for medical care, and because the employees of that hospital are there for work, and not worship, the test is reasonable. The issue is one of fairness: public-facing institutions must follow the law and abide by the same rules as everyone else with regard to their workers’ rights and consciences.

The fact that a religious conviction leads adherents to perform acts of public service, such as founding hospitals or soup kitchens, does not mean that the hospital or kitchen itself is any more exempt from generally applicable regulations than a hospital or soup kitchen founded by atheists. Such a rule would unfairly advantage religious institutions over nonreligious institutions, in violation of the Establishment Clause. Instead, where a religious institution decides – for whatever reason – to provide a public service, it is subject to the same rules that govern nonreligious public-service providers. The alternative would mean that food-safety laws would not apply to kosher butchers, that child-safety laws would not apply to church-affiliated daycare, and that building codes wouldn’t apply to the construction of churches and mosques. In short, allowing an institution’s *motivation* to subject it to a lesser set of regulations is a recipe for chaos.

Finally, it should be noted that the objection of some religious institutions to the contraceptive-coverage rule is nothing new. Indeed, religious institutions serving the public have long decried as a violation of religious liberty a host of laws designed to promote gender and racial equality. In the 1960s, for example, [some religious groups attacked](#) enforcement of the Civil Rights Act of 1964 prohibiting racial discrimination in public accommodations. And in the 1980s, Bob Jones University – which opposed interracial dating – [unsuccessfully sought an exemption](#) from the law prohibiting tax-exempt schools from engaging in racial discrimination. [Other religiously affiliated institutions sought to give special benefits to male employees](#) on the grounds of a supposed Biblical command that men be the heads of households. Religious institutions’ current opposition to extending contraceptive coverage to women is, sadly, in line with these previous, now-discredited, positions. The policy is

a remedy for [discriminatory practices](#) that both exclude women’s health care from coverage and increase costs for services that only women need.

2) Both the original policy and the accommodation are legally and constitutionally sound.

[Contrary to loud claims by opponents](#), neither the Administration’s policy accommodation nor the prior rule violate constitutional principles or federal law. Indeed, one reason for all the fuss in Congress may be that opponents of the contraceptive-coverage requirement are aware they lack a robust legal basis for challenging the policy, and that they would not be supported in their claims even by conservative justices on the Supreme Court. Their case, in short, is a loser.

The two most relevant court decisions to date upheld similar state contraceptive-coverage requirements over objections by religiously-affiliated institutions – objections nearly identical to those now being launched in public and Congress. In one case, the [highest court of New York held](#) that a contraception coverage requirement that was *less* deferential to religious organizations did not substantially burden religious beliefs or practices because “when a religious organization chooses to hire nonbelievers it must, at least to some degree, be prepared to accept neutral regulations imposed to protect those employees’ legitimate interests in doing what their own beliefs permit.”

In a second case, the [California Supreme Court held](#) that Catholic Charities was not an arm of the church, but a “nonprofit public benefit corporation,” and emphasized that most of the organization’s employees “do not belong to the Catholic Church.” Consequently, the court wrote, it would be grossly unfair to allow the church hierarchy to veto the health rights of employees – a majority of whom are non-believers. The court also highlighted the crucial distinction between religious adherents and employees: “Only those who join a church impliedly consent to its religious governance on matters of faith and discipline.”

Indeed, the Supreme Court has repeatedly emphasized that conscience rights belong to individuals, not institutions. For example, in [McCreary County v. ACLU of Kentucky](#), the Court noted that “[t]he Framers and the citizens of their time intended...to protect the integrity of individual conscience in religious matters...” [Wallace v. Jaffree](#) similarly held that “the Court has unambiguously concluded that the individual freedom of conscience protected by the First Amendment embraces the right to

select any religious faith or none at all.” And in [Glickman v. Wileman Brothers & Elliott, Inc.](#), the Court proclaimed that “at the ‘heart of the First Amendment [is] the notion that an individual should be free to believe as he will, and that in a free society one’s beliefs should be shaped by his mind and his conscience.’”

Yet the individual conscience rights of employees are utterly disregarded by the opponents of this rule who seek a broad religious exemption that would adversely affect a host of other actors – including women, children, and the families of those employees. The Bishops thus seek a religious exemption from a neutral law at the expense of third parties. But as the court observed in the California decision, “[w]e are unaware of any decision in which...the United States Supreme Court...has exempted a religious objector from the operation of a neutral, generally applicable law despite the recognition that the requested exemption would detrimentally affect the rights of third parties.”

[Opponents of the contraceptive-coverage rule point](#) to a recent Supreme Court [decision](#), *Hosanna-Tabor Evangelical Lutheran Church and School v. EEOC*, as evidence that the Court would find the rule unconstitutional. But that decision is irrelevant to the questions that would be posed by a challenge to the contraceptive-coverage requirement. *Hosanna-Tabor* was about whether a “called” teacher who taught classes at a religious school and had been qualified as a religious instructor through a specific internal process should be considered a “minister” for purposes of employment law. The Court’s decision – that she was indeed a minister and therefore was not able to pursue a discrimination claim – turned on their analysis of whether she was properly considered a religious employee. It did not disturb settled law regarding the test for public-facing institutions, as described above.

To the contrary, applying this test to the Administration’s accommodation shows that opponents of the law are unlikely to prevail in a constitutional challenge. The requirement that contraceptive coverage be available to employees through their health plans does not violate the Free Exercise Clause of the First Amendment because it is a neutral and generally applicable law. (And, as [we have demonstrated](#), all of the cases routinely cited by opponents of the law are beside the point.

In short, [no religious exemption to the rule would be required by the First Amendment](#). By providing an exemption for houses of worship and an accommodation for objecting organizations, the Administration has carefully balanced interests despite being under no legal obligation to do so. Indeed, the policy mirrors

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the concerns reflected in the New York and California state court decisions by protecting the conscience rights of individual employees to make their own decisions on matters of faith, privacy and health.

