

ACCESS TO CONTRACEPTION

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I. INTRODUCTION

In the 1965 case *Griswold v. Connecticut*, the United States (U.S.) Supreme Court struck down a state law that prohibited married couples from obtaining and using contraception as a violation of a marital right to privacy.¹ Through *Griswold's* progeny, the Court explained that all individuals, regardless of marital status, have a fundamental right to privacy that encompasses access to contraception.² However, although the legal and societal landscape has greatly changed since 1965, many individuals still face a myriad of barriers in accessing contraception.³ The modern debates surrounding contraception access entail a delicate

1. *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965).

2. *See Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687 (1977).

3. *See infra* Part III.

balancing act between the conflicting rights of various groups: pro-abortion and anti-abortion, health care providers and patients, and employers and employees.

The refueled controversy surrounding contraception, sparked by the Patient Protection and Affordable Care Act's (PPACA) requirements and cases like *Hobby Lobby*,⁴ continues to drive a national debate over religious freedom, personal autonomy, and access to medical care. The precise extent of the freedom to refuse contraception coverage due to religious objections remains the subject of litigation, particularly in light of the Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade*.⁵ Although *Griswold* remains intact under the *Dobbs* decision, the dissenting Justices in *Dobbs* note that the legal justifications for the majority's decision could destabilize the rights provided under *Griswold* if challenged in the future. The precise extent of the freedom to refuse contraceptive coverage due to religious objections remains the subject of litigation.

This Article provides an overview of the right to access to contraception, beginning with the definitions of different types of contraception in Part II.A, a summary of the history of the right to access to contraception in Part II.B, and a discussion of recent developments since the passage of the PPACA in Part II.C. Part III discusses barriers to access that people who can become pregnant still face, including refusal clauses⁶ and religious opposition in Part III.A, recent efforts to increase or restrict access in Part III.B, and the heightened barriers faced by particular groups in Part III.C.

II. PRESCRIPTION BIRTH CONTROL AND EMERGENCY CONTRACEPTION: A HISTORY

To better understand the history of prescription birth control and emergency contraception (EC), this section will discuss (A) various types of birth control and EC, (B) the right to access contraception generally, and (C) the current state of the PPACA.

A. TYPES OF CONTRACEPTION DEFINED

People in the U.S. use a variety of contraception methods to aid in family planning and the prevention of unplanned pregnancy. Data suggests that as of 2018, there are approximately seventy-three million women of reproductive age in the U.S., forty-six million of whom are sexually active and do not

4. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014).

5. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2331–32 n.9 (2022) (Breyer, Sotomayor & Kagan, JJ., dissenting).

6. Refusal clauses are statutes that protect healthcare providers from liability if they refuse to dispense contraception based on their religious or moral opposition. *Refusal Laws: Dangerous for Women's Health*, NARAL PRO-CHOICE AM. (Jan. 1, 2017), <https://perma.cc/Q73N-TPFE> [hereinafter NARAL: *Refusal Laws*].

want to become pregnant.⁷ Among women of reproductive age, approximately 65% are currently using contraception and over 99% of those who are sexually experienced have used at least one contraceptive method at some point in time.⁸ Of the women who currently use some form of contraception, 72% use nonpermanent methods, primarily condoms, intrauterine devices, and/or other hormonal methods, including pills, patches, and vaginal rings.⁹ Emergency contraception is also widely used among women of reproductive age; 2015 data suggests that approximately 23% of sexually-experienced women of reproductive age have used EC pills at some point in time.¹⁰

Prescription birth control is a dose of hormones prescribed by a healthcare provider for use on a regimented basis by a person who can become pregnant.¹¹ One form of prescription birth control is oral contraception, or “The Pill,” which prevents ovulation by thickening the cervical mucus in order to block sperm.¹²

While most people who can become pregnant using contraception in the U.S. still prefer the Pill, implantable contraceptives are also becoming increasingly popular.¹³ Some implantable contraceptives are inserted under the skin by a licensed medical professional, where they can remain for years.¹⁴ They can be removed by a licensed medical professional at any time.¹⁵ Three common forms of subdermal implantable contraception—Implanon, Norplant, and Jadelle—have been found to be extremely effective and easy to use.¹⁶ All three carry a low risk of side effects, though rare cases of bleeding disturbances and certain related side effects may occur.¹⁷ Good patient counseling efforts regarding these forms of contraception, including a discussion of potential side effects, is important to ensure high continuation rates, because the acceptability of side effects like irregular bleeding may differ across cultures.¹⁸ Overall, however,

7. *Fact Sheet: Contraceptive Use in the United States*, GUTTMACHER INST. (May 2021), <https://perma.cc/4PY2-P4TQ> [hereinafter *Contraceptive Use in the United States*].

8. *Id.*

9. *Id.*

10. *Id.* (citing Rubina Hussain & Megan L. Kavanaugh, *Changes in use of emergency contraceptive pills in the United States from 2008 to 2015*, *CONTRACEPTION: X* (2021), <https://perma.cc/4S7Y-68WT>).

11. *Birth Control*, U.S. FOOD & DRUG ADMIN., <https://perma.cc/W982-VFSA> (last updated Dec. 23, 2022) [hereinafter *Birth Control Medicines to Help You*].

12. *Id.*

13. *Contraceptive Use in the United States*, *supra* note 7.

14. *Birth Control Implant*, PLANNED PARENTHOOD (2022), <https://perma.cc/XVT2-9J4Z>.

15. *Id.*

16. Bahamondes L., *Subdermal implantable contraceptives versus other forms of reversible contraceptives or other implants as effective methods of preventing pregnancy: RHL Commentary*, WORLD HEALTH ORG. REPROD. HEALTH LIBR. (Dec. 1, 2008), <https://perma.cc/U9CM-HQUF>.

17. *Id.*

18. *Id.*

these types of implantable contraceptives appear to be a good option for all people who can become pregnant especially those in “under-resourced settings.”¹⁹

Emergency contraception is a post-coital method of preventing pregnancy when prophylactic contraception measures, like those discussed above, fail or are not used.²⁰ EC reduces the risk of pregnancy by stopping the release of an egg from the ovary, stopping the union of sperm with the released egg, or both, depending on the type of contraception.²¹ If fertilization has already occurred, the drug may also prevent implantation by inhibiting the attachment of the fertilized egg to the womb.²² Oral contraceptives and EC thus function in a similar way, but differ in timing and dosage.

Commonly referred to as “morning-after pills,” conventional EC contains either or both of the hormones estrogen and progestin (levonorgestrel)²³ or a synthetic progesterone antagonist (ulipristal acetate).²⁴ In 1997, the U.S. Food and Drug Administration (FDA) determined that EC pills are a safe and effective form of contraception.²⁵ The FDA first approved the “morning-after pill” Plan B, a set of two levonorgestrel pills, in 1999.²⁶ The FDA has since approved a number of emergency contraceptive pills.²⁷ Plan B lowers chances of pregnancy by 75–89% if taken within seventy-two hours of birth control failure or unprotected sex,²⁸ while ella, a prescription-only EC pill, is effective if taken within 120 hours.²⁹ If EC is taken outside this window, it becomes significantly less effective in preventing pregnancy.³⁰ Despite popular misconceptions and the portrayal of

19. Implantable contraceptives could be particularly good options for people in under-resourced settings because they are highly effective, easy to use, and carry a low risk of side effects. Additionally, they may be considered inexpensive and cost effective, since they are used for many years and can often be obtained at low prices through organizations such as the United Nations Population Fund. *Id.*

20. *FDA’s Decision Regarding Plan B: Questions and Answers*, U.S. FOOD & DRUG ADMIN., <https://perma.cc/N4KM-8MVT> (last updated Dec. 7, 2015) [hereinafter *Plan B: Q & A*].

21. *Id.*

22. *Id.*

23. Levonorgestrel, a synthetic hormone used to prevent pregnancy, has been utilized in birth control pills for over three decades. *Id.*

24. *Ella (Ulipristal Acetate) Prescribing Information*, U.S. FOOD & DRUG ADMIN. 1, <https://perma.cc/V4QC-RT2K> (last updated Apr. 2012) [hereinafter *Ella Prescribing Information*].

25. Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 62 Fed. Reg. 8610, 8610 (Feb. 25, 1997), <https://perma.cc/4MVN-AYVW>.

26. *See Plan B: Q & A*, *supra* note 20.

27. *See Plan B: Health care professionals Questions and Answers*, U.S. FOOD & DRUG ADMIN. (May 20, 2016), <https://perma.cc/SJV3-VVXN> (listing the various brand name and generic levonorgestrel pill types: Plan B, Plan B One Step, Take Action, Next Choice, Next Choice One Step, My Way, generic levonorgestrel tablets, After Pill, Fallback, and Opicion One-Step); *see also Emergency Contraception*, OFF. ON WOMEN’S HEALTH, U.S. DEP’T OF HEALTH & HUM. SERVS. (Jan. 27, 2022), <https://perma.cc/2HVK-76Z5> (noting two types of FDA-approved emergency contraceptives: ulipristal acetate, commonly known as Ella, and the various levonorgestrel formulations).

28. *See What’s the Plan B morning after pill?*, PLANNED PARENTHOOD, <https://perma.cc/BD56-LYMG> (last visited Mar. 5, 2023).

29. *See Birth Control Medicines to Help You*, *supra* note 11.

30. James Trussell, Elizabeth G. Raymond, & Kelly Cleland, *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy*, OFF. OF POPULATION RSCH., PRINCETON UNIV. 5 (Feb. 2017), <https://perma.cc/W2BG-86YY>.

EC as an “abortion pill,” EC pills become ineffective as contraception and will cause no harm to the fetus if taken after implantation of a fertilized egg.³¹

The pharmacology of EC continues to evolve. Mifepristone, commonly known as RU-486, works by blocking progesterone, a hormone needed for pregnancy to continue.³² This drug is typically taken in conjunction with a second drug called Misoprostol;³³ together, they are extremely effective in expelling an embryo and ending an early pregnancy.³⁴

In addition to these oral EC methods, a third form of EC has become increasingly common. ParaGard is a copper intrauterine device (IUD) that, if inserted within five days of unprotected intercourse or suspected contraceptive failure, reduces a person’s risk of pregnancy by more than 99.9%.³⁵ The device must be inserted into the uterus by a licensed healthcare provider and is not available over the counter.³⁶ When inserted properly, an IUD can remain effective at preventing pregnancy for eight to twelve years depending on the type.³⁷ IUDs cost up to \$1,300, but are free or low-cost with most insurance plans.³⁸ Although ParaGard is the most effective form of EC for reducing the chances of pregnancy³⁹ and the FDA has approved the device as a safe form of contraception, ParaGard has not been officially recommended for emergency usage.⁴⁰ Nevertheless, physicians do prescribe ParaGard as an EC and evidence indicates that it is successful.⁴¹

Medical definitions of contraceptives are of potential importance in jurisprudence due to debates over what constitutes an abortifacient. For example, in the 2014 Supreme Court case *Burwell v. Hobby Lobby Stores, Inc.*, the question of whether two forms of the morning-after pill and two forms of IUDs constituted abortifacients was central to the determination of whether the PPACA’s requirement that employers cover contraceptive care contravened that employer’s religious beliefs against abortion.⁴² The company in *Hobby Lobby* argued that any form of contraception that blocks a fertilized egg from implanting in the uterus is

31. *See id.* at 6–8.

32. Paige Kremser, Note, *Griswold, the FDA, & the State Legislator: The Regulation of Mifeprex*, 8 WM. & MARY J. WOMEN & L. 443, 443–44 (2002) <https://perma.cc/M6D3-NSEA>; *see also The Facts on Mifepristone*, PLANNED PARENTHOOD (2019), <https://perma.cc/89DL-WKLC>.

