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 requirements under the Patient Protection and Affordable Care Act ("PPACA") 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* noted that the legal justifications for the majority's decision could destabilize the rights provided under *Griswold* if challenged in the future.[6] 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 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 clauses[7] 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 want to

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, 2332 n.9 (2022) (Breyer, Sotomayor & Kagan, JJ., dissenting).

6. *Id.*

7. Refusal clauses are statutes that protect health care 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*].

become pregnant.[8] Among women ages 15–49, approximately 65% currently use contraception,[9] and over 99% of women ages 15–49 who have ever had sexual intercourse with a male have used at least one contraceptive method at some point in time.[10] Of the women who currently use some form of contraception, 72% use impermanent methods, primarily condoms, intrauterine devices, and/or other hormonal methods, including pills, patches, and vaginal rings.[11] Emergency contraception is also widely used among women of reproductive age; 2015–2019 data suggests that 23.5% of sexually-experienced women of reproductive age have used EC pills at some point in time.[12]

Prescription birth control is a dose of hormones prescribed by a health care provider for use on a regimented basis by a person who can become pregnant.[13] 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.[14]

While most of those who can become pregnant and are using contraception in the U.S. still prefer The Pill, implantable contraceptives are also becoming increasingly popular.[15] Some implantable contraceptives are inserted under the skin by a licensed medical professional, where they can remain for years.[16] They can be removed by a licensed medical professional at any time.[17] Three common forms of subdermal implantable contraception—Implanon, Norplant, and Jadelle—have been found to be extremely effective and easy to use.[18] All three carry a low risk of side effects, though rare cases of bleeding disturbances and certain related side effects may occur.[19] 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.[20] Overall, however,

8. *Contraceptive Use in the United States*, GUTTMACHER INST. (May 2021), https://perma.cc/LAD9-476S [hereinafter *Contraceptive Use in the United States by Demographics*].

9. *Current Contraceptive Status Among Women Aged 15–49: United States, 2015–2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Dec. 2018), https://perma.cc/BYP9-VVLA.

10. Kimberly Daniels & Joyce C. Abma, *Contraceptive Methods Women Have Ever Used: United States, 2015–2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, at 1 (Dec. 14, 2023), https://perma.cc/5RN4-UWRA.

11. *Contraceptive Use in the United States by Method*, GUTTMACHER INST. (May 2021), https://perma.cc/TG85-YJA6.

12. Daniels & Abma, *supra* note 10, at 4.

13. *Birth Control*, U.S. FOOD & DRUG ADMIN., https://perma.cc/W982-VFSA [hereinafter *Birth Control Medicines to Help You*].

14. *Id.*

15. *Contraceptive Use in the United States by Demographics*, *supra* note 8.

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

17. *Id.*

18. 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.

19. *Id.*

20. *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."[21]

Emergency contraception is a post-coital method of preventing pregnancy when prophylactic contraception measures, like those discussed above, fail or are not used.[22] 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.[23] 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)[24] or a synthetic progesterone antagonist (ulipristal acetate).[25] In 1997, the U.S. Food and Drug Administration (FDA) determined that EC pills are a safe and effective form of contraception.[26] The FDA first approved the "morning-after pill" Plan B, a set of two levonorgestrel pills, in 1999.[27] The FDA has since approved a number of emergency contraceptive pills.[28] Plan B lowers chances of pregnancy by 75–89% if taken within seventy-two hours of birth control failure or unprotected sex,[29] while ella, a prescription-only EC pill, is effective if taken within 120 hours.[30] If EC is taken outside this window, it becomes significantly less effective in preventing pregnancy.[31] Despite popular misconceptions and the portrayal of 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.[32]

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21. 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.*

22. *Plan B One-Step (1.5 mg levonorgestrel) Information*, U.S. FOOD & DRUG ADMIN., https://perma.cc/2AMK-HUS3 [hereinafter *Plan B One-Step*].

23. *Id.*

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

25. *Ella (Ulipristal Acetate) Prescribing Information*, U.S. FOOD & DRUG ADMIN. 1, https://perma.cc/V4QC-RT2K [hereinafter *Ella Prescribing Information*].

26. 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.

27. *See Plan B One-Step*, *supra* note 22.

28. *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).

29. *See What's the Plan B morning after pill?*, PLANNED PARENTHOOD, https://perma.cc/BD56-LYMG.

30. *See Birth Control Medicines to Help You*, *supra* note 13.

31. 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.

32. *See id.* at 6–8.