Another claim objectors make is that the no-copay-contraception rule violates the First Amendment's guarantee of free association by forcing religiously affiliated employers "to associate with an ideology that violates their religious beliefs" – the precise claim made by seven state attorneys general who have [filed a lawsuit](#) objecting to the contraceptive-access rule. This claim – that obeying a law "associate[s] oneself" with the law's "ideology" – is absurd. Hundreds of laws oblige citizens, some with which they may disagree – but that does not mean that the laws violate everyone's First Amendment rights.

In addition, courts consistently hold that freedom of association is about association with *individuals*. For example, the Bishops' comments on the no-copay-contraception rule cited for support cases in which groups were permitted to exclude gay individuals. But nothing in this rule requires anyone to hire – or exclude – a particular individual contrary to their beliefs.

Opponents also claim that a federal law, the Religious Freedom Restoration Act (RFRA), is violated by the contraceptive-coverage requirement. Yet the requirement does not substantially burden the exercise of religion, [despite attempts by Rep. Trey Gowdy \(R-SC\) to conduct a "legal analysis"](#) by asking witnesses at the Issa hearing panel their thoughts on the question.

No matter how emphatic the claims to the contrary, providing preventive health services without cost sharing *has nothing to do with the "exercise" of religion*. Virtually all cases upholding RFRA-based challenges have focused on the practice of religious worship. The Supreme Court, for example, in [Gonzales v. O Centro Espirita Beneficente](#), upheld a RFRA-based challenge to the Controlled Substances Act, allowing a religious sect to drink an hallucinogenic tea as part of a ritual.

Unsurprisingly, none of the Oversight Committee's witnesses actually made a claim that any kind of sexual activity is central to, or even a part of, their worship or religious practice. In fact, the health needs addressed by the requirement have no relation to any recognized religious practice.

The test under RFRA is also a relatively high bar – to violate the law, a provision must "substantially" burden religious exercise. Even if the contraception requirement does burden "religious exercise," the burden, particularly under the accommodation, is minimal.

First, the law does not compel speech. The limited instances in which the courts have found unconstitutional compelled speech are cases in which a speaker was forced to make a particular statement of belief.² As the California Supreme Court [held](#), "Catholic [organizations'] compliance with a law regulating health care benefits is not speech."

Nothing in the coverage policy requires the Catholic Church – or any religious institution – to articulate support for the government policy. This was true even in the absence of a modification for religiously-affiliated institutions, but the Administration's new proposal allows these organizations to distance themselves even further by allowing them to opt out of notifying employees that coverage is available. Instead, the onus will be placed on insurance companies to reach out directly to employees – *in lieu of the employer* – when a qualifying institution refuses.

At the same time, religious institutions are free to speak out against contraception – priests may inveigh against birth control in sermons; and churches may publish anti-contraception broadsides. They may even indicate to one and all that the availability of coverage for contraception is not the organization's choice, but the result of a government requirement.

Nor, [contrary to allegations](#), does the policy interfere with the "internal governance of religious institutions." The Bishops' [comments to HHS](#) on the rule on this point quoted the Supreme Court's decision in [Kedroff v. St. Nicholas Cathedral](#) for the proposition that churches can "decide for themselves, free from state interference, matters of church government as well as those of faith and doctrine." But that case concerned an intra-church dispute within the Russian Orthodox Church regarding a disagreement about deference to differing church authorities.

The notion that government should not interfere in the inner workings of religious institutions regarding who has authority to speak on religious matters is obvious and non-controversial. It is also wholly irrelevant to the appropriateness of a neutral, generally applicable policy that affects all employers equally. Here, there is no governmental intrusion upon the internal doctrinal workings of the church. The government is not mandating that women be ordained as priests. It is not determining the proper relationship between cardinals and bishops. In short, the contraception requirement has nothing to do with church governance.

Under RFRA, even *substantial* burdens on religious exercise are permitted if they advance a compelling state interest. As [we show in our comments to the rule](#),

the no-copay-contraception requirement furthers several compelling governmental interests, including an interest in women’s health, children’s health, equality, autonomy, and the health and well-being of couples and families. Even [a co-sponsor of RFRA acknowledges](#), that, in this instance, there are competing liberty interests. It should be axiomatic that the government has a compelling interest in both the health of its people, and in their freedom to direct their lives according to their own beliefs.

The government also has a compelling interest in ending gender discrimination. Title VII of the Civil Rights Act of 1964 stipulates that employers with fifteen or more employees may not discriminate in pay and benefits. In December 2000, the EEOC [issued a holding](#) that Title VII bars employer-sponsored health insurance plans that provide prescription drug coverage from failing to provide coverage of contraceptives.

In enacting the preventive services provision in the debate over the Affordable Care Act, Congress cited similar concerns about the inequitable cost burdens on women for needed healthcare. Sen. Barbara Mikulski (D-MD), the driving force behind the amendment, [emphasized that](#) “[w]omen of childbearing age incur 68 percent more out-of-pocket healthcare costs than men,” and noted that women “face gender discrimination.”

The courts have also agreed that eliminating gender discrimination is a compelling state interest. In [Catholic Charities of Sacramento, Inc. v. Superior Court](#), the California Supreme Court held that a contraceptive-coverage statute “serves the compelling state interest of eliminating gender discrimination.” The court pointed to the same evidence as Sen. Mikulski: “women during their reproductive years spent as much as 68 percent more than men in out-of-pocket health care costs, due in part to the cost of prescription contraceptives and the various costs of unintended pregnancies, including health risks, premature deliveries and increased neonatal care.” Such an interest has also been recognized in several other court challenges to plans’ failure to provide contraceptive coverage under Title IV, which bars gender discrimination. (A helpful analysis by the National Women’s Law Center of the EEOC decision and related cases is [here](#).)

None of the pending legal claims, [including the one filed by seven state Attorneys General](#), are sufficiently robust to survive a thorough legal analysis. The lawsuits [brought by the Becket Fund](#) and the [Alliance Defense Fund](#) are [premature](#), and likely to be dismissed until the new policy has been finalized. Once the accommodation has been clarified by a rule, it will be clear that there is no First Amendment violation or other legal infringement, as explained at length above.