33. *See* Kremser, *supra* note 32, at 444.

34. *Id.*

35. *How do IUDs work as emergency contraception?*, PLANNED PARENTHOOD, <https://perma.cc/Z3WZ-EPCQ> (last visited Feb. 24, 2023).

36. *Id.*

37. *Id.*

38. *Id.*

39. Michelle C. Bosworth, Patti L. Olusola, & Sarah B. Low, *An Update on Emergency Contraception*, 89 AM. FAM. PHYSICIAN 545, 546 (Apr. 1, 2014), <https://perma.cc/J3H4-69FM>.

40. *Proposed Prescribing Information*, U.S. FOOD & DRUG ADMIN. 4 (Sept. 2005), <https://perma.cc/7RL6-LKQV>.

41. *See* Bosworth, Olusola, & Low, *supra* note 39.

42. *See Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 682, 691 (2014). This case is discussed further *infra* Part II, Section A(4).

tantamount to abortion.⁴³ Similarly, in *Little Sisters of the Poor v. Sebelius*, the complaint filed in the district court alleged that emergency contraceptives and certain IUDs are abortifacients that can “cause the death of an embryo by preventing it from implanting in the wall of the uterus.”⁴⁴ In both of these cases, the federal courts failed to review whether the plaintiffs’ beliefs that various forms of contraception cause abortions were scientifically supported.⁴⁵

B. THE RIGHT TO ACCESS TO CONTRACEPTION

In 1965, the Supreme Court held that a married couple has a constitutional right to privacy that secures their access to contraception.⁴⁶ In *Griswold v. Connecticut*, a director of Planned Parenthood and a doctor provided medical advice, information, and instructions to married couples regarding contraception.⁴⁷ They were arrested pursuant to a state law prohibiting both the use of and provision of assistance in obtaining contraception.⁴⁸ The Supreme Court held that the penumbras of existing constitutional rights encompassed a general right to privacy, and that fundamental to this right of privacy is the marital relationship.⁴⁹ Thus, the Court held, the state must not legislate so broadly as to restrict the marital decision of whether or not to bear children.⁵⁰ In his majority opinion, Justice Douglas raised the hypothetical situation of allowing police officers to search the “sacred precincts of marital bedrooms” for contraception to demonstrate that the “very idea is repulsive to the notions of privacy surrounding the marriage relationship.”⁵¹ The right to privacy was, thus, considered one of the unenumerated rights provided by the Bill of Rights by virtue of the Ninth Amendment.⁵²

In 1972, *Eisenstadt v. Baird* clarified that the right to privacy extended to all adults, regardless of marital status.⁵³ The Court stated that “[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁵⁴ Thus, the Court moved away from grounding the right to use contraception in the privacy

43. *Id.* at 697–98, n.7.

44. Class Action Complaint, *Little Sisters of the Poor Home for the Aged v. Sebelius*, 6 F. Supp. 3d 1225 (D. Colo. Dec. 27, 2013) (No. 1:13CV02611), 2013 WL 5331098 at 9, ECF No. 1.

45. See Meredith Rachel Mandell, *When Religious Belief Becomes Scientific Opinion: Burwell v. Hobby Lobby and the Unraveling of Federal Rule 702*, 12 NW. J.L. & Soc. POL’Y 92, 93 (2016) <https://perma.cc/Z25V-93J7>; see also *Little Sisters of the Poor Home for the Aged*, 6 F. Supp. 3d 1225.

46. *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

47. *Id.* at 480.

48. *Id.*

49. *Id.* at 484–85.

50. *Id.* at 485.

51. *Id.* at 485–86.

52. *Id.* at 486 (Goldberg, J., concurring) (“[T]he concept of liberty . . . embraces the right of marital privacy though that right is not mentioned explicitly in the Constitution”); see also *Lawrence v. Texas*, 539 U.S. 558, 565 (2003); *Martin v. Covington*, 541 F. Supp. 803, 804 (E.D. Ky. 1982).

53. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

54. *Id.*

protected by the intimate marital relationship toward a broader right of privacy rooted in individual decision-making and autonomy. The inherent right of individuals to make their own decisions regarding if and when to have a child was, therefore, encompassed in the fundamental right to privacy and protected under the Fourteenth Amendment's Due Process Clause.⁵⁵

Although *Eisenstadt* extended the right to privacy to all adults, whether it applied to minors was unclear, with some states criminalizing the sale of contraception to minors.⁵⁶ Five years later in *Carey v. Population Services International*, the Supreme Court held that the right to privacy does in fact apply to minors.⁵⁷ The Court further held that restrictions on minors' rights are only permissible if the state is protecting a significant interest that is not present for similarly-situated adults.⁵⁸ This ruling, and the notion of minors' right to privacy, clashed with a sometimes-asserted parental right to notification.⁵⁹ As noted earlier, the right to privacy is viewed as a right to make reproductive decisions free from state interference,⁶⁰ but whether freedom from parental involvement should also be included in this right is still debated.⁶¹

In 1980, the Sixth Circuit held that clinics had no constitutional obligation to notify parents before dispensing contraception to minors.⁶² It reasoned that clinics were not depriving parents of a liberty interest because they were not preventing parents from participating in the reproductive decisions of their children.⁶³ In 1998, the U.S. House of Representatives attempted to require public clinics to notify the parents of minors seeking contraception by passing the Parental Notification Act, but this bill was tabled.⁶⁴ Congress has since passed no federal legislation on this matter.

55. See *Lawrence*, 539 U.S. at 574; see generally *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997).

56. In New York, for example, it was a crime to sell or distribute contraception of any kind to a minor under the age of sixteen. See N.Y. EDUC. LAW § 6811(8) (McKinney 1972), *invalidated by Carey v. Population Servs. Int'l*, 431 U.S. 678, 681 (1977).

57. *Carey*, 431 U.S. at 693.

58. *Id.* (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75 (1976)).

59. See generally Lynn D. Wardle, *Parents' Rights vs. Minors' Rights Regarding the Provision of Contraceptives to Teenagers*, 68 NEB. L. REV. 216 (1989) <https://perma.cc/4QH6-XNSF> (discussing the tension between the constitutional rights of minors and their parents in accessing contraception).

60. See Joshua T. Shaw, *Conceiving Plan B: A Proposal to Resolve the Conflict Between Women and Conscientiously Objecting Pharmacists over Access to Emergency Contraceptives*, 16 WASH. & LEE J. CIV. RTS. & SOC. JUST. 563, 587–88 (2010) <https://perma.cc/2W6J-VRPX>.

61. Proponents often argue that abortion rights should be treated exactly like other rights of minors and that parental involvement will encourage abstinence. In contrast, opponents of parental involvement note that requiring consent or notification is neither safe nor viable for many young people. See Elizabeth L. Musser, *Mandating Parental Involvement in Minors' Abortions*, 13 BERKELEY WOMEN'S L.J. 282, 284–86 (1998) <https://perma.cc/JK7N-XVFG>.

62. *Doe v. Irwin*, 615 F.2d 1162, 1169 (6th Cir. 1980).

63. *Id.* at 1168–69.

64. Parental Notification Act of 1998, H.R. 4721, 105th Cong. (1998).

In 2007, the Third Circuit, in *Anspach v. City of Philadelphia*, also addressed the question of whether a parent has a constitutional right to notification before a pharmacy sells contraception to a minor.⁶⁵ In that case, a clinic dispensed EC to a sixteen-year-old without notifying her parents.⁶⁶ Her parents argued that this lack of notification violated their Fourteenth Amendment liberty interest.⁶⁷ The Third Circuit, however, held that the clinic would have violated the daughter's Fourteenth Amendment right to privacy if it had notified her parents.⁶⁸ Minors continue to face many barriers to contraception access.⁶⁹

Ultimately, the Constitution protects individuals' right to privacy in their choice of whether or not to bear children. However, this right is only a right to freedom from state interference in the decision to obtain contraception; it is not a positive right to guaranteed access to contraception.⁷⁰ People who can get pregnant seeking to use prescription birth control still encounter difficulties in obtaining a prescription, getting the prescription filled, or receiving insurance coverage for that prescription, especially given the controversy surrounding the use of EC pills.

C. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA, or the Act) was signed into law.⁷¹ The Act called for significant reforms to health insurance to "make affordable health insurance available to more people."⁷² Notably, the Act requires newly-issued health insurance plans, including Medicaid, to cover essential health benefits, including women's preventive services.⁷³ In 2011, the Department of Health & Human Services (HHS) issued guidelines based on a study commissioned from the Institute of Medicine (IOM),⁷⁴ explaining that the

65. *Anspach ex rel. Anspach v. City of Phila., Dep't. of Pub. Health*, 503 F.3d 256, 260 (3d Cir. 2007).

66. *Id.* at 258–59.

67. *Id.* at 262.

68. *Id.*

69. See discussion *infra* Part III, Section C(1).

70. See *Shaw, supra* note 60, at 587.

71. Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong., Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in various sections of 42 U.S.C.).

72. About the Affordable Care Act, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://perma.cc/5VNQ-7MQY> (last updated Mar. 17, 2022).

73. 42 U.S.C. § 300gg-13; see also *What Marketplace health insurance plans cover*, HEALTHCARE.GOV, <https://perma.cc/2GVD-9BZB> (last visited Feb. 24, 2023).

74. In response to the ACA, HHS commissioned a study from IOM "to review what preventive services are necessary for women's health and well-being and should be considered in the development of comprehensive guidelines for preventive services for women." Just two weeks after the study was issued, HHS adopted IOM's recommendations. *Clinical Preventive Services for Women: Closing the Gap*, INST. OF MED. OF THE NAT'L A.C.A. (2011), <https://perma.cc/U4YP-P596>; Debra A. McCurdy, *HHS Adopts IOM Recommendations for Women's Clinical Preventive Services*, REEDSMITH (Aug. 1, 2011), <https://perma.cc/E5N5-AMGV>.

preventive services required by the Act necessarily include, among other things, all FDA-approved contraception methods.⁷⁵

Under the PPACA, people who can get pregnant enrolled in most health plans are guaranteed coverage for all recommended preventive care, including all FDA-approved contraception services prescribed by a provider, without cost-sharing (i.e. without copays or deductibles).⁷⁶ Prior to the passage of the PPACA, gaps in contraceptive coverage were filled by some states' laws requiring contraceptive equity in health insurance coverage.⁷⁷ However, the PPACA has greatly increased the access insured people who can become pregnant (and those who qualify for Medicaid) have to contraceptive services. In 2020, fifty-eight million women could receive preventive care with no cost-sharing through their insurance.⁷⁸ On June 27, 2022, three days after *Roe v. Wade* was overturned, Secretaries of HHS, Department of Treasury, and Department of Labor sent a letter to health insurance issuers urging them to comply with the PPACA and provide coverage of preventive care, including contraceptive coverage, without cost-sharing.⁷⁹

While the PPACA remains "crucial to women's health,"⁸⁰ there are several groups of employers and health plans that may continue failing to provide access to contraception, leaving even some insured people exposed to the barriers to access that existed prior to the passage of the PPACA. The source of this failure is rooted in the PPACA's religious refusal clause.⁸¹

III. BARRIERS TO ACCESS TO CONTRACEPTION

Although a wide variety of contraceptive drugs and devices have been introduced to American society in recent decades, and constitutional and statutory rights to access contraception have been identified, barriers to access to contraception still exist. This section will discuss the role religious opposition and religious refusal clauses play in access to contraception, recent efforts to increase or restrict access to contraception, and particular subgroups that face barriers to access to contraception.

75. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39870 (July 2, 2013).

76. Xavier Becerra, Janet L. Yellen, & Martin J. Walsh, *Letter to Plans and Issuers on Access to Contraceptive Coverage*, HHS 1-2 (June 27, 2022), <https://perma.cc/G876-GUWN>.

