20YEARS CENTER FOR REPRODUCTIVE RIGHTS

July 5, 2012

VIA FACSIMILE AND FEDERAL EXPRESS

The Honorable Jay Nixon
Governor of Missouri
201 West Capitol Avenue
State Capitol Room 216
Jefferson City, MO 65101

Re: Senate Bill 749

Dear Governor Nixon,

The Center for Reproductive Rights opposes Senate Bill 749, which would prevent women from accessing insurance coverage for contraception and conflict with federal law.

The Center for Reproductive Rights is a non-profit advocacy organization that seeks to advance reproductive freedom as a fundamental human right. A key part of our mission is ensuring that women throughout the United States have meaningful access to high-quality, comprehensive reproductive health care services. We believe this bill would allow employers, insurance companies and others to impose their own religious or moral beliefs on their employees or subscribers by preventing them from obtaining insurance coverage for critical reproductive health care. Moreover, this bill is likely preempted by federal law.

I. Contraception Is Essential For Women's Health

"The typical American woman wants to have two children. That means she will spend roughly five years being pregnant, recovering from a pregnancy or trying to become pregnant, and three decades trying to avoid an unintended pregnancy."[1] Access to a full range of available contraceptive methods in order to prevent unintended pregnancy is essential to women's health and well-being, as unintended pregnancy leads to adverse health outcomes for women and, if the pregnancy is carried to term, for the child.[2] Ensuring that women have the tools they need to

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[1] CHAVKIN ET AL., WOMEN'S HEALTH AND HEALTH CARE REFORM: THE KEY ROLE OF COMPREHENSIVE REPRODUCTIVE HEALTHCARE 3 (2010), *available at* http://www.jiwh.org/attachments/Women%20and%20Health%20Care%20Reform.pdf.. *See also* Guttmacher Institute, *Facts on Contraceptive Use in the United States*, June 2010.

[2] For example, there is an increased risk of adverse outcomes if a pregnancy follows too closely (within 18 months) after a prior pregnancy, such as prematurity and low birth weight. Unintended pregnancy is also associated with shorter or no breastfeeding. Women with unintended pregnancy are at increased risk of experiencing physical violence, and infants born of an unintended pregnancy are also more likely to be abused. An unintended pregnancy can also have a profound impact on a woman's life, including on educational and career opportunities – at a minimum, if carried to term, childbearing implies a lifetime of responsibility and care for the child and is one of the most serious, if not the most serious, commitments a person can make. *See generally* IOM (Institute of Medicine),

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plan the number and spacing of their children is vital to their health and the health of their families.[3]

Contraception use is widely supported and practiced. In fact, more than 99% of women 15 to 44 years of age who have ever had sexual intercourse with a male have used at least one contraceptive method.[4] Nonetheless, unintended pregnancy presents a serious public health concern in this country, accounting for 49% of all pregnancies (excluding miscarriages) and 44% of pregnancies resulting in a live birth.[5] Even women who use contraception at some points in their lives experience unintended pregnancy, in part due to inconsistent access to contraception stemming from lack of funds or gaps in insurance coverage.[6] Other unintended pregnancies that occur among contraceptive users are the result of inconsistent or incorrect method use.[7] The alarming rate of unintended pregnancy even among those who use contraceptives at some point in their lives further underscores the need for insurance coverage to provide consistent and stable access to a woman's chosen method, as well as information and counseling to help them use it effectively.