Separately, the claims brought by the state Attorneys General on behalf of several plaintiffs all turn on an assertion the policy is problematic “[because it compels Plaintiffs to subsidize](#)” coverage. But because the rule will explicitly require insurers to pay for the coverage and the policy will be revenue neutral even for insurers (as explained in the next section), there is no subsidy, and therefore no injury.

Some Catholic organizations have raised the specter of dropping all health insurance for employees to avoid complying with the no-copay-contraception; others have said they would rather face criminal penalties rather than follow the law. At a [congressional hearing](#), for example, Christian Medical Association CEO David Stevens said dropping all health insurance coverage for all employees “would be something we have to consider,” and Jane Belford, Chancellor of the Archdiocese of Washington, stated when responding to the pre-accommodation rule that although dropping health insurance was “unthinkable,” the diocese would not obey the law extending contraceptive coverage to employees.

This refrain – that religiously objecting organizations will cut benefits unless it is given a special dispensation from obeying the law – is a common one. Ms. Belford [previously threatened](#) to cut off aid to 68,000 needy individuals, including one-third of Washington’s homeless population, if the District of Columbia recognized gay marriages. And when a civil-union law went into effect, the Catholic Church [displaced 350 foster children in its care and fired 58 employees in protest](#).

But in the present context, these threats are particularly hollow. In fact, numerous major Catholic-affiliated institutions *already* cover contraception. For example, the largest Catholic college in the U.S., DePaul University, [includes contraception](#) in its employee benefits, as do [Marquette University](#) and [many other Catholic-affiliated institutions](#). Because [28 states already mandate birth control coverage](#), some of these institutions cover birth control to comply with state law. However, even these institutions could avoid the birth control requirement by self-insuring or dropping prescription coverage. Instead, they have prioritized the health needs of their female employees.

Those who are persuaded by the Bishops’ arguments that contraception is immoral or undesirable are free to ignore the benefit. But the [98 percent of Catholic women who have used contraception](#), and employees of objecting organizations who are not Catholic, should be entitled to make that choice for themselves, as a matter of their own beliefs and health.

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As a general observation, religious employers (as well as non-religious ones) already cover health services to which they may, in principle, object. For example, Catholic employers' health insurance plans may cover maternity care for unwed mothers or HIV tests without regard to sexual orientation; Mormon employers' insurance may cover emergency services for injuries that happen to have been caused by reckless, alcohol-fueled behavior.

Indeed, the extent to which public institutions can claim an affiliation with religious groups is often less than obvious. Hospitals, for instance, including religiously-affiliated ones, take many more federal and taxpayer dollars than religious contributions, and are subject to generally applicable health, safety and licensing standards. And in many instances, the religious affiliations of organizations are quite tenuous. When a hospital in Arizona, St. Joseph's Hospital and Medical Center, had its religious affiliation terminated several years ago due to a decision to allow doctor to perform a medically necessary abortion, [news reports indicated](#) that the only thing that changed was that Catholic mass could no longer be held at the hospital.

Putting aside the broad support for coverage on the part of Catholics (which [in polls](#) is the same as that of the general population) and its widespread use, even practicing Catholics have filed claims against institutions that fail to provide coverage for contraception, alleging that they are trampling both employees' rights and federal anti-discrimination law. For just one example, among the witnesses at the Issa hearing was William Theirfelder, President of Belmont Abbey College, which has already [brought a lawsuit](#) against the policy. As Theirfelder indicated in [his testimony](#), in 2007, eight faculty members at Belmont, including some Catholic professors, complained to the EEOC about a change in policy at the school to exclude coverage of contraceptives for employees.

At the time, a practicing Catholic and philosophy professor, Janette Blandford, [indicated that her view](#) that contraception should be covered differed from the Church's position on the issue. (We only know her identity because Theirfelder [revealed](#) all of the names of the complaining employees in an email to faculty, students and staff about the case, a petty act of bullying that the EEOC found created a "chilling effect.") In 2009, the EEOC [issued a letter](#) noting that Belmont Abbey's failure to provide contraception coverage was in violation of the law against gender discrimination.

The Catholic hierarchy also has historically debated the question of contraception. Around the same time as the Supreme Court's historic 1965 decision in

[Griswold v. Connecticut](#), which upheld the right to access contraception as within a constitutional "zone of privacy," the Catholic Church was embroiled in an internal debate about whether contraception could be authorized. A secret international panel of conservative Catholics and theologians, as part of the [Pontifical Commission on Birth Control](#), recommended [overwhelmingly to rescind the ban](#) because it was essentially an extension of the "rhythm" method already approved by the Church and "it is natural to man to use his skill in order to put under human control what is given by physical nature."

As Catholics for Choice [explains](#):

Lay members presented the findings of surveys they had conducted of devout Catholic couples about their experiences with the rhythm method; some of the women present testified about their own use of the method. What the commission heard challenged their thinking about the role of fertility and contraception within marriage. They heard that contrary to the assertion of the hierarchy that natural family planning brought couples closer together, it often drove them apart. They heard of couples who became obsessed with sex because of the unnatural restrictions placed upon spontaneous demonstrations of affection. And they heard women speak of childbearing as one of many roles they played as wives, mothers and partners and of the importance of the non-procreative sexual bond to marriage.

A recent [blog post](#) relates a short version of the story:

After the advent of the pill, Pope John XXIII appointed six lay people, referred to as the Pontifical Commission on Birth Control, to study the morality of birth control and population issues. The pope died that same year, and his successor, Pope Paul VI, expanded the Commission, adding a substantial number of clergy, including Cardinals, bishops, and priests, and appointed an executive committee of 15 bishops to construct the final report. The commission voted overwhelmingly to encourage the Church to rescind its ban on contraception and declared it not "intrinsically evil." The

final votes included “yeas” from 30 of 35 laypeople, 15 of 19 theologians, and 9 of 12 bishops (3 bishops abstained).