77. Thirty states and D.C. have laws requiring insurance plans to cover contraception. *State and Federal Contraceptive Coverage Requirements: Implications for Women and Employers*, KFF (Mar. 29, 2018), <https://perma.cc/M5XQ-EB7P>.

78. *Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act*, ASSISTANT SEC'Y FOR PLANNING & EVAL., HHS (Jan. 11, 2022), <https://perma.cc/8GZL-WNWT>.

79. See Becerra, Yellen, & Walsh, *supra* note 76.

80. Thalea Gauthier, *The Affordable Care Act is Crucial to Women's Health*, CMTY. CATALYST (Mar. 21, 2022), <https://perma.cc/ZJK2-2ES2>.

81. Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (2010). Religious refusal clauses are discussed further *infra* Part III, Section A.

A. REFUSAL CLAUSES AND RELIGIOUS OPPOSITION

Despite its widespread usage in modern society, some individuals and institutions oppose contraception on religious or moral grounds. The debate over when life begins fuels many of these objections. Questions about insurance coverage for contraceptives often center on tensions between an employee's right to non-discrimination in the workplace and an employer's claim of religious freedom of expression.⁸² The passage of the PPACA greatly expanded contraceptive coverage.⁸³ Nonetheless, several groups of employers and health plans still may deny coverage for contraceptives based on religious refusal.

1. The Social and Legal Controversy Surrounding Contraception

Almost all women in the U.S. in their childbearing years who have had sex have used some form of contraception.⁸⁴ However, some individuals and institutions maintain moral, ethical, or religious opposition to contraception.⁸⁵ These moral objections vary among different groups, but most object to contraception because it is inherently wrong,⁸⁶ has negative consequences,⁸⁷ or leads to "immoral behavior."⁸⁸ These objections are fueled in large part by the debate over when life begins.⁸⁹

82. *End the Use of Religion to Discriminate*, AM. C.L. UNION, <https://perma.cc/X69A-WEKS> (last visited Feb. 23, 2023).

83. *The Affordable Care Act's Birth Control Benefit is Working for Women*, NAT'L WOMEN'S L. CTR. 1 (Dec. 2016), <https://perma.cc/HC8U-6FPR>.

84. Kimberly Daniels, William D. Mosher, & Jo Jones, *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, 62 NAT'L HEALTH STAT. REP. 1, 1 (Feb. 14, 2013), <https://perma.cc/7RAX-94RP> (finding that 99% of women of childbearing age who have had sex have used some form of contraception at least once).

85. Frank Newport, *Americans, Including Catholics, Say Birth Control Is Morally OK*, GALLUP (May 22, 2012), <https://perma.cc/PZ9P-76LH> (showing 8% of U.S. adults think use of birth control is morally wrong and 3% think it depends on the situation).

86. Those who oppose contraception purport that contraception is inherently wrong because it is "unnatural," "anti-life," and is a form of "abortion," or because it separates sex from reproduction. *Moral case against contraception*, BBC, <https://perma.cc/4CUS-W6JY> (last visited Mar. 5, 2023).

87. *Id.* (listing the bad consequences cited by those who morally object to contraception, which include the following: contraception prevents potential human life from being conceived, including those who, if born, might benefit humanity; contraception can be used as a eugenic tool; and contraception may lead to depopulation).

88. Arguments that contraception leads to immoral behavior include: facilitating extramarital sex, causing widespread sexual immorality, and enabling people to have sex solely for pleasure. *Id.*

89. *See, e.g.*, Susan A. Crockett, Donna Harrison, Joe DeCook, & Camilla Hersh, *Hormone Contraceptives Controversies and Clarifications*, AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS (Apr. 1999), <https://perma.cc/J3K4-RFJE> (Christian obstetricians and gynecologists explain that they are "committed to honoring the sanctity of human life from conception" who believe that "[f]ertilization, not implantation, marks the beginning of human life.").

Proponents of widespread contraception access argue that there is no valid reason to characterize contraception as morally wrong.⁹⁰ Contraception promotes procreative liberty, which is essential to individual autonomy; it provides health and familial benefits and reduces the number of possible abortions;⁹¹ and it has positive effects on gender equity, women's autonomy, and human quality of life, as population control can yield environmental benefits and reduce poverty.⁹² These groups also contend that moral arguments against contraception are misguided—they maintain that pregnancy occurs when a fertilized egg implants in a woman's uterine lining,⁹³ and therefore methods of contraception that prevent fertilization (or, at most, implantation) do not induce abortions.⁹⁴

The diametrically opposing views on when life begins and whether contraception is equivalent to abortion⁹⁵ are significant because different legal standards are applied to contraception and abortion, making it difficult to define guidelines for state involvement and regulation when the line between the two is blurred.⁹⁶ Contraception law invokes a "strict scrutiny" test, meaning that a state has the burden of showing that a compelling interest justifies restricting an individual's right to contraception.⁹⁷ In contrast, until the 2022 *Dobbs* decision, abortion law was guided by the less stringent "undue burden" test; courts permitted state involvement in a person's choice to abort due to the state's interest in the life of the fetus and the health of the pregnant person, as long as the state's involvement did not put an undue burden on the pregnant individual.⁹⁸

The Court clarified the undue burden standard in *Whole Women's Health v. Hellerstedt*, in which the Court considered whether a Texas law imposed an undue burden on a person's right to seek an abortion because it required abortion facilities to satisfy the same minimum standards required for ambulatory surgical centers and have admitting privileges at a local hospital located no more than

90. *Moral Case for Contraception*, BBC, <https://perma.cc/HW74-Y8GX> (last visited Mar. 5, 2023) [hereinafter *Moral Case for Contraception*].

91. See *Family planning/contraception FAQ Sheet*, WORLD HEALTH ORG. (Nov. 9, 2020), <https://perma.cc/TLL7-QL96>.

92. *Moral Case for Contraception*, *supra* note 90.

93. Letter from National Women's Law Center et al. to Michael O. Leavitt, Secretary, Dep't of Health & Hum. Servs. (July 22, 2008), <https://perma.cc/98NW-X3LD>.

94. See Joerg Dreweke, *Contraception Is Not Abortion: The Strategic Campaign of Antiabortion Groups to Persuade the Public Otherwise*, 17 GUTTMACHER INST. POL'Y REV. 14, 15 (2014), <https://perma.cc/4BCJ-HTCW>.

95. See Crockett, Harrison, DeCook, & Hersh, *supra* note 89; *Moral Case for Contraception*, *supra* note 90.

96. See Gwendolyn Prothro, *RU 486 Examined: Impact of a New Technology on an Old Controversy*, 30 MICH. J.L. REFORM 715, 719 (1997) <https://perma.cc/PS5H-B7ZD>.

97. *Id.* at 723.

98. *Planned Parenthood v. Casey*, 505 U.S. 833, 874 (1992), *overruled by Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022) (holding that provisions of the Pennsylvania Abortion Control Act of 1982 were invalid and adopting an "undue burden" test for determining whether state regulations had the purpose or effect of placing substantial obstacles in the path of a woman seeking an abortion before viability).

thirty miles away.⁹⁹ Ultimately, since the requirements resulted in many clinic closures—which meant “fewer doctors, longer wait times, and increased crowding” as well as increased driving distances¹⁰⁰—and yet provided “few, if any, health benefits for women,” the new restrictions presented substantial obstacles that unduly burdened an individual’s constitutional right to seek an abortion.¹⁰¹

Determining the appropriate legal standard for contraception is more complex due to “the ‘grey’ period between fertilization and implantation.”¹⁰² RU-486,¹⁰³ which has the capacity to inhibit development during this “grey” period and “prevent ovulation, implantation or retention of a fertilized egg by the uterus after implantation,” posed particularly difficult questions of regulation, as it “can be difficult to determine which uses of RU-486 are contraceptive and which are abortive.”¹⁰⁴ The law continues to evolve in an effort to strike a balance between women’s individual autonomy and health needs, and the sincerely held moral and religious beliefs of healthcare providers, employers, and insurers opposed to providing access to contraception.

2. The History of Refusal Clauses

Shortly after the 1972 *Eisenstadt* decision, the Supreme Court held in *Roe v. Wade* that the right of personal privacy was broad enough to encompass an individual’s decision to terminate a pregnancy.¹⁰⁵ The Court stated that a person’s decision to terminate a pregnancy involved a fundamental liberty interest that should be free from government intrusion.¹⁰⁶ As in *Griswold* and *Eisenstadt*, the Court in *Roe* held this liberty interest was rooted in the zone of privacy created and protected by the Bill of Rights.¹⁰⁷

In response to the *Roe* decision, the federal government and state legislatures began to adopt “refusal clause” or “conscience clause” statutes.¹⁰⁸ These statutes permitted a broad range of individuals and institutions—including hospitals, hospital employees, health care providers, employers, and insurers—to refuse to pay for, refer, or counsel patients about medical treatment which went against the individual’s or institution’s moral, ethical, or religious beliefs.¹⁰⁹

99. See *Whole Woman’s Health*, 579 U.S. 582, 608–23 (2016), *abrogated by* *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

100. *Id.* at 613.

101. *Id.* at 624.

102. Prothro, *supra* note 96, at 718.

103. Discussed *supra* Part II, Section A.

104. Prothro, *supra* note 96, at 733.

105. *Roe v. Wade*, 410 U.S. 113, 152–53 (1973), *overruled by* *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

106. *Id.*

107. *Id.*; see also *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 484–85 (1965).

108. NARAL: *Refusal Laws*, *supra* note 6.

109. *Id.*

The first statute, the Health Programs Extension Act of 1973,¹¹⁰ allowed health care providers and individuals who benefited from government funding to refuse to provide abortion or sterilization services if doing so was against their religious or moral beliefs.¹¹¹ However, in 1974, the statute was amended such that no individual could be required to perform—or assist in performing—any healthcare services or research activity funded by the HHS.¹¹² Following Congress’s lead, forty-seven states and the District of Columbia (D.C.) passed laws permitting certain medical personnel, health facilities, and institutions to refuse to provide abortion care.¹¹³

Refusal clauses remain an issue today because of how broadly they are interpreted.¹¹⁴ Although initially enacted to ensure that objecting health care providers were not forced to participate in abortion-related activities, which such providers may have considered tantamount to murder, refusal clauses now extend to other family planning devices, such as prescription birth control.¹¹⁵

Consequently, the earlier concern about access to contraception has reemerged, pitting professional autonomy and individual religious freedom against women’s rights to reproductive health care and family planning. Today, there are many active challenges over both the scope and applicability of refusal clauses.¹¹⁶ Abortion law underwent a radical change in 2022 with the Supreme Court’s ruling in *Dobbs* that the Constitution does not actually provide the right to an abortion, and this area of the law is quickly evolving.

3. Anti-Discrimination vs. Employers’ Religious Opposition

With regard to insurance coverage of contraception, an employee’s right to nondiscrimination in the workplace is difficult to balance with an employer’s claim of religious freedom of expression, where each side claims its constitutional right should predominate.

Since 2000, most employers have been required to provide coverage of contraception as part of their health plans if they provide coverage for other prescription drugs and preventive services—or else risk violating Title VII.¹¹⁷ More than half

110. Health Programs Extension Act of 1973, 42 U.S.C.A. § 300a-7 (West, Westlaw through P.L. 114-327).

111. NARAL: *Refusal Laws*, *supra* note 6, at 1.

112. *Id.*

113. *Id.*

114. *Id.*

115. Holly Teliska, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 234 (2005) <https://perma.cc/9MN2-78AT>.

116. *See, e.g.*, *Stormans, Inc. v. Wiesman*, 794 F.3d 1064, 1087-88 (9th Cir. 2015) (upholding a D.C. regulation requiring individual pharmacists to timely deliver all prescription medications, such as Plan B and *ella*, regardless of religious or moral objections).