II. Contraceptive Equity Is Critical to Protect Access to Contraception and Prevent Discrimination

"Contraceptive equity" laws are statutes that require insurers to provide insurance coverage for contraception to the same degree that they cover other prescription drugs. These

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Clinical Preventive Services for Women: Closing the Gaps (2011); Guttmacher Institute, *Facts on Contraceptive Use in the United States*, June 2010; *The best intentions: unintended pregnancy and the well-being of children and families*. 1995. Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences; Sarah S. Brown and Leon Eisenberg, editors; National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women*, 2010; Mohllajee AP et al. *Pregnancy intention and its relationship to birth and maternal outcomes.* AM. J. OBSTET. GYNECOL. 2007; 109:678-86; Kuroki L et al. *Is a previous unplanned pregnancy a risk factor for a subsequent unplanned pregnancy?* AM. J. OBSTET. GYNECOL. 2008; 199:517.e1-517.e7; Bennett et al. *Unintended rapid repeat pregnancy and low education status: Any role for depression and contraceptive use?* AM. J. OBSTET GYNECOL. (2006) 194, 749-54; Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care — United States: a report of the CDC/ ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006; 55 (No. RR-6).

[3] Moreover, the right to decide the number and spacing of one's children is recognized in both international and United States law. *See Griswold v. Connecticut,* 381 U.S. 479, 485-86 (1965) (married couples have a constitutional right to access contraception); *Eisenstadt v. Baird*, 405 U.S. 438,453-55 (1972) (extending same right to unmarried persons); CTR. FOR REPRODUCTIVE RIGHTS, FAMILY PLANNING IS A HUMAN RIGHT (2008), *available at* http://reproductiverights.org/sites/default/files/documents/BRB_Contra.pdf (cataloguing the various human rights treaty bodies that have recognized family planning as a human right).

[4] CDC, NATIONAL SURVEY OF FAMILY GROWTH ,VITAL AND HEALTH STATISTICS, USE OF CONTRACEPTION IN THE UNITED STATES 1982-2008 (Aug. 2010) *available at* http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf.

[5] IOM (Institute of Medicine). 2011. *Clinical Preventive Services for Women: Closing the Gaps.* Washington, DC: The National Academies Press. Notably, this rate of unintended pregnancy is far higher than in other developed countries, and 42% of unintended pregnancies end in abortion.

[6] Guttmacher Institute, Improving Contraceptive Use In the United States 3 (2008), *available at* http://www.guttmacher.org/pubs/2008/05/09/ImprovingContraceptiveUse.pdf.

[7] Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 39 PERSP. ON SEXUAL AND REPRODUCTIVE HEALTH 90, 90 (2007), *available at* https://guttmacher.org/pubs/psrh/full/3909007.pdf.

types of statutes recognize the critical importance of contraception for women's health, as well as the need to avoid discriminating on the basis of sex.[8] In 2001, Missouri enacted a "contraceptive equity" law that requires any health benefit plan that "provides coverage for pharmaceutical benefits" to "provide coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug."[9] While this statute was an important step towards ensuring access to contraception for Missouri women, Missouri's contraceptive equity law included a number of exceptions for individuals, employers and health insurers who have religious or moral objections to the use of contraception.[10] However, the law requires enrollees in any plan that excludes contraception plans to be allowed to separately purchase contraceptive coverage. Therefore, under current Missouri law, all employees do have access to such coverage, even if they must purchase the coverage separately.[11]

Senate Bill 749 amends the existing law in a discriminatory, harmful way; instead of placing the emphasis on expanding access to contraception, it emphasizes allowing individuals, employers *and insurers* to refuse to include contraceptive coverage in their health plans,

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[8] *See* Cornelia T.L. Pillard, *Our Other Reproductive Choices: Equality In Sex Education, Contraceptive Access, And Work-Family Policy*, 56 EMORY L.J. 941, 967-68 (2007) (noting that "failure of otherwise comprehensive insurance plans to cover prescription contraceptives is a significant form of sex discrimination" and that "more than twenty states have enacted contraceptive equity laws. . . . [and] where state law does not require such coverage, sex discrimination lawsuits have established an entitlement to contraceptive equity under Title VII, as a handful of courts and the federal Equal Employment Opportunity Commission have held that employers that offer otherwise comprehensive insurance coverage of drugs and devices must also cover birth control").

[9] MO. STAT. ANN. § 376.1199(1)(4).

[10] Specifically, the statute provides that the following entities are not required to provide contraceptive coverage equally with all other prescription drugs:

> (1) Any health carrier may offer to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;
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> (2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan associated with such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;
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> (3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section. For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

MO. STAT. ANN. § 376.1199(4).