The pharmacology of EC continues to evolve. Mifepristone, also known as RU-486, works by blocking progesterone, a hormone needed for pregnancy to continue.[33] This drug is typically taken in conjunction with a second drug called Misoprostol;[34] together, they are extremely effective in expelling an embryo and ending an early pregnancy.[35]

In addition to these oral EC methods, a third form of EC has become increasingly common. Copper intrauterine devices ("IUDs"), such as Paragard or Mirena, if inserted within five days of unprotected intercourse or suspected contraceptive failure, can reduce a person's risk of pregnancy by more than 99.9%.[36] The device must be inserted into the uterus by a licensed health care provider and is not available over the counter.[37] When inserted properly, an IUD can remain effective at preventing pregnancy for up to eight to twelve years depending on the type.[38] IUDs cost up to $1,300, but are free or low-cost with most insurance plans.[39] IUDs are the most effective form of EC for reducing the chances of pregnancy and the FDA has approved the device as a safe form of contraception.[40] However, ParaGard has not been officially recommended for emergency usage,[41] although the CDC notes that IUDs can be used as emergency contraception.[42] Nevertheless, physicians do prescribe ParaGard as an EC and evidence indicates that it is successful.[43]

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.[44] The company in *Hobby Lobby* argued that any form of contraception that blocks a fertilized egg from implanting in the uterus is

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

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

35. *Id*.

36. *How do IUDs work as emergency contraception?*, PLANNED PARENTHOOD, https://perma.cc/Z3WZ-EPCQ.

37. *Id*.

38. *Id*.

39. *Id*.

40. Michelle C. Bosworth, Patti L. Olusola, & Sarah B. Low, *An Update on Emergency Contraception*, 89 AM. FAM. PHYSICIAN 545, 546 (2014).

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

42. *Classifications for Emergency Contraception*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://perma.cc/6KRL-33FJ.

43. *See* Bosworth, Olusola, & Low, *supra* note 40.

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

tantamount to abortion.[45] 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."[46] 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.[47]

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.[48] In *Griswold v. Connecticut*, a director of Planned Parenthood and a doctor provided medical advice, information, and instructions to married couples regarding contraception.[49] They were arrested pursuant to a state law prohibiting both the use of and provision of assistance in obtaining contraception.[50] 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.[51] Thus, the Court held, the state must not legislate so broadly as to restrict the marital decision of whether or not to bear children.[52] 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."[53] The right to privacy was, thus, considered one of the unenumerated rights provided by the Bill of Rights by virtue of the Ninth Amendment.[54]

In 1972, *Eisenstadt v. Baird* clarified that the right to privacy extended to all adults, regardless of marital status.[55] 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."[56] Thus, the Court

45. *Id*. at 697–98, n.7.

46. 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).

47. *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 93, 102 (2016); *see also Little Sisters of the Poor Home for the Aged*, 6 F. Supp. 3d 1225 (D. Colo. 2013).

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

49. *Id*. at 480.

50. *Id*.

51. *Id*. at 484–85.

52. *Id*. at 485.

53. *Id*. at 485–86.

54. Griswold v. Connecticut, 381 U.S. 479, 486–87 (1965) (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).

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

56. *Id*.

moved away from grounding the right to use contraception in the privacy 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.[57]

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.[58] Five years later in *Carey v. Population Services International*, the Supreme Court held that the right to privacy does in fact apply to minors.[59] 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.[60] This ruling, and the notion of minors' right to privacy, clashed with a sometimes-asserted parental right to notification.[61] As noted earlier, the right to privacy is viewed as a right to make reproductive decisions free from state interference,[62] but whether freedom from parental involvement should also be included in this right is still debated.[63]

In 1980, the Sixth Circuit held that clinics had no constitutional obligation to notify parents before dispensing contraception to minors.[64] 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.[65] 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.[66] Congress has since passed no federal legislation on this matter.

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

58. 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).

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

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

61. *See generally* Lynn D. Wardle, *Parents' Rights vs. Minors' Rights Regarding the Provision of Contraceptives to Teenagers*, 68 NEB. L. REV. 216 (1989) (discussing the tension between the constitutional rights of minors and their parents in accessing contraception).

62. *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).

63. 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).

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

65. *Id.* at 1168–69.