A minority report from dissenting members on the Pontifical Commission noted that a change in this policy [would reflect poorly on the Church](#):

It should likewise have to be admitted that for a half a century the Spirit failed to protect Pius XI, Pius XII, and a large part of the Catholic hierarchy from a very serious error. This would mean that the leaders of the Church, acting with extreme imprudence, had condemned thousands of innocent human acts, forbidding, under pain of eternal damnation, a practice which would now be sanctioned.

When the encyclical *Humanae Vitae* was published by the pope in 1968, the teaching on contraception was unchanged. But the decision was not well aligned, even then, with the views of the laity. [A report by Catholics for Choice](#) cites contemporary public opinion surveys: “[b]y 1974, 83 percent of Catholics said they disagreed with *Humanae Vitae*” on the matter of contraception.

3) The Administration’s policy accommodation fairly balances the interests of employers and employees and is based on the economic realities of the insurance marketplace.

Religiously objecting institutions that do not currently provide coverage for contraception in their health insurance plans were granted a significant accommodation by the Obama Administration when it announced on February 10, 2012, that such employers will not be required to subsidize coverage for contraception (as all other health insurance sponsors will have to do starting in August of 2012). Rather, insurers will include contraceptive coverage for employees at no charge to either the employer or the employee.

In response to this [fair and balanced](#) accommodation, some have questioned [whether the proposal is an accounting ruse](#), suggesting employers will have to cover the costs of birth control coverage through higher premiums.

This argument, obviously, ignores HHS’s explicit promise in the [published Final Rule](#) that the new policy for objecting employers will require that “there be no

charge for the contraceptive coverage,”³ and assumes, without evidence, that insurance companies will violate the clear requirements of the law by increasing premiums. (As a side-note, an unsupported assertion that some “bad actors” may disobey a law is rarely viewed as a reason to doubt the public policy behind the law.)

Regardless, [an editorial in the Wall Street Journal](#) argued:

The reality, as with all mandated benefits, is that these costs will be borne eventually via higher premiums. The balloon may be squeezed differently over time, and insurers may amortize the cost differently over time, but eventually prices will find an equilibrium.

This analysis, by predicting cost effects over time, gets it precisely wrong. It is certainly the case that coverage will require insurance companies [to provide up-front payments](#) for services and prescriptions. But because all insurance is a bet against future costs, the fact that contraception coverage is revenue-neutral over the medium term (because contraception averts both unintended pregnancies and improves maternal and child health outcomes) means that over time, *there will be no costs* to equalize.

It is for this reason that the National Business Group on Health, in a steely-eyed business analysis for the insurance industry that included number-crunching by a PricewaterhouseCoopers actuary, [already recommended in 2007](#) that insurers provide contraception coverage free of “cost sharing” (*i.e.*, no co-pays or deductibles) for employees. [Actuarial studies demonstrate](#) that the upfront costs of adding contraception to a health insurance plan are very low, and that these costs must be measured over time against the savings from fewer unintended pregnancies. A 2009 study of the cost effectiveness of 15 forms of birth control found that all of them were cost-effective when compared to no method, and that long-term contraception methods that do not rely on user compliance are the most cost-effective.⁴

Because cost is a significant barrier to effective and consistent contraceptive use, providing no-copay insurance coverage for contraceptives will both expand access and increase the number of women who use the most highly effective methods. As noted in [Guttmacher’s 2011 IOM testimony](#):

...three recent studies have found that lack of insurance is significantly associated with reduced use of

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prescription contraceptives, even when controlling for a range of sociodemographic factors. One of these studies also indicated that prescription contraceptive use increased between 1995 and 2002 among privately insured women because of state contraceptive coverage mandates enacted during that period, although the evidence on this point is less strong.

History also demonstrates that premiums do not necessarily rise when insurers are required to include birth control in their plans. More than a decade ago, Congress required plans in the Federal Employees Health Benefits (FEHB) program to cover all FDA-approved contraceptive methods. Around the same time, Hawaii prohibited employers from excluding contraceptive services or supplies from health insurance coverage. Again [according to Guttmacher](#), neither of these cases resulted in higher premiums.

Further evidence of a lack of cost concern may be found in the utter silence from employers regarding anticipated costs from the new policy, and telegraphed acquiescence of insurers, which (somewhat understandably) [quietly grumbled about the “precedent” while supporting the notion of contraception coverage](#). Given the new requirement, if the *Journal's* theory were right, employers in general should be vocally raising concerns regarding the potential for increases in premium costs for plans. Yet there has not been a peep from employers raising purely economic objections to the coverage requirement. In sum, the premium cost-shifting argument is itself a ruse.

[Some opponents](#) of the policy, as well as the USCCB, also suggest that they retain “[moral concerns](#)” regarding the accommodation, because, “that coverage is still provided as a part of the objecting employer’s plan, financed in the same way as the rest of the coverage offered by the objecting employer.” In other words, because contraceptive coverage will be offered by the insurer, an employer would still be somehow linked to that aspect of the coverage – even though they will not, in fact, be charged for it or be required to communicate about it.

The Bishops’ continuing opposition to this arrangement reveals how they have shifted the goalposts over the course of this debate – now it is not only paying for contraceptive coverage that is objectionable, but the very knowledge that an employee might obtain a service despite the disapproval of her employer.

When considered fully, this conclusion is extraordinary. In effect, the Bishops’ argument is that because an objecting employer purchases a product from an insurer, it somehow gives that employer the right to direct the insurer’s other activities, including offering an additional covered benefit free of charge. It also relies on an erroneous view of [how health insurance actually works](#).

When an employer purchases a health insurance policy for its employees, the insurance company does not create a special, separate account for the premiums it collects from that employer and its employees and hold those funds to pay only for the claims of those employees. Rather, those premium dollars are commingled with those of dozens, hundreds, or perhaps thousands of other employer groups; these [pooled funds](#) are then used to pay claims for the enrollees in all of those groups. Some of the funds are used for administrative expenses, and some are invested. No individual customer of the insurance company has a right, merely by virtue of being a customer and purchasing a plan, to direct what the insurer does with that customer’s specific funds. Once paid to the insurer, the funds of an objecting religious employer lose their identity and become those of the insurer. The employer may not direct how the insurer invests, spends or otherwise uses those dollars.