[11] *See id.* §§ 6(2)-(3).

regardless of the subscribers or employees' personal beliefs. Instead of attempting to balance an employee's right to access equal coverage with potential objections to that coverage, as Missouri's existing contraceptive equity law does, Senate Bill 749 allows an insurer's moral convictions or religious beliefs to dictate the type of care subscribers and employers can access. Moreover, Senate Bill 749 adds a host of penalties to the law, allowing the attorney general to bring civil actions against anyone deemed to have infringed on an entity or person's rights to refuse to provide this coverage to others, and allowing other civil actions as well as the potential for damages, attorney's fees, costs and expenses. Ultimately, this bill broadly empowers insurers and others to deny insurance coverage for critical reproductive health care to Missouri women, who will be more at risk for unintended pregnancy as a result.

III. Senate Bill 749 Will Be Wholly or Partially Preempted by Federal Law

The Affordable Care Act ("the Act"), enacted by Congress in 2010 and upheld by the Supreme Court in *National Federation of Independent Businesses v. Sebelius*,[12] created a comprehensive new system for health care coverage throughout the country. A key part of the Act is a new federal requirement that all health insurance plans offer certain preventative services without cost-sharing (requiring co-pays) from enrollees,[13] including preventative services relating to women's preventative care and cancer screening.[14] As required by the Act, the Department of Health and Human Services (DHHS) has promulgated regulations, based on expert recommendations and public input, relating to which services must be provided to women under all plans without cost-sharing.[15] For women's preventative services, this coverage must include "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[16] DHHS has also proposed an accommodation for certain religious employers to allow them to refrain from paying for or communicating about contraception coverage, while maintaining the coverage benefit for employees at those institutions.[17]

As in all cases where the federal government acts pursuant to its constitutional powers, federal law preempts existing state laws with which it conflicts.[18] In this case, the Act coexists

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[12] 567 U.S. __ (2012).

[13] The preventative services mandate applies to all health insurance plans whether offered in or outside of the state exchanges that will be established also as a result of the Act. 42 U.S.C. § 300gg-13. The only plans that need not offer these services immediately are those that are considered "grandfathered" under the Act, 42 U.S.C. § 18011; those plans will be required to offer these services if they make any significant changes to the plan, such as significantly increase copayments or deductibles or eliminate covered benefits. 26 C.F.R. § 54.9815-1251T.

[14] 42 U.S.C. § 300gg-13(4). These are described in detail in the "Women's Preventative Services: Required Plan Coverage Guidelines" as developed by the Health Resources and Services Administration (HRSA)

[15] 76 Fed. Reg. 46625 (proposed Aug. 3, 2011) (to be codified at 26 C.F.R. § 54.9815–2713T). Under the Act and subsequent federal regulations, all "non-grandfathered plans and issuers are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012." 77 Fed. Reg. 8725-26 (proposed Feb. 15, 2012).

[16] *Id.* at 8725.

[17] 76 Fed. Reg. 46623 (proposed Aug. 3, 2011) (to be codified at 26 C.F.R. § 54.9815–2713T).

[18] *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 540-41 (2001) ("State action may be foreclosed by express language in a congressional enactment"). *Cf. California Div. of Labor Standards Enforcement v. Dillingham*

with some state health insurance laws but preempts others. In the context of contraception and contraceptive equity laws in particular, the Department of Health and Human Services has noted that:

> States have adopted laws requiring that certain health insurance issuers provide contraceptive coverage. Some of these laws contain exemptions related to religious organizations, but the scope of the exemptions varies among the States. Generally, Federal health insurance coverage regulation creates a floor to which States may add consumer protections, but may not subtract. This means that, in States with broader religious exemptions than that in the final regulations, the exemptions will be narrowed to align with that in the final regulations because this will help more consumers.[19]