117. *Commission Decision on Coverage of Contraception*, EQUAL EMP’T OPPORTUNITY COMM’N (Dec. 14, 2000), <https://perma.cc/P638-DMXE>.

of the states have also mandated “contraceptive equity” to eliminate gender discrimination;¹¹⁸ however, many have exemptions for employers and insurers who object to covering contraception for religious reasons.¹¹⁹ One example is California’s Women’s Contraception Equity Act (WCEA), which generally requires employers and insurers (even religiously affiliated ones) to provide contraception coverage, but also contains a narrow exemption for religion.¹²⁰

When challenged, state courts have generally upheld these contraception mandates, even where only a narrow religious exemption was allowed.¹²¹ It is possible that the PPACA’s anti-discrimination provisions could restrict state-level conscience protections that extend too far.¹²² As of March 2023, this issue has yet to be brought to the courts.

State-level religious refusal statutes surged following the 2015 Supreme Court *Obergefell v. Hodges* decision, which legalized same-sex marriage.¹²³ Religious refusals take many forms, including religious schools firing female teachers who become pregnant outside of wedlock,¹²⁴ graduate students in training to become social workers refusing to counsel gay people,¹²⁵ pharmacies turning away

118. Twenty-nine states and D.C. require insurers that cover prescription drugs to provide coverage of approved contraception: AZ, AR, CA, CO, CT, DE, GA, HI, IL, IA, ME, MD, MA, MI, MO, MT, NV, NH, NJ, NM, NY, NC, OR, RI, VA, VT, WA, WV, WI. *Insurance Coverage of Contraceptives*, GUTTMACHER INST. (Nov. 1, 2022), <https://perma.cc/E8XA-6U64> [hereinafter *Insurance Coverage of Contraceptives*]; see also Julie Rovner, *Rules Requiring Contraceptive Coverage Have Been In Force for Years*, NAT’L PUB. RADIO (Feb. 10, 2012, 12:01 AM), <https://perma.cc/N6KJ-KXPA>. Of those, twenty states allow certain employers and insurers to refuse to provide such coverage on religious grounds: AZ, AR, CA, CT, DE, HI, IL, ME, MD, MA, MI, MO, NV, NJ, NM, NY, NC, OR, RI, WV. See Michelle L. Oxman, *State Mandates for Insurance Coverage of Contraception Before and After Health Reform*, WOLTERS KLUWER L. & BUS. 4, 15 (Oct. 2013), <https://perma.cc/LWU8-PBF5>. Eight states do not permit refusal by any employer or insurer: CO, GA, IA, MT, NH, VT, WA, WI. *Id.*

119. See, e.g., MO. ANN. STAT. § 376.1199 (West, Westlaw through 2022 101st Gen. Assemb.); see also *Insurance Coverage of Contraceptives*, *supra* note 118.

120. CAL. HEALTH & SAFETY CODE § 1367.25 (West, Westlaw through 2022 Reg. Sess. ch. 997), *superseded by* 42 U.S.C. § 1395w-26(b)(3)(B)(i), *as recognized in* Cal. Ass’n of Health Plans v. Zingale, 2001 WL 1334987 (C.D. Cal. Aug. 29, 2001).

121. See, e.g., *Catholic Charities of Sacramento v. Superior Ct.*, 85 P.3d 67, 79 (Cal. 2004) (exemption only allowed for “religious employers,” defined as a nonprofit under federal tax code whose sole purpose is inculcation of religious values which primarily employs and serves only adherents of their own faith tradition); *Catholic Charities of the Diocese of Albany v. Serio*, 28 A.D.3d 115, 137 (N.Y. App. Div. 2006) (exemption for ecclesiastical bodies, but not faith-based entities whose primary purpose is not the inculcation of religious values), *cert. denied*, 552 U.S. 816 (2007).

122. Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act’s Nondiscrimination Mandate*, 124 YALE L.J. 7, 7 (2015), <https://perma.cc/A5Y8-T9ET>.

123. See *Past Anti-LGBT Religious Exemption Legislation Across The Country*, AM. C.L. UNION, <https://perma.cc/G9K5-TRC6> (last visited Mar. 5, 2023); see also Thomas E. Berg, *Protecting Same-Sex Families and Religious Dissenters After Obergefell*, RELIGIOUS FREEDOM INST. (July 14, 2016), <https://perma.cc/BQ6Q-HULG>.

124. *End the Use of Religion to Discriminate*, AM. C.L. UNION 1, <https://perma.cc/Z2R2-GCSL> (last visited Nov. 18, 2022).

125. *Id.*

women seeking to fill birth control prescriptions,¹²⁶ and business owners refusing to provide insurance coverage for contraception for their employees.¹²⁷ The litigation battles around religious refusals are unlikely to disappear in the next several years, particularly in the area of insurance coverage for contraception.¹²⁸

4. *Hobby Lobby* and Its Aftermath

After passage of the PPACA and the Supreme Court ruling in *National Federation of Independent Businesses v. Sebelius (NFIB)*,¹²⁹ the PPACA's rules on women's preventive health services became active.¹³⁰ As of January 1, 2013,¹³¹ women enrolled in most health plans were guaranteed coverage for all recommended preventive care, including all FDA-approved contraception services prescribed by a provider, without cost-sharing (i.e., without copays or deductibles).¹³²

However, there are several groups of employers and health plans that may fall outside of this requirement based on religious refusal. First, group health plans of certain religious employers qualify for complete exemption from the law.¹³³ These fully exempt religious employers include churches and other houses of worship, as defined by Sections 6033(a)(3)(A)(i) and (iii)¹³⁴ of the Internal Revenue Code.¹³⁵

126. *Id.*

127. *Id.*

128. Caroline Mara Corbin, *Punting on substantial religious burden, the Supreme Court provides no guidance for future RFRA challenges to anti-discrimination laws*, SCOTUSBLOG (May 17, 2016), <https://perma.cc/5WNG-G8SQ> (discussing how the Supreme Court left core issues regarding the religious exemption to the contraception rule of the PPACA unresolved in its decision to remand *Little Sisters of the Poor*); see also *Where the Public Stands on Religious Liberty v. Nondiscrimination*, PEW RESEARCH CTR. (Sept. 28, 2016), <https://perma.cc/U43F-VLGY> (demonstrating the divisiveness of religious refusals in American public opinion).

129. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 569 U.S. 519, 588 (2012) (holding the "individual mandate" of the Affordable Care Act constitutional under Congressional power vested in the Taxing and Spending Clause).

130. 42 U.S.C.A. 300gg-13(a)(4) (West, Westlaw through P.L. 117-214) ("[W]ith respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph"); see also 45 C.F.R. § 147.130(a)(1)(iv) (2022).

131. *Contraceptive Coverage in the New Health Care Law: Frequently Asked Questions*, NAT'L WOMEN'S L. CTR. 1 (Sept. 2014), <https://perma.cc/CLB7-TY7X>.

132. See 45 C.F.R. § 147.130(a)(1)(iv) (2015); see also *Fact Sheet: Women's Preventive Services Coverage and Non-Profit Religious Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, <https://perma.cc/4PJD-9NZJ> (last visited Feb. 24, 2023) [hereinafter *CMS Fact Sheet*].

133. 45 C.F.R. § 147.131(a) (2015).

134. 26 U.S.C.A. §§ 6033(a)(3)(A)(i) (West, Westlaw through P.L. 117-214) ("churches, their integrated auxiliaries, and conventions or associations of churches"), 6033(a)(3)(A)(iii) (West, Westlaw through P.L. 117-214) ("the exclusively religious activities of any religious order").

135. 45 C.F.R. § 147.131(a) (2022); see also *CMS Fact Sheet*, *supra* note 132.

Prior to 2018, two other types of employers could also qualify for an accommodation from the law: non-profit religious organizations¹³⁶ and, after the Supreme Court's 2014 ruling in *Burwell v. Hobby Lobby Stores, Inc.*,¹³⁷ "closely-held" for-profit organizations.¹³⁸ In *Hobby Lobby*, the Court held the HHS "contraception mandate" requiring employers to provide their female employees with no-cost access to contraception, violated the Religious Freedom Restoration Act as applied to closely-held corporations.¹³⁹ Hobby Lobby, a family-owned corporation, objected on religious grounds to two forms of the morning-after pill and two forms of IUDs.¹⁴⁰ The company's owners believed that life begins at conception, and that any form of contraception that blocks a fertilized egg from implanting in the uterus is tantamount to abortion, which they considered murder.¹⁴¹ Under *Hobby Lobby*, if non-profit religious or closely-held organizations objected to the use of contraception on religious grounds, they did not have to contract, arrange, pay, or refer a person for contraception services coverage.¹⁴²

In 2018, the Trump administration created even broader exemptions for religious beliefs and moral objections that applied to more entity types.¹⁴³ In the 2020 consolidated cases of *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania* and *Trump v. Pennsylvania*, the Supreme Court upheld these expanded exemptions.¹⁴⁴ As a result, almost any entity that objects to providing coverage of contraceptives based on sincerely held religious beliefs or moral convictions is exempt from the contraception mandate.¹⁴⁵ The moral conviction exemption does not apply to publicly traded entities; however, the religious beliefs exemption does.¹⁴⁶

How far this freedom to refuse contraception coverage extends is still the subject of litigation. For example, while the corporations objecting in *Hobby Lobby* were opposed to only four of eighteen methods provided under the Affordable

136. 26 U.S.C.A. § 6033(a)(3)(C)(iii) (West, Westlaw through Pub. L. No. 117-214).

137. *Hobby Lobby*, 573 U.S. at 690–91.

138. *Id.* at 682–83.

139. *Id.* The Religious Freedom Restoration Act provides protection for the free exercise of religion. The government shall not "substantially burden" such exercise, even if the burden is from a law of general applicability, unless the government can show that application of the burden to the person is (1) in furtherance of a compelling governmental interest and (2) the least restrictive means of furthering that interest. Individuals seeking relief under this statute are entitled to judicial relief from an Article III court. 42 U.S.C.A. § 2000bb-1 (West, Westlaw through P.L. 117-262).

140. *Id.* at 700–01.

141. Warren Richey, *Hobby Lobby 101: explaining the Supreme Court's birth control ruling*, CHRISTIAN SCI. MONITOR (July 10, 2014), <https://perma.cc/73XK-A483>.

142. *Id.* at 731.

143. Amy Goldstein, *Trump administration issues rules letting some employers deny contraceptive coverage*, WASH. POST (Nov. 7, 2018), <https://perma.cc/QMF4-J8KY>.

144. *Supreme Court Upholds Rules Expanding Exemptions to ACA's Contraceptive Mandate*, FISHER PHILLIPS (July 13, 2020), <https://perma.cc/PT47-FG83>.

145. *Id.*

146. *Id.*

Care Act's (ACA) mandate (two forms of the morning-after pill and two forms of IUDs), subsequent orders issued by the Court suggest the right to refuse extends to all forms of contraception.¹⁴⁷ Even if a person who can become pregnant works for a qualified religious employer, they are entitled to the same contraception coverage at no cost as others under the PPACA; the health insurer must provide it to the employee directly without using the objecting employer's funds.¹⁴⁸ Thus, people who are employed by exempt religious employers still receive the same benefits as people employed by other employers subject to the ACA.