Yet under the Bishops’ logic, a religious employer would have the right to object to an insurance company’s investments of its funds in, say, a media company that produces “profane” material, or a defense contractor, as some of those funds may have come from a premium payment made by that employer. By extension, a religious employer could object to an insurer covering contraception or other objectionable services for enrollees in *another* employer’s health plan, as the insurer’s pool of funds contain *some* dollars that came from the objecting religious employer.

Furthermore, in most employer-sponsored health insurance plans, employees pay some share of the premium. In such situations, it makes even less sense that an objecting religious employer could prohibit the insurer and the enrollee from arranging for contraceptive coverage. An employer would ordinarily have no right to prevent employees from spending their income as they like, or from contracting for services. The Bishops fail to explain why an employer that pays some of the premium, but has expressly disavowed paying for contraception, should be able to prevent an enrollee who also pays for the policy, from accepting an additional benefit offered by an insurer.

To take this point one step further, health insurance coverage and other benefits are part of what is often referred to as “total compensation.” They are part of how employers compensate employees, which include wages or salary, stock options, and benefits (such as health insurance, disability insurance, contributions to a retirement plan, and paid vacation).

An employer that morally opposes the consumption of alcohol may not prohibit an employee from spending her wages on wine, or prescribe acceptable locations for an employee to go on vacation. And an employer that has a religious objection to contraception could not prevent an employee from spending her own funds to buy birth control pills. Religious employers should not be able to stand in the way of women’s health care by conditioning one form of compensation – health benefits – on conformity with the employer’s religious and moral views.

Leaving the employment context, but extending this logic, religious objectors’ position is tantamount to a claim that they should be able to restrict the unrelated commercial activities of medical suppliers or drug companies to their hospital, merely because those activities involved supplies or drugs to which they have a religious objection. This concept of religious liberty stretches the principle beyond recognition to encompass unfettered economic coercion.

Opponents of the Administration’s accommodation also complain that Catholic health *insurers* will violate religious principles by providing coverage for contraception. But the reality is that Catholic health insurance companies have been providing or arranging for contraceptive coverage for years.

A [survey conducted by Catholics for Choice](#) found that half of Catholic managed care plans were providing contraceptive coverage for enrollees; almost half covered tubal ligations. Plans have devised various ways of providing these needed services despite the religious teachings of the church, including contracting with non-Catholic providers to provide the services; arranging for the funds received from the employer or government program that pay for contraception to go to a third-party administrator; or arranging with another insurer to handle payment and provision of contraception.

In addition, many Catholic health plans participate in the Medicaid program, in which coverage for contraception/family planning is not only a mandatory service, but one that must be provided to enrollees without cost sharing (sound familiar?). Catholic Medicaid plans, like their commercial counterparts, have figured

out ways to participate in this insurance program. For example, they form a partnership with a non-Catholic insurer that provides coverage for contraception, or set up a [billing arrangement](#) in which funds for family planning go to a third party that, in turn, pays claims for contraceptive services and supplies.

These arrangements demonstrate that Catholic insurers have little difficulty administering health care coverage that includes contraception. Moreover, they belie the loud complaints by opponents of the rule and new accommodation that even being associated with a plan that includes contraceptive coverage is an assault on religious freedom. Catholic health plans have voluntarily entered the Medicaid managed care market in droves, with full knowledge that family planning is a covered service. These plans have not deemed the program so tainted by the legal requirement for this coverage that they refuse to participate in the overall Medicaid program. They have simply devised administrative workarounds to avoid directly paying for contraception while still affording their enrollees access to it, as required by law. There is no reason that religious insurers should have any more difficulty with this new coverage policy for contraception than they have had previously with similar requirements.

Finally, opponents argue that the new policy modification will be unworkable in the case of religiously-objecting employers that self-insure. The Administration has indicated that it will develop a workable policy for self-insured plans that is consistent with the goals of the new rulemaking: ensuring access to no-copay coverage for women, without placing a cost on objecting employers. With regard to the specific case of self-insured employers, the information published in the Federal Register [explicitly states](#):

The Departments intend to develop policies to achieve the same goals for self-insured group health plans sponsored by non-exempted, non-profit religious organizations with religious objections to contraceptive coverage.

Over the course of a year and a half, an appropriate solution will be developed and finalized. Given the flexible arrangements undertaken by Catholic insurance companies, as explained above, it should be clear that a number of possibilities exist for a policy result that will meet all of the stated goals. Development of a reasonable and workable solution seems all the more likely when we consider the strong expressions of support for the accommodation from groups like the [Catholic Health Association](#) and the [Association of Jesuit Colleges and](#)

[Universities](#), both of which include self-insured employers in their membership.

4) Birth control coverage is a mainstream and commonsense part of preventive care for women.

Responding to the modified policy announced on February 10, the [USCCB restated](#) their opposition to the contraception coverage requirement, calling it a “grave moral concern” and suggesting that “pregnancy is not a disease.”

Yet no one is suggesting pregnancy is a disease. Setting aside the fact that many American women – including one third of teen users – [use birth control for non-contraceptive reasons](#), respect for life and the experience of pregnancy demands that we take steps to ensure that pregnancies are healthy and wanted. As an earlier Institute of Medicine panel remarked in 1995:

The committee urges, first and foremost, that the nation adopt a new social norm: All pregnancies should be intended – that is, they should be consciously and clearly desired at the time of conception. This

goal has three important attributes. First, it is directed to all Americans and does not target only one group. Second, it emphasizes personal choice and intent. And third, it speaks as much to planning for pregnancy as to avoiding unintended pregnancy. Bearing children and forming families are among the most significant and satisfying tasks of adult life, and it is in that context that encouraging intended pregnancy is so central.⁵

Birth control also prevents unintended pregnancy, and the panoply of negative economic, social, and health outcomes that occur for both mother and child when a pregnancy is unintended. [Healthy People 2010 summarizes](#) the grave medical risks of unintended pregnancy:

Medically, unintended pregnancies are serious in terms of the lost opportunity to prepare for an optimal pregnancy, the increased likelihood of infant and maternal illness, and the likelihood of abortion ... The mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal

care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development.