66. 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.[67] In that case, a clinic dispensed EC to a sixteen-year-old without notifying her parents.[68] Her parents argued that this lack of notification violated their Fourteenth Amendment liberty interest.[69] 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.[70] However, minors continue to face many barriers to contraception access.[71]

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.[72] 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.[73] The Act called for significant reforms to health insurance to "make affordable health insurance available to more people."[74] Notably, the Act requires newly-issued health insurance plans, including Medicaid, to cover essential health benefits, including women's preventive services.[75] In 2011, the Department of Health & Human Services ("HHS") issued guidelines based on a study commissioned from the Institute of Medicine ("IOM"),[76] explaining that the preventive services required by the

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

68. *Id.* at 258–59.

69. *Id.* at 262.

70. *Id.*

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

72. *See* Shaw, *supra* note 62, at 587.

73. 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.).

74. About the Affordable Care Act, U.S. DEP'T OF HEALTH & HUM. SERVS., https://perma.cc/5VNQ-7MQY.

75. 42 U.S.C. § 300gg-13; s*ee also What Marketplace health insurance plans cover*, HEALTHCARE.GOV, https://perma.cc/2GVD-9BZB.

76. 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. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 2 (2011); Debra A. McCurdy, *HHS Adopts IOM Recommendations for Women's Clinical Preventive Services*, REEDSMITH (Aug. 1, 2011), https://perma.cc/E5N5-AMGV.

Act necessarily include, among other things, all FDA-approved contraception methods.[77]

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).[78] Prior to the passage of the PPACA, gaps in contraceptive coverage were filled by some states' laws requiring contraceptive equity in health insurance coverage.[79] 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.[80] On June 27, 2022, three days after *Roe v. Wade* was overturned, the 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.[81]

While the PPACA remains "crucial to women's health,"[82] 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.[83]

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.

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

78. Letter from Xavier Becerra, Sec'y, Dep't Health and Hum. Servs., Janet L. Yellen, Sec'y, Dep't of Treasury, & Martin J. Walsh, Sec'y, Dep't of Labor, to Group Health Plan Sponsors and Issuers, HHS (June 27, 2022), https://perma.cc/G876-GUWN.

79. 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.

80. *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.

81. *See* Becerra, Yellen, & Walsh, *supra* note 78.

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

83. Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 246 (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 nondiscrimination in the workplace and an employer's claim of religious freedom of expression.[84] The passage of the PPACA greatly expanded contraceptive coverage.[85] 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.[86] However, some individuals and institutions maintain moral, ethical, or religious opposition to contraception.[87] These moral objections vary among different groups, but most object to contraception because it is inherently wrong,[88] has negative consequences,[89] or leads to "immoral behavior."[90] These objections are fueled in large part by the debate over when life begins.[91]

Proponents of widespread contraception access argue that there is no valid reason to characterize contraception as morally wrong.[92] Contraception promotes procreative liberty, which is essential to individual autonomy; it provides health

84. *End the Use of Religion to Discriminate*, AM. C.L. UNION, https://perma.cc/X69A-WEKS.

85. *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.

86. Brittni Frederiksen, Usha Ranji, Michelle Long, Karen Diep, & Alina Salganicoff, *Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage*, KFF (Nov. 3, 2022), https://perma.cc/5QKF-5YN3 (finding that 90% of women ages 18 to 64 have used contraception at some point in their reproductive years.).

87. Megan Brenan, *Americans Say Birth Control, Divorce Most 'Morally Acceptable'*, GALLUP (June 9, 2022), https://perma.cc/Z8PX-BE46 (showing 5% of U.S. adults think use of birth control is morally wrong and 3% think it depends on the situation).

88. 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.

89. *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).

90. 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.*

91. *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.").

92. *Moral Case for Contraception*, BBC, https://perma.cc/HW74-Y8GX [hereinafter *Moral Case for Contraception*].

and familial benefits and reduces the number of possible abortions;[93] 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.[94] 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,[95] and therefore methods of contraception that prevent fertilization (or, at most, implantation) do not induce abortions.[96]

The diametrically opposing views on when life begins and whether contraception is equivalent to abortion[97] 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.[98] 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.[99] 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.[100]

The Court clarified the undue burden standard in *Whole Woman'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 thirty miles away.[101] Ultimately, since the requirements resulted in many clinic closures—which meant "fewer doctors, longer wait times, and increased crowding" as well as increased driving distances[102]—yet provided "few, if any, health

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

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

95. Letter from Nat'l Women's Law Ctr. et al. to Michael O. Leavitt, Sec'y, Dep't of Health & Hum. Servs. (July 22, 2008), https://perma.cc/98NW-X3LD.