5. *Little Sisters of the Poor v. Burwell*

In *Little Sisters of the Poor Home for the Aged v. Burwell*, a Catholic religious organization argued that self-certifying as an entity with sincerely held religious beliefs or moral convictions against contraception—by either signing the Employee Benefits Security Administration Form 700 that organizations must file or by writing directly to HHS—violates their faith and their rights under the Religious Freedom Restoration Act.¹⁴⁹ Religious nonprofit organizations are required to file this form or write to HHS to trigger their accommodation, with also activates payments for contraception coverage through the health insurer directly.¹⁵⁰ Little Sisters believed that taking either action would make them indirectly responsible for providing contraception services to their employees, which they considered against the Catholic faith.¹⁵¹

After the trial court denied Little Sisters' motion for a preliminary injunction,¹⁵² the Tenth Circuit rejected Little Sisters' emergency application for an injunction pending appeal.¹⁵³ Little Sisters then filed an emergency application with the U.S. Supreme Court, which the Court granted.¹⁵⁴ The Supreme Court held preliminarily that Little Sisters should not be required to fill out the self-certification form, on the condition that they file a notice with the HHS that they are a religious organization and have religious objections to providing contraceptive coverage.¹⁵⁵

147. See *Autocam not required to offer birth control despite law*, DETROIT NEWS (Jan. 7, 2015), <https://perma.cc/HW35-TG7F>.

148. CMS *Fact Sheet*, *supra* note 132.

149. Brief on the Interim Final Regulations, *Little Sisters of the Poor Home for the Aged v. Burwell*, 794 F.3d 1151 (10th Cir. 2015) (No. 13-1540) 2014 WL 4489994 at *6–8.

150. 45 C.F.R. § 147.131(b)(3) (2015).

151. “Among other things, this means that the Little Sisters cannot allow their health plan to facilitate, participate in, or partner with others in providing sterilization, contraception, or abortion.” *Id.* at *3.

152. *Little Sisters of the Poor Home for the Aged v. Sebelius*, 6 F. Supp. 3d 1225, 1246 (D. Colo. 2013).

153. Little Sisters of the Poor's Emergency Application for Injunctive Relief Pending Appellate Review or, in the Alternative, Petition for Writ of Certiorari and Injunction Pending Resolution, *Little Sisters of the Poor Home for the Aged v. Sebelius*, 794 F.3d 1151 (10th Cir. 2015), No.13A691, 2013 WL 6984066.

154. See *Little Sisters of the Poor Home for the Aged v. Sebelius*, 571 U.S. 1171 (2014).

155. *Id.*

Later, the Tenth Circuit held that the accommodation does not impose a substantial burden on plaintiffs' religious exercise or violate plaintiffs' First Amendment rights¹⁵⁶ and Little Sisters filed for a petition for certiorari. In November 2015, the Supreme Court granted certiorari to address the question of whether religiously-affiliated nonprofits have a valid religious objection to a rule that allows them to opt out of the requirement to provide contraceptive care coverage for their employees under the ACA¹⁵⁷ and *Little Sisters* was consolidated with six other cases: *Roman Catholic Archbishop of Washington v. Burwell*, *East Texas Baptist University v. Burwell*, *Priests for Life v. Burwell*, *Southern Nazarene University v. Burwell*, *Geneva College v. Burwell*, and *Zubik v. Burwell*.¹⁵⁸

After hearing oral argument, the Court issued a *per curiam* opinion, vacating and remanding the cases to the circuit courts in light of both Petitioners and Respondents confirming that contraceptive coverage could be provided to the Respondents' employees, through the Respondents' insurance companies, without any notice from the Respondents.¹⁵⁹ The Court instructed the courts of appeals to offer the parties an opportunity to arrive at an approach that accommodates the challenges of religious exercise while at the same time ensuring that those covered by the health plans received contraceptive coverage.¹⁶⁰ The Court even offered a proposed modification of the accommodation, in which the government would not require objecting nonprofits to self-certify that they oppose contraception or to identify their insurers.¹⁶¹ Instead, the government would take an organization's decision to contract for a health plan that does not cover contraception to be a notice of a religious objection and by default require the insurer to provide it instead.¹⁶²

B. EFFORTS TO INCREASE OR RESTRICT ACCESS TO CONTRACEPTION

This section reviews recent efforts to increase access to contraception by reclassifying it as an over-the-counter medication, as well as attempts to restrict access to contraception through religious refusals clauses, Medicaid restrictions, and targeted regulation of RU-486, which can act as a contraceptive, an EC, or as an abortifacient.

1. Over-the-Counter Accessibility

Despite religious opposition and efforts to limit access to contraception, the past fifteen years have seen an increase in pressure to make contraception available over the counter. In August 2006, the Food and Drug Administration approved Plan B as an over-the-counter drug for buyers eighteen years of age or

156. *Little Sisters of the Poor*, 794 F.3d at 1205.

157. *Zubik v. Burwell*, 577 U.S. 971 (2015).

158. *Zubik v. Burwell*, 578 U.S. 403 (2016).

159. *Id.* at 408.

160. *Id.*

161. *Id.*

162. *See id.*

older, but required that the drug only be administered to those seventeen years old or younger via prescription.¹⁶³ In July 2009, the FDA approved Plan B One-Step—a single-dose version of Plan B consisting of only one levonorgestrel tablet¹⁶⁴ and announced that Plan B One-Step would be available over-the-counter to those seventeen years of age and older and by prescription to those younger than seventeen.¹⁶⁵ In April 2013, after plaintiffs challenged an HHS directive to the FDA forcing the agency to deny a citizen’s petition to make Plan B available over the counter to people who can become pregnant of all ages, the U.S. District Court for the Eastern District of New York ordered the FDA to approve the petition and make Plan B or Plan B One-Step available over the counter without age restrictions.¹⁶⁶ Initially, instead of making Plan B available without age restrictions, the FDA made Plan B One-Step available only to those fifteen years of age and older.¹⁶⁷ However, in June 2013, the FDA made Plan B One-Step available over the counter without any age restrictions.¹⁶⁸ The FDA also approved the generic forms of Plan B One-Step for over-the-counter sale without a requirement for proof of age, though the labels on these generic drugs state that they are intended for women seventeen and older.¹⁶⁹ Ella, approved by the FDA in 2010, remains available by prescription only.¹⁷⁰

Supporters of increased access to contraception applauded the FDA’s decision to expand over-the-counter access to Plan B One-Step, stating that this increase in access will help many more people avoid unintended pregnancies.¹⁷¹ In 2011, approximately half of the 6.61 million pregnancies that occurred in the U.S. were unintended, but women who used contraception properly accounted only for 5% of those pregnancies, showing the effectiveness of contraception in avoiding unintended pregnancy.¹⁷² Opponents of EC spoke out against the increased access to Plan B, concerned about the decreased opportunity for guidance from pharmacists regarding a drug with forty times the dosage of levonorgestrel as other

163. *Plan B One-Step (1.5 mg levonorgestrel) Information*, U.S. FOOD & DRUG ADMIN. (Dec. 23, 2022), <https://perma.cc/VQW7-AWGP>.

164. *Id.* at 1.

165. *Id.*

166. *Tummino v. Hamburg*, 936 F. Supp. 2d 162, 197 (E.D.N.Y. 2013).

167. Press Release, U.S. Food & Drug Admin., FDA approves Plan B One-Step emergency contraceptive without a prescription for women 15 years of age and older (Apr. 30, 2013), <https://perma.cc/RBR3-6BDQ>.

168. Press Release, U.S. Food & Drug Admin., FDA approves Plan B One-Step emergency contraceptive for use without a prescription for all women of child-bearing potential (June 20, 2013), <https://perma.cc/GQL7-ZVP5>.

169. *Id.*

170. *Ella Prescribing Information*, *supra* note 24.

171. See Mathew Herper, *The Plan B Absurdity: Emergency Contraception Is Treated Like a Drug That Could be Abused*, FORBES (May 3, 2013), <https://perma.cc/PRY6-6G8W>.

172. *Unintended Pregnancy in the United States*, GUTTMACHER INST. (Jan. 2019), <https://perma.cc/UD72-ETZH>.

forms of birth control.¹⁷³ Opponents were also concerned that the decision would encourage minors to rely on Plan B as “Plan A”: a primary method of birth control.¹⁷⁴

Even though Plan B One-Step is available without a prescription, barriers to access still exist. The ACA mandate requires coverage of only prescribed contraception, and state health plans do not always mandate coverage of over-the-counter drugs; the full cost of non-prescription EC could therefore hinder accessibility.¹⁷⁵ Developments continue at the state level; in May 2016, for instance, the Maryland legislature passed the Contraceptive Equity Act.¹⁷⁶ Under the Act, Maryland requires insurance companies to cover over-the-counter emergency contraceptives at no cost, as well as prohibits copayments for any type of contraceptive, putting the state at the forefront of contraception access expansion.¹⁷⁷

Despite this progress, other barriers to accessing over-the-counter EC remain. Some pharmacies continue to store Plan B One-Step behind the pharmacy counter to prevent it from being stolen,¹⁷⁸ which may have consequences for consumer access. For example, pharmacies may delay those seeking emergency contraceptive pills from speaking with knowledgeable staff or subject them to unnecessary embarrassing questions.¹⁷⁹ Research conducted by the Pharmacy Access Partnership and the Pacific Institute for Women’s Health shows that young women are more likely to seek EC if it is possible to have a private conversation with a pharmacist.¹⁸⁰ As a result, these groups developed the Client Confidentiality Card (the “C-Card”) to enable women to request EC in a private, discreet manner.¹⁸¹

There have also been efforts to make birth control available without a prescription. A study conducted in 2014 indicated that the rate of accidental pregnancies could decrease by a quarter if birth control was made available over the counter

173. See, e.g., Alexandra Sifferlin, *Critics and Supporters React to Decision to Expand OTC Access to Plan B*, TIME (May 1, 2013), <https://perma.cc/X8MP-VWSX> (quoting statement of Penny Nance, President of Concerned Women for America).

174. *Id.*

175. *Insurance Coverage of Contraceptives*, *supra* note 118.

176. Contraceptive Equity Act, Ch. 437, MD. CODE ANN., INS. § 15-826 (West, Westlaw through all legislation of the 2022 Reg. Sess. of the Gen. Assemb.).

177. *Id.*

178. Holly Quan, *Many Bay Area Drug Stores Still Have Morning After Pill Behind the Counter*, CBS LOCAL (Aug. 1, 2013), <https://perma.cc/J8TS-T7N4>.

179. *Access to Emergency Contraception*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (July 2017), <https://perma.cc/6D89-RA2K>.

180. See, e.g., Rebecca Bowers, *Update on Emergency Contraception: Has Status Change Increased Access?*, 28 CONTRACEPTIVE TECH. UPDATE 97, at 1 (2007).

181. The top portion of the card contains general information about EC, and the bottom portion contains a message to be torn off and given to the pharmacist. The message states, “Dear Pharmacist, I would like to obtain emergency contraception. Please help me learn about this important back up birth control method in a confidential way.” *Id.* at 2.

and covered by insurance.¹⁸² Consensus that people should have over-the-counter access to birth control is growing, though debates continue over whether non-prescription birth control would or should be fully covered by insurance.

In May 2015, Senate Republicans introduced a bill aimed at encouraging pharmaceutical companies to take the necessary steps to gain approval for the sale of “routine-use” birth control without a prescription.¹⁸³ The legislation would have waived the FDA filing fee and made such applications a top priority for the FDA.¹⁸⁴ This bill met opposition from reproductive health organizations, however, because it would not have guaranteed insurance coverage of non-prescription birth control.¹⁸⁵ The bill failed to gain the necessary political momentum, as Senate Democrats proposed a competing bill requiring insurance to cover over-the-counter birth control.¹⁸⁶

In June 2019, House Democrats first introduced the Affordability is Access Act.¹⁸⁷ If passed, the bill would require the HHS, the Department of Labor, and the Department of Treasury to specify that private health insurance plans must cover over-the-counter contraceptives approved by the FDA, even without a prescription, and prohibit retailers from interfering with access to oral contraceptives that are meant for routine, daily use and are FDA-approved for use without a prescription.¹⁸⁸ The bill was also introduced in the Senate in May 2022, but has not made progress beyond introduction and referral to committees in either chamber.¹⁸⁹

Some states have already made efforts to make birth control accessible over the counter.¹⁹⁰ In 2013, California passed a bill authorizing pharmacists to furnish self-administered hormonal contraceptives without a prescription.¹⁹¹ Oregon followed suit in 2015, allowing pharmacists to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives.¹⁹² In April 2016, as a result of the California legislature’s efforts to provide timely access to hormonal contraceptives, the state established protocols that pharmacists must

182. Diana G. Foster, M. Antonia Biggs, Kathryn A. Phillips, Kate Grindlay, & Daniel Grossman, *Potential Public Sector Cost-Savings from Over-the-Counter Access to Oral Contraceptives*, 91 *CONTRACEPTION J.* 373, 377 (2015) <https://perma.cc/Z7X4-7EYG>.