In light of this compelling medical evidence, it is [downright insulting](#) for opponents of contraception to argue – as [Bishop Lori did](#) before Congress – that it is no more essential to women than a [ham sandwich](#).

Nearly half – 49% – of pregnancies in the U.S. are unintended – a rate far higher than in other developed countries,⁶ and 42% of unintended pregnancies end in abortion. [Data from the Guttmacher Institute](#) further underscore the problem:

- There are 62 million U.S. women in their childbearing years (ages 15 to 44);
- 7 in 10 women of reproductive age (43 million women) are sexually active and do not want to become pregnant, but could become pregnant if they and their partners fail to use a contraceptive method; and
- The typical U.S. woman wants only two children. To achieve this goal, she must use contraceptives for roughly three decades.

As preventive health care, birth control works. [As noted by Guttmacher:](#)

... publicly funded contraceptive services and supplies alone help women in the United States avoid nearly two million unintended pregnancies each year. In the absence of such services (from family planning centers and from doctors serving Medicaid patients), estimated U.S. levels of unintended pregnancy, abortion and unintended birth would be nearly two-thirds higher among women overall and nearly twice as high among poor women.

Over 99% of women of reproductive age who have ever had sex [have used contraception at least once](#). Catholic women have used contraception [at almost the same rate](#) (98%).

[Some opponents](#) recently suggested that these statistics prove that women are, as one critic ridiculously asserted, “[lavishly contracepted](#),” thereby obviating the need for no-copay insurance coverage. It is certainly worth noting that many of the same critics of family planning funding in annual budget fights in Congress are now suggesting that contraception grows on trees. More importantly, these oft-cited statistics do not represent the percentage of women who currently have consistent access to birth control, nor are they the percentage of women currently using birth control. For birth control to be effective at preventing unintended pregnancy, it must be used consistently. Women who can access and pay for birth control outside of their regular health insurance coverage are fortunate – and may not always be so fortunate. An inability to pay or access birth control for just one cycle will undermine its effectiveness.

What the above statistics *do* indicate is that women, almost universally, accept contraception as an appropriate and approved means of preventing unintended pregnancy. In addition, as [Irin Carmon’s article demonstrates](#), the no-copay coverage will allow women, for the first time, to choose the most effective contraceptive method for them:

Public health experts are also hoping that the new insurance mandates will help women switch to the more effective forms of birth control they have told researchers they’d be interested in, like the IUD, the implant or sterilization. These have far lower failure rates — around 1 percent or less — than typical use of condoms, at 17 percent, or the pill, at 9 percent. (The one method the Catholic Church approves of, officially termed “fertility-awareness-based methods” has a failure rate of 25 percent.)

For a glimpse of what the lives of women and families would look like should the policies of some anti-contraception religious organizations be reflected in law in the U.S., we can look to the Philippines, where a ban on contraception heavily influenced by the Catholic church continues today to result in [tragically high](#) unintended pregnancy and unsafe abortion rates, as reported in CRR’s 2010 report on the Philippines, [Forsaken Lives](#). As a 2008 Time magazine [article](#) noted:

Archbishop Paciano Aniceto, who chairs the influential Commission on Family and Life for the Catholic Bishop’s

Conference in the Philippines, calls birth control advocates “propagandists of a culture of death.” Sex, he says, is a privilege and should always be open to the transmission of life. Former mayor Atienza agrees. Family planning advocates have been “brainwashed” by the West, he says. His ban succeeded, he adds, by teaching Manila’s “innocent and ignorant” women “true” Filipino values.

Time drew out the comparisons between the Philippines and the U.S. in more recent [coverage](#):

The [Philippines’] high unmet need for contraception means that almost half of pregnancies are unwanted and about 500,000 per year result in abortion. All too often, these procedures are **unsafe**. Every year, an estimated 60,000 Filipinas are injured trying to terminate a pregnancy. About 1,000 die from abortion-related complications. ... Behind the Manichean religious rhetoric espoused by some conservative Catholics hide plain truths about public health: access to contraception decreases maternal mortality and lowers the number of abortions. This is true in the Philippines and it is true in the U.S.

5) Emergency contraception is essential to women’s health and is not an “abortion drug.”

Opponents of the rule, including [the USCCB](#), [assert that](#) the use of emergency contraception is equivalent to an abortion, and therefore that the requirement for coverage of “all methods” of FDA-approved contraception is objectionable:

The mandate forces coverage of sterilization and abortion-inducing drugs and devices as well as contraception. Though commonly called the “contraceptive mandate,” HHS’s mandate also forces employers to sponsor and subsidize coverage of sterilization. And by including all drugs approved by the FDA for use

as contraceptives, the HHS mandate includes drugs that can induce abortion, such as “Ella,” a close cousin of the abortion pill RU-486.

The Bishops’ claim that emergency contraception is abortion inducing does not reflect scientific reality. Emergency contraception works by inhibiting or delaying ovulation or other pre-pregnancy processes. Without a pregnancy, there can be no abortion.

The Bishops and others often assert that not only does emergency contraception inhibit ovulation, it also prevents a fertilized egg from implanting in the uterus. Setting aside whether such a process would be equivalent to abortion (the scientific view is that it would not be, as pregnancy is defined as beginning at implantation), this claim is also contrary to scientific evidence.

The most recent studies conducted on levonorgestrel-based emergency contraception (LNG ECP) confirm that it has no effect on implantation. The Emergency Contraception Statement from the International Federation of Gynecology and Obstetrics (FIGO) affirms that LNG ECP impairs ovulation and might affect sperm function, but that it does not inhibit implantation and has no effect on an existing pregnancy.

Inhibition or delay of ovulation is LNG ECPs principal and possibly only mechanism of action. Review of the evidence suggests that LNG ECPs cannot prevent implantation of a fertilized egg. Language on implantation should not be included in LNG ECP product labeling. The fact that LNG ECPs have no demonstrated effect on implantation explains why they are not 100% effective in preventing pregnancy, and are less effective the later they are taken.