DHHS has determined that it would be "appropriate" to "take[] into account the effect on the religious beliefs of certain religious employers if coverage of contraceptives were requiring group health plans in which employees in certain religious positions participate"[20] and promulgated regulations that include an exemption "that respects the unique relationship between a house of worship and its employees in ministerial positions."[21] DHHS is now considering a further accommodation for employers and health plans that do not fit within the traditionally narrow "religious employer" mandate. This accommodation would potentially accommodate "non-exempt, non-profit religious organizations' religious objections to covering contraceptive services" while at the same time "assuring that participants and beneficiaries covered under such organizations' plans received contraceptive coverage without cost-sharing."[22]

Constr., N.A., Inc., 519 U.S. 316, 325 (1997) ("[F]ederal law is said to bar state action in fields of traditional state regulation, [but the Court] ha[s] worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." (quotations omitted)). In this case, the Act does not preempt state laws that are consistent with its provisions but does preempt state law where there is a direct conflict with either the law's terms or the regulations promulgated as a result of the Act. 42 U.S.C. § 18041(d).

[19] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 16,501, 16,507-08 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147). The Departments have further provided for a "temporary safe harbor" for "[o]rganizations that qualify for an exemption under State law but do not qualify for the exemption under the final regulations." *Id.* Moreover, "[d]uring this transition period, [before the preventative services requirement becomes effective] State laws that require contraceptive coverage with narrower or no religious exemptions will continue." *Id.*

[20] 76 Fed. Reg. 46623 (proposed Aug. 3, 2011).

[21] *Id.* DHHS subsequently promulgated a regulation including that accommodation. 76 Fed. Reg. 46626 (proposed Aug. 3, 2011). DHHS has also noted that "such an accommodation [is] consistent with the policies of States that require contraceptive services coverage." 76 Fed. Reg. 46623 (proposed Aug. 3, 2011).

[22] 76 Fed. Reg. 16503. For example, the original accommodation was described as applying to "a religious employer" defined as "(1) has the inculcation of religious values as its purpose; (2) primarily employs religious persons who share its religious tenents; (3) primarily serves persons who share its religious tenents and (4) is a nonprofit organization under [various provisions of the tax code]." 76 Fed. Reg. 46623 (proposed August 3, 2011). Other versions of this accommodation have since been discussed and a final rule is pending. The scope of the federal exception for religious employers is still being determined, but will be in place by August 2013. DHHS has

In contrast, SB 749 allows a broad range of individuals and entities to deny coverage for contraception to employees on the basis of religious or moral objections. While DHHS will be promulgating an accommodation for religious employers, it will not permit the broad range of refusals contemplated by the bill. Therefore, to the extent that SB 749 provides a broader refusal provision than the federal regulations, it will be preempted by federal law. [23]

IV. Conclusion

Missouri has already recognized the importance of equity in insurance coverage for contraception along with other prescription drugs. Missouri law also takes into account the potential for certain employers, insurers and individuals to have religious objections to such coverage and provides a related exemption. SB 749 amends the law in a manner that allows individuals, health plans and employers to place their beliefs above the health of Missouri women. Moreover, SB 749 will likely be preempted in whole or in part by the Affordable Care Act, which by regulation requires contraceptives to be covered for all women. In light of these concerns, and of the critical importance of access to contraception for women in Missouri, we urge you to veto this legislation.

Sincerely,

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subsequently issued regulations that established a "temporary safe harbor" for religious employers while the scope of the accommodation is determined.

[23] *Arizona v. United States*, __ S. Ct. ___ , 2012 WL 2368661 at *14 (2012) ("[S]tate laws are preempted when they conflict with federal law. This includes cases where compliance with both federal and state regulations is a physical impossibility, and those instances where the challenged state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." (quotations and citations omitted)). Existing Missouri law may also be partly preempted as a result of the accommodation determined by DHHS, but the approach found in Missouri Statutes Annotated § 376.1199 is more likely to be at least somewhat compatible with the federal accommodation than the far broader range of refusals contemplated by SB 749.