96. *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).

97. *See* Crockett, Harrison, DeCook, & Hersh, *supra* note 91; *Moral Case for Contraception*, *supra* note 92.

98. *See* Gwendolyn Prothro, *RU 486 Examined: Impact of a New Technology on an Old Controversy*, 30 MICH. J.L. REFORM 715, 719 (1997).

99. *Id.* at 723.

100. 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).

101. *See* Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 608–23 (2016), *abrogated by* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

102. *Id.* at 613.

benefits for women," the new restrictions presented substantial obstacles that unduly burdened an individual's constitutional right to seek an abortion.[103]

Determining the appropriate legal standard for contraception is more complex due to "the 'grey' period between fertilization and implantation."[104] RU-486,[105] 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."[106] 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 health care 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.[107] The Court stated that a person's decision to terminate a pregnancy involved a fundamental liberty interest that should be free from government intrusion.[108] As in *Griswold* and *Eisenstadt*, the Court in *Roe* held that this liberty interest was rooted in the zone of privacy created and protected by the Bill of Rights.[109]

In response to the *Roe* decision, the federal government and state legislatures began to adopt "refusal clause" or "conscience clause" statutes.[110] 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.[111]

The first statute, the Health Programs Extension Act of 1973,[112] 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.[113] However, in 1974, the statute was amended such that no

103. *Id.* at 624.
104. Prothro, *supra* note 98, at 718.
105. Discussed *supra* Part II, Section A.
106. Prothro, *supra* note 98, at 733.
107. Roe v. Wade, 410 U.S. 113, 152–53 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).
108. *Id.*
109. *Id.*; *see also* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972); Griswold v. Connecticut, 381 U.S. 479, 484–85 (1965).
110. NARAL: *Refusal Laws*, *supra* note 7.
111. *Id.*
112. Health Programs Extension Act of 1973, 42 U.S.C.A. § 300a-7 (West, Westlaw through P.L. 118-119).
113. NARAL: *Refusal Laws*, *supra* note 7, at 1.

individual could be required to perform—or assist in performing—any health care services or research activity funded by HHS.[114] 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.[115]

Refusal clauses remain an issue today because of how broadly they are interpreted.[116] 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.[117]

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.[118] 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.[119] More than half of the states have also mandated "contraceptive equity" to eliminate gender discrimination;[120] however, many have exemptions for employers and insurers who

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114. *Id.*

115. *Id.*

116. *Id.*

117. 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).

118. *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).

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

120. 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

object to covering contraception for religious reasons.[121] 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.[122]

When challenged, state courts have generally upheld these contraception mandates, even where only a narrow religious exemption was allowed.[123] It is possible that the PPACA's anti-discrimination provisions could restrict state-level conscience protections that extend too far.[124] As of March 2024, 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.[125] Religious refusals take many forms, including religious schools firing female teachers who become pregnant outside of wedlock,[126] graduate students in training to become social workers refusing to counsel gay people,[127] pharmacies turning away women seeking to fill birth control prescriptions,[128] and business owners refusing to provide insurance coverage for contraception for their employees.[129] The litigation battles around religious refusals are unlikely to disappear in the next several years, particularly in the area of insurance coverage for contraception.[130]

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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 (2013). Eight states do not permit refusal by any employer or insurer: CO, GA, IA, MT, NH, VT, WA, WI. *Id.*

121. *See, e.g.*, MO. ANN. STAT. § 376.1199 (West, Westlaw through 2023 First Reg. Sess. of the 102d Gen. Assemb.); *see also Insurance Coverage of Contraceptives*, *supra* note 120.

122. CAL. HEALTH & SAFETY CODE § 1367.25 (West, Westlaw through Ch. 1 of 2023-24 1st Extraordinary Sess., and urgency legislation through Ch. 888 of 2023 Reg. Sess.), *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).

123. *See, e.g.*, Catholic Charities of Sacramento v. Superior Ct., 85 P.3d 67, 79 (Cal. 2004) (providing 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) (providing 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).

124. 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. 2470, 2476 (2015).

125. *See Past Anti-LGBT Religious Exemption Legislation Across The Country*, AM. C.L. UNION, https://perma.cc/G9K5-TRC6; *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 (discussing the potential impact of state religious freedom provisions).

126. *End the Use of Religion to Discriminate*, *supra* note 84.