The [World Health Organization](#) has also stated that levonorgestrel-alone emergency contraceptive pills (LNG ECP) “[do] not prevent a fertilized egg from attaching to the uterine lining. The primary mechanism of action is to stop or disrupt ovulation; LNG ECP use may also prevent the sperm and egg from meeting.”

Emergency contraception [does not harm an](#)

[established pregnancy](#), much less terminate it, and is therefore not what would [commonly be understood](#) as “abortion-inducing.” Instead, by delaying ovulation, use of emergency contraception can reduce the risk of an unwanted pregnancy by [75 percent or more if used correctly](#).

The [American Academy of Pediatrics Policy Statement on Emergency Contraception](#) finds that use of emergency contraception could prevent half of all unintended pregnancies and abortions in the United States. Given the grave consequences of unintended pregnancy and the narrow window of time in which it is necessary to act to avert a pregnancy, it is essential that women and families receive accurate medical information about the effects of emergency contraception, in order to fully weigh their options.

Distortion of the science makes it more difficult, not easier, to help women avoid unintended pregnancies. It is unfortunate that emergency contraception, which is safe and available without a prescription for women over 17 years of age, and is the most effective way to prevent pregnancy following intercourse, has been politicized. In such an environment, it is essential that public health guidelines reflect the [scientific consensus](#), and allows women and families to make the critical decision regarding whether or not to use emergency contraception.

6) Sterilization is a common form of birth control. Denying access, especially when it is medically recommended, can have devastating consequences.

Contrary to assertions by opponents, sterilization is a common form of birth control and one that is recommended for certain women’s health. American women rely increasingly on sterilization as a form of contraception as they get older. In 2002, 50% of women 40 and older relied on this method.⁷ Sterilization is more commonly used by women with more children, and those with lower education and income.⁸ Post-partum sterilizations are often recommended for women who have had three or more c-sections because they face increased risk of significant pregnancy complications with a subsequent c-section delivery.

When women cannot access sterilization, the consequences can be severe. [Research by Lori Freedman and Debra Stulberg](#) reveals that the primary disadvantage of working in a Catholic hospital cited by physicians was the inability to perform sterilizations, particularly following a c-section delivery (which eliminates the need for a second procedure). This physician sentiment was borne

out by fact-finding research conducted by the Center for Reproductive Rights in three communities in which previously secular hospitals came under Catholic control.

One doctor described in vivid detail the impact of the denial of sterilization services required by strict adherence to Catholic doctrine:

There are only so many c-sections a woman should have. With every one the next pregnancy is markedly compromised. [T]here's a higher risk the placenta can implant on the uterine scar ... you can't get the placenta out, there's morbid hemorrhage [she demonstrates by turning on the faucet until the water runs vigorously]. ...It's absolutely unconscionable ... The Pope, the Cardinal, the Board is not going to be there, not going to be here when she is hemorrhaging, bloody, you can't see, it's horrible, the uterus is cut, she needs a massive transfusion. Six months later she still looks awful, like death warmed over; she can't take care of the little ones she has.⁹

For women with difficulty accessing reversible contraceptive methods, sometimes sterilization is the only viable option; removing it as an option can literally be fatal. All of the physicians we interviewed told stories of women under their care who had been unable to obtain sterilizations, and who subsequently became pregnant when they did not want to be; most tragically, one woman who had wanted the procedure and had six children had died in childbirth.

As noted above, for many women a post-partum sterilization is recommended when additional pregnancies are not only undesired but would threaten the woman's health. Refusing to perform a sterilization following childbirth in such circumstances means denying to a patient wanted and needed medical care, and will also mean that the woman must subject herself to a second, unnecessary surgical procedure at another institution. This means another round of anesthesia and the risk of infection and complications that normally accompany surgery. Moreover, this burden is being placed upon a woman who has just given birth and is not only recovering but has the responsibilities of caring for a newborn.

In addition to the personal burden and health consequences, a second surgery at a separate facility means additional costs. The refusal of religious health care institutions to provide sterilization as part of delivery not only forces upon women needless additional medical

intervention, it drives up healthcare costs that either the woman herself or her insurance plan must cover.

For women for whom an immediate post-partum sterilization is medically indicated, refusal to allow this procedure to be performed based on religious directives to which a hospital subscribes amounts to an unethical denial of care. The American College of Obstetricians and Gynecologists, while acknowledging the legitimate place for individual provider conscience in medicine, [warns that](#) "conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient."

The College notes that refusal is particularly common in the field of reproductive health care: "[i]t is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant."

Addressing sterilization specifically, the ACOG committee opinion states: "Although conscientious refusals stem in part from the commitment to 'first, do no harm,' their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way — either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks."

Conclusion

Unlike many places in the world in which religious law either predominates, or in which religious law pertaining to personal matters exists alongside a civil code, America is not — even partially — a theocracy.

Nor has it ever been. Its history and constitution appropriately preserve a wide swath of authority for both religions and religious people in matters concerning the internal workings of churches, mosques and synagogues and the exercise of religious rituals. But when it comes

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to public life, we generally preserve a neutral posture towards religion in order to allow believers of many faiths, and non-believers in any faith, to work and live alongside one another under a common government.

This arrangement often requires mutual tolerance of differences and practical accommodations of a variety of views. It requires clear demarcations for individual freedoms. And it requires respect for a necessary zone of privacy so individuals can wrestle with moral questions in the quiet of their own conscience. Not all of these decisions will be consistent with the views of people of faith. But it is fundamental to the American identity that they are freely chosen, within the parameters set by the body politic acting for all the people.

There is no purity in such an arrangement for those who live in this pluralistic society. For example, religious organizations cannot control what employees do with their paychecks even if they are paying the salary. They cannot control who moves in next door, even if those neighbors engage in activities that offend. They cannot discriminate when hiring for non-ministerial positions, even within a house of worship. They cannot deface billboards without sanction, even if the images are directly contrary to their beliefs.