183. *Allowing Greater Access to Safe and Effective Contraception Act*, S. 1438, 114th Cong. (2015).

184. *Id.* at 1–2.

185. *See, e.g.*, Press Release, Planned Parenthood, Planned Parenthood on Republican Birth Control Bill: “Insult to Women” (May 21, 2015), <https://perma.cc/J8UJ-GAH4> (quoting Planned Parenthood President Cecile Richards).

186. Charlotte Alter, *Why Over-the-Counter Birth Control Is Stalled*, *TIME* (Dec. 23, 2015, 1:49 PM), <https://perma.cc/H8XH-5B9R>.

187. H.R. 3296, 116th Cong. (2019).

188. *Id.*

189. *Id.*; S. 4347, 117th Cong. (2022).

190. *State Reproductive Health Access Policies*, *POWER TO DECIDE*, <https://perma.cc/Q3YW-P86A> (last visited Feb. 24, 2023).

191. S.B. 493 (Cal. 2013).

192. H.R. 2879 (Or. 2015).

follow when furnishing self-administered hormonal contraception.¹⁹³ The patient is required to complete a self-screening survey, which is then reviewed, and the pharmacist evaluates the patient's seated blood pressure.¹⁹⁴ The patient has the choice of the form of contraceptive: oral, transdermal, vaginal, or the Depo-Provera shot.¹⁹⁵ Patients are also given information and counseling with regard to dosage; effectiveness; potential side effects; safety; the importance of receiving recommended preventative health screenings; and pertinent health information, such as that hormonal contraception does not protect against sexually transmitted diseases.¹⁹⁶

While consensus over the need for over-the-counter birth control continues to grow, the FDA has yet to approve such a change. It remains unclear whether over-the-counter contraception could be covered by insurance.¹⁹⁷ The result will determine whether over-the-counter status will actually result in increased access to birth control for women, particularly for low-income and younger women.

2. Refusal Clauses and Medicaid Restrictions

States often subvert federal regulation intended to increase access to contraception through refusal clauses and Medicaid restrictions. Arizona, Arkansas, Georgia, Idaho, Mississippi, and South Dakota have passed broad conscience clauses that may allow pharmacists to refuse to dispense EC.¹⁹⁸ South Dakota, for example, allows pharmacists to refuse to dispense medication if there is "reason to believe" that such medication could be used to cause an abortion or to destroy an "unborn child,"¹⁹⁹ which includes a fertilized egg not yet implanted in the uterus.²⁰⁰

Other states have tried to limit pharmacists from refusing to fill prescriptions for personal reasons. For example, in 2007, the Washington State Board of Pharmacy adopted a rule requiring pharmacies to fill all prescriptions in a timely manner and specifically prohibiting pharmacists from referring a patient to another pharmacy to create a delay in the ability to receive and ingest medication.²⁰¹ The rule, however, allowed a pharmacy to accommodate a pharmacist's

193. 16 CAL. CODE REGS. § 1746.1 (2016).

194. *Id.* at 2.

195. *Id.* at 1.

196. *Id.* at 2.

197. *See infra* Part III, Section B(2).

198. ARIZ. REV. STAT. ANN. § 36-2154(B) (West, Westlaw through 2022 2nd Reg. Sess.); ARK. CODE ANN. § 20-16-304(5) (West, Westlaw through 2022 3rd Extra. Sess.); GA. COMP. R. & REGS. 480-5-.03(n) (West, Westlaw through Oct. 4, 2022); IDAHO CODE ANN. § 18-611(2) (West, Westlaw through 2022 Reg. Sess. & 1st Extra. Sess.); MISS. CODE ANN. § 41-107-5(1) (West, Westlaw through 2022 Reg. Sess.); S.D. CODIFIED LAWS § 36-11-70 (West, Westlaw through 2022 Reg. Sess. & Sup. Ct. R. 22-10).

199. S.D. CODIFIED LAWS § 36-11-70.

200. *Id.*; *see also* S.D. CODIFIED LAWS § 22-1-2(50A).

201. *See Stormans, Inc. v. Selecky*, 571 F.3d 960, 966 (9th Cir. 2009), *vacated as not ripe for review*, 586 F.3d 1109 (9th Cir. 2009).

religious objections by having another pharmacist available in the store.²⁰² Stormans, Inc., a Washington store operating a pharmacy with individual pharmacists, filed suit to challenge this rule, arguing that the requirement to fill all prescriptions violated their constitutional right to freedom of religion.²⁰³ In 2012, after the appellate court remanded the case for review on a lower standard of rational basis, the district court found that the regulations impeded individual pharmacists' religious liberties and struck down the rule.²⁰⁴ However, in July 2015, the Ninth Circuit overturned this decision, holding that the 2007 rule does not violate the religious liberty of businesses.²⁰⁵ Since the law was generally applicable, the court reasoned that the state need only prove it had a rational interest in implementing the rule.²⁰⁶ The court found that the rule was "rationally related to Washington's legitimate interest in ensuring that its citizens have safe and timely access to their lawful and lawfully prescribed medications."²⁰⁷

In addition to adopting religious refusal clauses, states can refuse to disburse Medicaid funds for EC. In 1990, Congress amended the Medicaid Act in order to establish specific reimbursement and coverage policies for outpatient drugs.²⁰⁸ The amendment included a provision stating that states could exclude or restrict coverage of certain outpatient drugs, including non-prescription drugs.²⁰⁹ When the FDA approved Plan B in July 1999, it was considered a prescription drug,²¹⁰ and thus the cost was recoverable under Medicaid.

However, when the FDA granted Plan B over-the-counter status for patients eighteen and older and Plan B One-Step over-the-counter status without age restrictions, states were suddenly allowed to revise their Medicaid plans to exclude Plan B and Plan B One-Step from coverage due to their change in classification to non-prescription drugs.²¹¹ States vary greatly in their Medicaid policies for over-the-counter Plan B coverage.²¹² Six states, for example, cover over-the-counter EC, while other states provide partial or no coverage of over-the-counter EC.²¹³ Those enrolled in Medicaid programs are particularly burdened by cost,

202. *Id.* at 966–67.

203. *Id.* at 967.

204. *Stormans, Inc. v. Selecky*, 844 F. Supp. 2d 1172, 1201 (W.D. Wash. 2012).

205. *Stormans, Inc. v. Wiesman*, 794 F.3d 1064, 1088 (9th Cir. 2015), *petition for writ of certiorari denied*, 136 S. Ct. 2433 (2016).

206. *Id.* at 1084.

207. *Id.*

208. *See Omnibus Budget Reconciliation Act of 1990*, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

209. *Id.*

210. Julie Rovner, *Timeline: The Debate over Plan B*, NAT'L PUB. RADIO (Aug. 28, 2006, 3:21 PM), <https://perma.cc/A32G-5F85>.

211. *See Emergency Contraception: Barriers to Access*, NAT'L WOMEN'S L. CTR. (Apr. 22, 2012), <https://perma.cc/N4H8-96N6> [hereinafter *NWLC Barriers*]. Debate over the decision to advocate for over-the-counter status for emergency contraception was discussed *supra* Part III, Section B(1).

212. *See id.*

213. Illinois, Maryland, New Mexico, Oregon, Washington, and Wisconsin provide Medicaid coverage for over-the-counter EC. *See Maryland Medical Assistance Program: OB/GYN/Family Planning Provider Services and Billing Manual*, MD. DEP'T OF HEALTH & MENTAL HYGIENE (Mar.

especially in states that provide no coverage of over-the-counter EC,²¹⁴ the hindrance created by this lack of coverage can decrease access to, and thus use of, contraception.

Since the passage and slow implementation of the ACA, insurance companies are required to cover all FDA-approved contraception methods without extra charges, such as co-pays.²¹⁵ However, because Plan B and other EC measures are now labeled as over the counter for certain age groups, it remains to be seen whether the new healthcare law will extend contraception insurance coverage to EC.

In 2016, Maryland implemented its own form of comprehensive contraception coverage,²¹⁶ and New York has since followed suit. The New York State Assembly passed a bill entitled the Comprehensive Contraception Coverage Act that requires insurance companies to pay for nearly twenty different forms of FDA-approved contraception.²¹⁷ The legislation, which was signed into law on April 12, 2019,²¹⁸ has three key requirements for insurance companies to meet: (1) “cover additional contraceptive methods for men and women with no copay;” (2) “provide coverage for emergency contraception purchased at community pharmacies;” and (3) “allow up to 12 months of contraceptives to be dispensed at one time.”²¹⁹ Ultimately the bill is intended to create more guidance on the contraceptive equity that the ACA seeks to accomplish.²²⁰

Currently, Supreme Court decisions such as *Hobby Lobby* have made it unclear how comprehensive contraception insurance coverage needs to be to comply with the ACA.²²¹ New York’s new legislation seeks to close any potential loopholes in coverage that may have been created by the Court’s decisions in order to ensure that all people assigned female at birth, regardless of economic status, have access to affordable contraception, whether that be traditional birth control

2012), <https://perma.cc/6XK6-4H9S>; *Medical Assistance Program Manual Supplement: Plan B for Emergency Contraception*, STATE OF N.M. (July 1, 2009), <https://perma.cc/96ZD-5D94>; *Apple Health Fee-for-Service Covered Over the Counter Drug List*, WASH. STATE HEALTH CARE AUTH. (Aug. 20, 2015), <https://perma.cc/AD9L-WS97>; *Our Medicaid Commitment to Family Planning*, ILL. DEP’T OF HEALTHCARE & FAM. SERVS. (Aug. 20, 2014), <https://perma.cc/ZK7H-EDBP>; *Health Care Coverage*, FORWARD HEALTH WIS. (Aug. 1, 2015), <https://perma.cc/3XCA-9P9F>. In Texas, EC is not covered under the Texas Medicaid Research and Demonstration Family Planning Waiver. *Texas Women’s Health Programs Report Fiscal Year 2020*, TEX. HEALTH & HUMAN SERVS. COMM’N, WOMEN’S HEALTH SERVS. DIV. 25 (2020), <https://perma.cc/83CR-GXML>.

214. *NWLC Barriers*, *supra* note 211.

215. *Contraceptive Coverage in the Health Care Law: Frequently Asked Questions*, NAT’L WOMEN’S L. CTR. (2016) [hereinafter *NWLC Contraceptive Coverage FAQ*].

216. See *supra* notes 176–177 and accompanying text.

217. Iman Fadlalla, *Senate urged to pass Comprehensive Contraception Coverage Act*, LEGIS. GAZETTE (Mar. 18, 2016), <https://perma.cc/ERL7-89P3>. See N.Y. CODE ANN. § S659A (2020).

218. *Senate Bill S659A*, N.Y. STATE SENATE, <https://perma.cc/93S6-KN44> (last visited Nov. 18, 2022).

219. *Id.*

220. *Id.*

221. *Id.*

or emergency contraception.²²² Other states may emulate New York in order to ensure all individuals are safeguarded against potential coverage loopholes created by Supreme Court decisions.