127. *Id.*

128. *Id.*

129. *Id.*

130. 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

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*),[131] the PPACA's rules on women's preventive health services became active.[132] As of January 1, 2013,[133] 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).[134]

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.[135] These fully exempt religious employers include churches and other houses of worship, as defined by Sections 6033(a)(3)(A)(i) and (iii)[136] of the Internal Revenue Code.[137]

Prior to 2018, two other types of employers could also qualify for an accommodation from the law: non-profit religious organizations[138] and, after the Supreme Court's 2014 ruling in *Burwell v. Hobby Lobby Stores, Inc.*,[139] "closely-held" for-profit organizations.[140] 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.[141] Hobby Lobby, a family-owned

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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).

131. 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).

132. 42 U.S.C.A. 300gg-13(a)(4) (West, Westlaw through P.L. 118-49) ("[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).

133. *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.

134. *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., https://perma.cc/4PJD-9NZJ [hereinafter *CMS Fact Sheet*].

135. 45 C.F.R. § 147.132 (2019).

136. 26 U.S.C.A. §§ 6033(a)(3)(A)(i) (West, Westlaw through P.L. 118-49) ("churches, their integrated auxiliaries, and conventions or associations of churches"), 6033(a)(3)(A)(iii) (West, Westlaw through P.L. 118-49) ("the exclusively religious activities of any religious order").

137. 45 C.F.R. § 147.132 (2019); *see also* CMS *Fact Sheet*, *supra* note 134.

138. 26 U.S.C.A. § 6033(a)(3)(C)(iii) (West, Westlaw through Pub. L. No. 118-49).

139. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 690–91 (2014).

140. *Id.* at 682–83.

141. *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. 118-49).

corporation, objected on religious grounds to two forms of the morning-after pill and two forms of IUDs.[142] 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.[143] 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.[144]

In 2018, the Trump administration created even broader exemptions for religious beliefs and moral objections that applied to more entity types.[145] 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.[146] 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.[147] The moral conviction exemption does not apply to publicly traded entities; however, the religious beliefs exemption does.[148]

The reach of this freedom to refuse contraception coverage 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 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.[149] 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.[150] 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

142. *Hobby Lobby*, 573 U.S. at 700–01.

143. Warren Richey, *Hobby Lobby 101: Explaining the Supreme Court's Birth Control Ruling*, CHRISTIAN SCI. MONITOR (July 10, 2014), https://perma.cc/73XK-A483.

144. *Hobby Lobby*, 573 U.S. at 731.

145. Amy Goldstein, *Trump Administration Issues Rules Letting Some Employers Deny Contraceptive Coverage*, WASH. POST (Nov. 7, 2018), https://perma.cc/QMF4-J8KY.

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

147. *Id.*

148. *Id.*

149. *See Autocam Not Required to Offer Birth Control Despite Law*, THE DETROIT NEWS (Jan. 7, 2015), https://perma.cc/HW35-TG7F.

150. *CMS Fact Sheet*, *supra* note 134.

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 thus their rights, under the Religious Freedom Restoration Act.[151] Religious nonprofit organizations are required to file this form or write to HHS to trigger their accommodation, which also activates payments for contraception coverage through the health insurer directly.[152] Little Sisters believed that taking either action would make them indirectly responsible for providing contraception services to their employees, which they considered to be against the Catholic faith.[153]

After the trial court denied Little Sisters' motion for a preliminary injunction,[154] on appeal, the Tenth Circuit rejected Little Sisters' emergency application for an injunction.[155] Little Sisters then filed an emergency application with the U.S. Supreme Court, which the Court granted.[156] The Supreme Court held that Little Sisters are not 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.[157]

Later, the Tenth Circuit held that this accommodation does not impose a substantial burden on plaintiffs' religious exercise nor violate plaintiffs' First Amendment rights,[158] 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 ACA.[159] *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*.[160]

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.[161] The Court instructed the appellate courts to

151. Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151, 1163 (10th Cir. 2015).
152. *Id.* at 1181.
153. *Id.* at 1168.
154. Little Sisters of the Poor Home for the Aged v. Sebelius, 6 F. Supp. 3d 1225, 1246 (D. Colo. 2013).
155. 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. 13-A691), 2013 WL 6984066.
156. *See* Little Sisters of the Poor Home for the Aged v. Sebelius, 571 U.S. 1171 (2014).
157. *Id.*
158. *Little Sisters of the Poor*, 794 F.3d at 1205.
159. Zubik v. Burwell, 577 U.S. 971 (2015).
160. Zubik v. Burwell, 578 U.S. 403 (2016).
161. *Id.* at 408.