And they cannot use their beliefs as a sword — using their faith as grounds to deny the right of another person to make their own decisions. Religious liberty, as it has been recognized by courts in constitutional deliberations, does not mean the liberty to impede others, particularly in public-facing institutions. The issue raised by this debate is not, in fact, whether religious liberty should be protected — but *whose* religious liberty deserves the protection of law.

The U.S. has a proud tradition of defending the right of the individual to moral self-determination in both religious and secular matters. The Obama Administration's accommodation allows employers that object to providing coverage for contraception to avoid both paying for and communicating about that coverage, while ensuring that employees have the same benefits as those that are generally available to others. This is a fair and workable balancing of interests and should have ended the controversy.

But that didn't happen. Opponents of this balance ask us to forsake *every* individual's moral and religious liberty — as well as control over our personal lives and health. Congress is currently contemplating bills and amendments that would create a far-reaching power — on moral *or* religious grounds — to foreclose every

person's access to the benefits of living in a free and open society. These bills would give state sanction to religious principles, and thereby trespass on the religious liberty of individuals that is essential to our history.

This would allow petty tyranny to triumph over autonomy, gender discrimination to prevail over equity, and institutional prerogatives to invade the zone of private decision-making around every woman's and family's decision to have a child or what treatment is needed for a life-threatening illness such as HIV.

Employees would be forced to cede to their religious conscience rights to their bosses. Employers could deny neonatal benefits to gay and lesbian employees or to a mother whose child was born out of wedlock. Christian Scientist churches would be entitled to deny all medical coverage except spiritual care if they chose to do so.

It would encode in law a chaos of preferences — empowering unsympathetic administrators to control intimate and critical matters of bodily integrity and health best left to women and their doctors. It would treat employees reporting for a job as unwitting volunteers for whatever religious precept might be subscribed to by the organization's leaders. Even more fundamentally, such a move would threaten the religious pluralism that is an essential part of the American tradition, by allowing quintessentially public functions to be subordinated to religious aims.

The courts have been very clear and logical in striking this balance. Generally applicable laws do not violate the First Amendment because they are the *sine qua non* of governing an ordered society. Religious organizations, when acting in their religious role or on matters of internal governance like they do in houses of worship, receive considerable deference from the courts — although even organizations like churches are subject to many generally applicable laws, such as health and safety rules, or building codes.

But institutions that voluntarily assume a public role, including those with religious affiliations, are subject to the same laws as everyone else. Those institutions have *chosen* to primarily employ members of the general public, to primarily serve the general public, and assign themselves a mission that is not primarily religious in purpose or goal.

The significance of this issue for health and well-being cannot be overstated. The availability of effective, modern methods of contraception allows individuals the freedom to plan their lives, preserves dignity in one's personal

relations, and has been fundamental in facilitating the full participation of women in public life by allowing them to better plan their pregnancies and lives.

Access to effective and affordable birth control is important for many medical reasons impacting women's health: it sometimes even saves their lives. But if contraception is too expensive or not easily accessible, women fail to use it regularly. Today in the U.S., nearly half of all pregnancies are unintended. This high rate has tragic consequences for maternal and child health, and increases the number of abortions.

This shocking state of affairs can be greatly remedied by allowing women far greater access to the most effective forms of contraception, including long-acting forms and sterilization. The Administration's policy accomplishes these important goals.

It is essential that we make these benefits available equally to all members of the public, as part of a new baseline for public health. And it is essential, on principle, that on matters of public health and personal decision-making, we ask that all public-facing institutions offer the same benefits to workers, rather than creating a patchwork system of gaps and exceptions that perpetuates gender discrimination and harms women and families.

Against this backdrop, the Administration's accommodation appears generous indeed. Employers won't have to pay for contraception or even communicate about it. No one is compelled to use the benefit or pay for contraception under the policy, and no provider is compelled to furnish services. It will remain the employee's decision to make concerning what is right for them and their family, as it should be. Both fairness — and our constitutional tradition of respect for individual religious liberty — demand no less.

Endnotes

- 1 As stated by the IOM Committee on Unintended Pregnancy in 1995:

The committee urges, first and foremost, that the nation adopt a new social norm: All pregnancies should be intended – that is, they should be consciously and clearly desired at the time of conception. This goal has three important attributes. First, it is directed to all Americans and does not target only one group. Second, it emphasizes personal choice and intent. And third, it speaks as much to planning for pregnancy as to avoiding unintended pregnancy. Bearing children and forming families are among the most significant and satisfying tasks of adult life, and it is in that context that encouraging intended pregnancy is so central.

Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, *The Best Intentions: Unintended Pregnancy and the well-being of children and their families* (Sarah S. Brown & Leon Eisenberg, eds.,1995).
- 2 For example, the Supreme Court struck down as unconstitutional a law requiring motorists to display the motto, “Live Free or Die,” on license plates. *Wooley v. Maynard*, 430 U.S. 705 (1977). Similarly, the state may not compel students to salute the flag or recite the Pledge of Allegiance. *Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943).
- 3 “Under this approach, the Departments will also require that, in this circumstance, there be no charge for the contraceptive coverage. Actuaries and experts have found that coverage of contraceptives is at least cost neutral when taking into account all costs and benefits in the health plan.” Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012).
- 4 James Trussell et al., *Cost effectiveness of contraceptives in the United States*, 79 *CONTRACEPTION* 5, 12 (2009).
- 5 Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, *The Best Intentions: Unintended Pregnancy and the well-being of children and their families* (Sarah S. Brown & Leon Eisenberg, eds.,1995).
- 6 For example, the unintended pregnancy rate in France is 33%; in Edinburgh, Scotland, it is only 28%. Association of Reproductive Health Professionals, *Reducing Unintended Pregnancy in the United States (2008)*, available at <http://www.arhp.org/publications-and-resources/contraception-journal/january-2008>.
- 7 Lolita M. Chan & Carolyn L. Westoff, *Tubal sterilization trends in the United States*, *FERTILITY AND STERILITY* 1, 4 (June 2010).
- 8 *Id.* at 3.
- 9 Interview with Dr. Gwen Patterson, Sierra Vista Regional Health Center in Sierra Vista, Arizona, November 17, 2010.