3. Regulation of Abortifacients

On September 28, 2000, the FDA approved mifepristone, commonly known as RU-486, for the termination of early pregnancy based on data collected from clinical trials in the U.S. and France.²²³ According to FDA requirements, a physician administering RU-486 must present the patient with a medication guide and provide the opportunity to ask questions after reviewing the materials.²²⁴ The doctor must also obtain a signed patient agreement before distributing the medicine.²²⁵ Beyond these federal requirements, each state may dictate its own requirements for doctors dispensing RU-486.²²⁶ Despite the FDA's approval, the legal guidelines for regulation of RU-486 in the U.S. remain unresolved, and have been hotly contested following the overturn of *Roe v. Wade*.²²⁷

RU-486 poses particularly difficult regulatory questions because it has the potential to function as a contraceptive, an EC, or an abortifacient.²²⁸ As such, it “‘blurs the distinction between contraception and abortion’. . . [however], RU-486’s range of effectiveness suggests that there is not a bright-line distinction between preventing and terminating pregnancy in its early stages.”²²⁹ This blurring makes it impossible to utilize a strict bright-line approach to regulation of the drug, as it is unclear whether contraception or abortion law should govern. The 2022 *Dobbs* decision also complicates this issue in states where abortion is no longer legal. Thus far, no guiding principle has dictated which test should dispose of the question, creating ambiguities with important consequences for the health and bodily autonomy of individuals who can become pregnant.

222. *Legislative Memo: Comprehensive Contraception Coverage Act*, AM. C.L. UNION OF N.Y., <https://perma.cc/U58Q-2DWU> (last visited Nov. 18, 2022).

223. An early pregnancy is defined as forty-nine days or less, counting from the beginning of the last menstrual period. Jeremy Manier & Barbara Brotman, *FDA Gives Final OK To Abortion Pill*, CHI. TRIB. (Sept. 29, 2000), <https://perma.cc/EA4Q-TC2R>.

224. *See Approval Letter, MIFEPREX (Mifepristone) Tablets*, U.S. FOOD & DRUG ADMIN. 1, 2 (Sept. 28, 2000), <https://perma.cc/B63X-GAKJ>.

225. *Id.*

226. *See, e.g.*, ARK. CODE ANN. § 20-16-1504 (Westlaw, West through the end of the 2022 3rd Extra. Sess. of the 93rd Arkansas Gen. Assemb.) (requiring physician to have signed contract with a physician who agrees to handle complications); OKLA. STAT. tit. 63, § 1-729a (Westlaw, West through Ch. 395 (End) of the 2nd Sess. of the 58th Leg. (2022)) (requiring physicians to report to the drug manufacturer any serious event or adverse reaction experienced by the patient within one year after use).

227. Renee C. Wyser-Pratte, *Protection of RU-486 as Contraception, Emergency Contraception and as an Abortifacient Under the Law of Contraception*, 79 OR. L. REV. 1121, 1121 (2000) <https://perma.cc/7XNV-4M65>; *see also* Devlin Barrett, *After Roe ruling, Garland gears up for the next legal battles*, WASH. POST (June 24, 2022) <https://perma.cc/A3EX-QR32>.

228. Kremser, *supra* note 32, at 446–47.

229. *Id.* at 455.

C. GROUPS FACING HEIGHTENED BARRIERS TO ACCESS

Prescription birth control and EC regulations make access especially problematic for several groups—specifically, children, immigrant women, survivors of sexual assault, and people insured through Medicaid.²³⁰ These groups are often impeded by their lower economic status and their lack of protection under U.S. law.²³¹ This section examines the particular barriers faced by (i) minors, (ii) low-income individuals, and (iii) other groups, such as immigrants and survivors of sexual assault.

1. Minors

Following the Supreme Court's decision in *Carey v. Population Services*,²³² many states expanded the scope of minors' access to contraception. While four states still lack an explicit policy regarding a minor's authority to consent to contraceptive services,²³³ twenty-three states and D.C. explicitly allow all minors to consent, even without parental involvement.²³⁴ Additionally, twenty-four states allow minors to consent to contraceptive services under certain conditions, such as when the minor's health would be jeopardized by being refused contraceptives,²³⁵ the minor is married,²³⁶ the minor is a parent,²³⁷ or the minor has

230. *NWLC Barriers*, *supra* note 211.

231. In 2010, 19.9% of immigrants in the U.S. lived in poverty. *Immigrants in the U.S.: A Profile of America's Foreign-Born Population*, CTR. FOR IMMIGR. STUDIES, <https://perma.cc/CJP2-DRBT> (last visited Nov. 6, 2022). In the eighteen to sixty-four age range, immigrant women are significantly less likely than women born in the U.S. to have health insurance (66.3% of immigrant women compared with 84.6% of U.S.-born women). *The Status of Women in the States: Spotlight on Immigrant Women*, INST. FOR WOMEN'S POL'Y RES., <https://perma.cc/XBV9-PUW2> (last visited Nov. 18, 2022). The passage of the ACA caused a dramatic drop in the rate of uninsurance among women in the U.S. aged eighteen to twenty-four, from 24.9% to 15.9%. *The Status of Women in the States: Spotlight on Millennials*, INST. FOR WOMEN'S POL'Y RES., <https://perma.cc/JB6G-K4TD> (last visited Nov. 18, 2022).

232. 431 U.S. 678, 685 (1977) (holding minors have constitutional right to privacy that encompasses decisions about their own use of contraception).

233. These states are North Dakota, Ohio, Rhode Island, and Wisconsin. *Minors' Access to Contraceptive Services*, GUTTMACHER INST., <https://perma.cc/9QQF-2VZ9> (last visited Nov. 6, 2022) [hereinafter *Guttmacher Minors' Access*].

234. Alaska, Arizona, Arkansas, California, Colorado, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Montana, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, Washington, and Wyoming. *Id.* For an example of a state code allowing all minors to obtain contraception, *see* CAL. FAM. CODE § 6925 (West, Westlaw through Ch. 997 of 2022 Reg. Sess.).

235. *Guttmacher Minors' Access*, *supra* note 233. For an example of a state code allowing a minor whose health is jeopardy to obtain contraception, *see* FLA. STAT. ANN. § 381.0051 (West, Westlaw through chs. from the 2022 2nd Reg. Sess. in effect through July 1, 2022).

236. Nineteen states allow married minors to consent. *Guttmacher Minors' Access*, *supra* note 233. For an example of a state code allowing married minors to obtain contraception, *see* ME. REV. STAT. ANN. tit. 22, § 1503 (West, Westlaw through the 2022 2nd Reg. Sess. of the 130th Leg.).

237. Five states allow minors who are parents to consent. *Guttmacher Minors' Access*, *supra* note 233. For an example of a state code allowing minor parents to obtain contraception, *see* MISS. CODE ANN. § 41-42-7 (West, Westlaw current with laws from the 2022 Reg. Sess. effective through July 1, 2022).

previously been pregnant.²³⁸

In contrast, abortifacients, such as RU-486, pose special challenges, as states have differing parental notification or consent standards for contraception and abortion. Whereas parental notification may require proof that both parents are informed before a minor can receive services, parental consent requires that either one or both parents actually consent to the services before they are provided to the minor.²³⁹ While the abortion laws in each state are rapidly evolving following the 2022 *Dobbs* decision, fourteen states and D.C. allow minors to access abortion services without any sort of parental involvement.²⁴⁰

Parental involvement for minor's access to EC is debated. Supporters of a parental notification or consent requirement for EC point to the alleged harm that could be caused when minors purchase EC without the guidance of a doctor or parent, questioning whether minors can fully understand the reproductive choices they are making.²⁴¹ These supporters also argue that since minors are restricted from making other decisions related to their health, such as buying tobacco, minors should not be granted complete control over their reproductive choices.²⁴² On the other side, supporters of an absolute right to privacy for minors believe that "many young people will not avail themselves of important services if they are forced to involve their parents."²⁴³ For example, parental notification can have a "significant deterrent effect on a minor's use of Title X clinics."²⁴⁴ Requiring parental involvement can add another strenuous obstacle to overcome in situations in which minors are already dealing with stringent restrictions.²⁴⁵ Furthermore, the U.S. has the highest teenage pregnancy rate of the world's

238. Five states allow minors who were previously pregnant to consent. Guttmacher Minors' Access, *supra* note 233. Ten states allow minors to consent when other requirements are met, such as graduating from high school, reaching a minimum age, demonstrating maturity, or receiving a referral from a member of a clergy or a doctor. *Id.* For an example of a state code allowing certain categories of minors to consent to use of contraception without parental consent, see ALA. CODE § 22-8-4 (West, Westlaw through Act 2022-442 of the 2022 Reg. & 1st Spec. Sess.) (allowing minors fourteen or older to consent to use of contraception).

239. *Parental Involvement in Minor's Abortions*, GUTTMACHER INST., <https://perma.cc/8562-WVPD> (last visited Nov. 6, 2022).

240. Those states are: AK, CA, CT, HI, IL, ME, MN, NV, NJ, NM, NY, OR, VT, and WA. *Parental Consent and Notification Laws*, PLANNED PARENTHOOD (Nov. 3, 2022) <https://perma.cc/79BQ-U48L>.

241. Sarah C. Brandt, *The Availability of Plan B to Minors in the Aftermath of Tummino v. Torti*, 14 J. GENDER, RACE & JUST. 199, 217 (2010).

242. *Id.* at 218.

243. *An Overview of Minors' Consent Law*, GUTTMACHER INST., <https://perma.cc/6QVR-DSHW> (last updated Nov. 6, 2022).

244. Stephanie Bornstein, *The Undue Burden: Parental Notification Requirements for Publicly Funded Contraception*, 15 BERKELEY WOMEN'S L.J. 40, 41-42 (2000).

245. A minor already has a short window in which to seek EC; adding a requirement to seek parental consent may shorten this window even more. For example, Plan B is most effective if taken within seventy-two hours of intercourse. Brandt, *supra* note 241, at 219.

most developed countries.²⁴⁶ Supporters of increased access to contraception continue to point to this statistic as indicative of the substantial barriers to access to contraception that minors face and the need for uninhibited access.²⁴⁷

Minors in low-income communities face particularly difficult impediments, as they are less likely to have adequate access to reproductive health services and resources, such as contraception.²⁴⁸ Because they are less likely to have the money to pay for a doctor's appointment, minors in low-income communities are less able to obtain prescriptions for certain forms of contraception.²⁴⁹ Therefore, parental consent requirements create a higher barrier for low-income minors, who are more likely to seek contraception from publicly funded clinics.²⁵⁰

Even in states where minors may be able to obtain contraception without parental consent or without a prescription, transportation to clinics can be an issue, as minors in poorer communities are less likely to have easy access to transportation.²⁵¹ New York has attempted to aid these transportation issues by establishing School-Based Health Centers (SBHCs).²⁵² There are currently over 387 SBHCs across the five boroughs of New York City located primarily where there is limited access to health care.²⁵³ In addition to providing free medical care regardless of insurance or immigration status, the SBHCs also provide high school students with access to reproductive health services including contraception, since under New York state law parental consent is not required.²⁵⁴

2. Low-Income Women

While the ACA has guaranteed birth control at no cost to most insured patients, many still face financial barriers when trying to access contraception.²⁵⁵ More than 20% of public healthcare providers report that most of their clients seeking contraception have difficulty paying for their visit.²⁵⁶ For insured and uninsured

246. *Teen Pregnancy Rates Declined in Many Countries Between the Mid-1990s and 2011*, GUTTMACHER INST. (Jan. 23, 2015), <https://perma.cc/X648-QSRM>.

247. *See Committee Opinion No. 615: Access to Contraception*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, 2–3 (Reaffirmed 2022), <https://perma.cc/EE3K-8VWZ>.

248. Brandt, *supra* note 241, at 199 (citing Sydney Kokjohn, *The Imposition of an Age Restriction on Over-the-Counter Access to Plan B Emergency Contraception: Violating Constitutional Rights to Privacy and Exceeding Statutory Authority*, 9 MINN. J.L., SCI. & TECH. 369, 383 (2008) <https://perma.cc/HZ3F-42AY>).

249. Brandt, *supra* note 241, at 219.

250. Bornstein, *supra* note 244, at 42.

251. Brandt, *supra* note 241, at 219.

252. *School Based Health Centers*, N.Y.C. DEP'T OF EDUC., <https://perma.cc/QS28-GMTU> (last visited Jan. 21, 2023).

253. *Id.*

254. *Id.*

255. *See Issues: Birth Control*, NARAL PRO-CHOICE AM., <https://perma.cc/FP96-EZ8J> (last visited Jan. 21, 2023).

256. David J. Landry, Junhow Wei, & Jennifer J. Frost, *Public and private providers' involvement in improving their patients' contraceptive use*, CONTRACEPTION 1, 4 (Mar. 13, 2008), <https://perma.cc/26KD-3J8E>.

low-income individuals, the cost of accessing contraception can include the cost of transportation to and from pharmacies and clinics.²⁵⁷ Additionally, these people also face difficulties due to their potentially inflexible work schedules or inability to secure necessary childcare.²⁵⁸ This reality is even worse for African American, Latina, American Indian, and Alaskan Native people who can become pregnant.²⁵⁹

Additionally, the cost of the contraception itself can be prohibitive. In 2020, birth control pills cost up to about \$50 a month.²⁶⁰ In states that do not allow online prescriptions, the medical exam required for the prescription can cost up to \$250, meaning birth control pills can cost up to \$850 a year for the uninsured.²⁶¹ The ACA had no apparent effect on the cost of birth control pills for uninsured individuals.²⁶² Data indicates that the cost of birth control is often higher in low-income areas,²⁶³ and surveys indicate that people who are struggling financially are likely to use birth control inconsistently—or stop using it altogether—in order to save money.²⁶⁴

Two solutions have emerged for low-income individuals seeking contraception: Medicaid coverage and Title X-funded clinics. Medicaid eligibility has been greatly expanded since the passage of the ACA.²⁶⁵ Before the ACA was passed, most states did not extend Medicaid coverage to low-income people unless they were pregnant;²⁶⁶ the ACA expanded eligibility to all adults with incomes at or below 138% federal poverty level (FPL).²⁶⁷ The Supreme Court's 2012 ruling in *NFIB* made this expansion a state option;²⁶⁸ however, as of March 2023, thirty-

257. Olivia Lewis, *Demand for Contraceptives Increases as Barriers to Access Persist*, DIRECT RELIEF (Sept. 26, 2022, 3:00 AM), <https://perma.cc/H569-TMHX>.

258. *Understanding Contraceptive Deserts*, POWER TO DECIDE, <https://perma.cc/ST4Y-3PBD> (last visited Jan. 21, 2023).

259. See generally Brittini Frederiksen, Usha Ranji, Michelle Long, Karen Diep, & Alina Salganicoff, *Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage*, KAISER FAM. FOUND. (Nov. 3, 2022), <https://perma.cc/882T-JU4U>.

260. *How Much do Birth Control Pills Cost?*, PLANNED PARENTHOOD (June 29, 2020), <https://perma.cc/85KT-6D2G>.

261. *Id.*

262. See Olga Khazan, *Why Some Women Still Can't Get Birth Control*, ATLANTIC MONTHLY (Nov. 6, 2016), <https://perma.cc/MDC5-59U3>.

263. Catherine Pearson, *Cost Of Birth Control Higher In Some Low-Income Neighborhoods Than In Wealthy Ones*, HUFFPOST (May 6, 2013), <https://perma.cc/F5D2-WBT9>.

264. See *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions*, GUTTMACHER INST. (Sept. 2009), <https://perma.cc/8GDC-7TQW>.

265. See Rachel Garfield, Kendall Orgera, & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Oct. 19, 2016), <https://perma.cc/6DAA-EYU2>.

266. Cynthia Pellegrini & Nicole Garro, *Medicaid Expansion: Benefits for Women of Childbearing Age and Their Children*, HEALTHAFFAIRS.ORG (Feb. 22, 2013), <https://perma.cc/D8T6-X3JT>.

267. Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, & Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*, KAISER FAM. FOUND. (Mar. 26, 2020), <https://perma.cc/5RTJ-E2ZW>.

268. *A Guide to the Supreme Court's Affordable Care Act Decision*, KAISER FAM. FOUND. (July 2012), <https://perma.cc/W32M-N73H>.

six states have set their income eligibility levels to at least 138% FPL.²⁶⁹ Fifteen states continue to deny Medicaid coverage to childless, low-income adults altogether.²⁷⁰ For those who have Medicaid coverage, birth control is available without cost sharing, meaning that patients “will not be charged a co-payment for the services and the costs of the services will not be applied to the deductible.”²⁷¹

For those who are not eligible for Medicaid, the best resource for obtaining contraception is the funding provided by Title X. This federal program funds a network of over 4,100 family planning centers, serving approximately 3.5 million clients every year.²⁷² There are three income levels at which individuals can qualify for free or low-cost birth control under the Title X funding: (1) people with incomes below 100% FPL are eligible to receive services, including birth control, at no cost; (2) those with incomes between 101–250% FPL are charged on a sliding scale, based on ability to pay; and (3) individuals with incomes above 250% FPL are charged in accordance with the “reasonable cost of providing services.”²⁷³ Between 2010 and 2016, the number of women likely in need of public support for contraceptive services and supplies rose 8% overall. Among women below 250% of federal poverty guidelines, there was a 12% increase.²⁷⁴

3. Other Groups

Immigrants often lack access to contraception due to linguistic barriers and issues with documentation. A 2005-2006 study in California found that Spanish-speaking females aged eighteen and younger have a harder time accessing EC from pharmacies than their English-speaking counterparts.²⁷⁵ Customers must present identification to purchase it, which may create a barrier for immigrants who lack government-issued identification.²⁷⁶ Undocumented individuals often face particularly arduous barriers to contraceptive access. In 2016, the American Civil Liberties Union (ACLU) filed a lawsuit against the HHS over the allocation of federal funds to religiously affiliated organizations that deny access to abortion and

269. Brooks, Roygardner, Artiga, Pham, & Dolan, *supra* note 267.

270. *Id.*

271. NWLC *Contraceptive Coverage FAQ*, *supra* note 215.

272. *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, GUTTMACHER INST. (Oct. 2019), <https://perma.cc/5HMB-REM3>.

273. *Private and Public Coverage of Contraceptive Services and Supplies in the United States*, KAISER FAM. FOUND. (July 10, 2015), <https://perma.cc/T9HR-MJT5>.

274. *Publicly Supported Family Planning Services in the United States*, *supra* note 272, at 1.

275. Only 24% were successful. Olivia Sampson, Sandy K. Navarro, Amna Khan, Norman Hearst, Tina R. Raine, Marji Gold, Suellen Miller, & Heike Thiel de Bocanegra, *Barriers to Adolescents' Getting Emergency Contraception Through Pharmacy Access in California: Difference by Language and Region*, 41 PERSPS. SEXUAL & REPROD. HEALTH 110, 113 (2009) <https://perma.cc/X8RQ-E3K5>.

276. Reena Singh, *New barriers to emergency contraception access for rape victims: A report from Connecticut*, WOMEN'S HEALTH ACTIVIST 1 (May 1, 2007), <https://perma.cc/2TMC-36DB>.

contraception to unaccompanied, immigrant minors placed in their care while they await their immigration detention hearings.²⁷⁷

Survivors of sexual assault also face barriers to EC access. General access is limited because some hospitals refuse to provide EC to survivors of rape or sexual assault, instead requiring that these patients go to a pharmacy to get the drug after their medical examination.²⁷⁸ Fifty-five percent of Catholic hospitals, which comprise the nation's largest group of not-for-profit hospitals, do not provide EC, including to sexual assault survivors.²⁷⁹ Mergers between religious and secular hospitals are increasing, and the resulting system may adopt religious restrictions that further hinder access to contraception.²⁸⁰ This can be problematic for survivors, who often need to obtain the medication immediately.²⁸¹ Moreover, some pharmacists still refuse to dispense EC based on their personal beliefs, and survivors may be confronted with criticism or harassment at the pharmacy counter.²⁸²

IV. CONCLUSION

In the post-ACA world, access to contraception has been greatly improved. In the thirteenth year since the legislation was passed, insured people who can become pregnant are now, more than ever, eligible to obtain contraception with no out-of-pocket costs. Even those employed by religiously affiliated entities are eligible for the same benefits. Additionally, now that over half of states, including D.C., have opted into the Medicaid expansion, more low-income individuals are eligible for Medicaid benefits, which entitle them to the same free or low-cost access to contraception. Access to EC has similarly improved and continues to improve each year. While the variety of EC options people who can become pregnant can choose from continues to grow, Plan B One-Step is now available to all such individuals without a prescription and without age restrictions, which greatly increases access for minors.

However, barriers to access remain a harsh reality for many. Financial obstacles prohibit uninsured or low-income individuals from receiving the contraception they need. Most traditional forms of birth control still require a prescription. Even though Plan B One-Step is readily available over the counter, this can create further cost barriers as the ACA does not require coverage of non-prescription items. The existence of parental notification and consent requirements

277. Erik Eckholm, *Suit Challenges U.S. Over Abortions and Birth Control for Immigrant Minors*, N.Y. TIMES, June 24, 2016, at A3, <https://perma.cc/3R8A-4YTW>.

278. See Singh, *supra* note 276.

279. NARAL: *Refusal Laws*, *supra* note 6; see also CATHOLIC HEALTH CARE IN THE UNITED STATES, CATHOLIC HEALTH ASS'N, <https://perma.cc/K9CP-VK5P> (last updated June 2022) (emphasizing the prevalence of Catholic hospitals in the U.S.).

280. There were 171 mergers between religious and secular (non-religious) hospitals between 1990 and 2001. In many cases, reproductive health services are lost when restrictive religious rules are imposed on the nonsectarian hospital as a condition of the merger. *Religious Hospitals, Mergers & Refusal Clauses*, LAW STUDENTS FOR REPROD. JUST. 1, 2 (2012), <https://perma.cc/X5RB-AQSY>.

281. *Id.* at 1.

282. *Id.* at 3–4.

in some states continues to burden minors' ability to access EC in a timely and effective manner. The state-by-state nature of these issues also presents an interesting and sometimes difficult dynamic for progress: some state laws provide greater protection for patients' interests, while others consider healthcare providers' interests to be much stronger. Some hospitals, doctors, and pharmacists still refuse to provide any services that may interfere with personally held religious beliefs—opposition which infringes on individuals' rights to make their own contraceptive choices. Abortion access laws are rapidly evolving post-*Dobbs*, and the precise extent of the freedom to refuse contraceptive coverage due to religious objections remains the subject of litigation. Ultimately, the threat of expanded conscience clause refusals, the perennial efforts to defund Planned Parenthood, and the staunch opponents of continued Title X funding all remain unwelcome reminders of potential barriers to access that may have to be addressed in the future.

Perhaps most influential of all, medical and technological advancements provide a unique and necessary contribution to this issue. It is imperative that the state of the law reflects these fast-growing medical advancements. Access to contraception remains an intersectional issue, and from policy to technology, a growing number of people have a stake in the ongoing debate of when life begins. But ultimately, what matters most in this polarizing discussion is the individual ability—no matter the age, immigration status, or income level—to obtain contraception. The issue of contraceptive access will continue to evolve in the post-*Dobbs* landscape.