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 receive contraceptive coverage.[162] 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.[163] 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 require the insurer to provide it by default instead.[164]

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 (FDA) approved Plan B as an over-the-counter drug for buyers eighteen years of age or older, but required that the drug only be administered to those seventeen years old or younger via prescription.[165] In July 2009, the FDA approved Plan B One-Step—a single-dose version of Plan B consisting of only one levonorgestrel tablet[166]—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.[167] 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.[168] 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

162. *Id.*
163. *Id.* at 407.
164. *Id.* at 407–08.
165. *Plan B One-Step (1.5 mg levonorgestrel) Information*, U.S. FOOD & DRUG ADMIN. (Dec. 23, 2022), https://perma.cc/VQW7-AWGP.
166. *Id.* at 1.
167. *Id.*
168. *See* Tummino v. Hamburg, 936 F. Supp. 2d 162, 197 (E.D.N.Y. 2013).

and older.[169] However, in June 2013, the FDA made Plan B One-Step available over the counter without any age restrictions.[170] 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.[171] Ella, approved by the FDA in 2010, remains available by prescription only.[172]

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.[173] 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.[174] 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 forms of birth control.[175] Opponents were also concerned that the decision would encourage minors to rely on Plan B as "Plan A": a primary method of birth control.[176]

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.[177] Developments also continue at the state level: in May 2016, for instance, the Maryland legislature passed the Contraceptive Equity Act.[178] Under this Act, Maryland requires insurance companies to cover over-the-counter emergency contraceptives at no cost and prohibits copayments for any type of contraceptive, putting the state at the forefront of contraception access expansion.[179]

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

170. Press Release, FDA approves Plan B One-Step emergency contraceptive for use without a prescription for all women of child-bearing potential (June 20, 2013), U.S. FOOD & DRUG ADMIN., https://perma.cc/GQL7-ZVP5.

171. *Id.*

172. *Ella Prescribing Information*, *supra* note 25.

173. *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.

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

175. *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).

176. *Id.*

177. *See Insurance Coverage of Contraceptives*, *supra* note 120.

178. Contraceptive Equity Act, Ch. 437, MD. CODE ANN., INS. § 15-826 (West, Westlaw through legislation effectice through May 9 of the 2024 Reg. Sess. of the Gen. Assemb.).

179. *Id.*

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,[180] 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.[181] 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.[182] As a result, these groups developed the Client Confidentiality Card (the "C-Card") to enable women to request EC in a private, discreet manner.[183]

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 and covered by insurance.[184] 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.[185] The legislation would have waived the FDA filing fee and made such applications a top priority for the FDA.[186] This bill met opposition from reproductive health organizations, however, because it would not have guaranteed insurance coverage of non-prescription birth control.[187] 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.[188]

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180. 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.

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

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

183. 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.

184. 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).

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

186. *Id.* at 1–2.

187. *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).

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

In June 2019, House Democrats first introduced the Affordability is Access Act.[189] 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.[190] The bill was also introduced in the Senate in May 2022, but it has not made progress beyond introduction and referral to committees in either chamber.[191]

Some states have already made efforts to make birth control accessible over the counter.[192] In 2013, California passed a bill authorizing pharmacists to furnish self-administered hormonal contraceptives without a prescription.[193] Oregon followed suit in 2015, allowing pharmacists to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives.[194] 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 follow when furnishing self-administered hormonal contraception.[195] The patient is required to complete a self-screening survey, which is then reviewed, and the pharmacist evaluates the patient's seated blood pressure.[196] The patient has the choice of the form of contraceptive: oral, transdermal, vaginal, or the Depo-Provera shot.[197] 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 infections.[198]

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.[199] 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,

189. H.R. 3296, 116th Cong. (2019).
190. *Id*.
191. *Id*., S. 4347, 117th Cong. (2022).
192. *State Reproductive Health Access Policies*, POWER TO DECIDE, https://perma.cc/Q3YW-P86A.
193. S.B. 493 (Cal. 2013).
194. H.R. 2879 (Or. 2015).
195. 16 CAL. CODE. REGS. § 1746.1 (2016).
196. *Id*. at 2.
197. *Id*. at 1.
198. *Id*. at 2.
199. *See infra* Part III, Section B(2).

Georgia, Idaho, Mississippi, and South Dakota have passed broad conscience clauses that may allow pharmacists to refuse to dispense EC.[200] 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,"[201] which includes a fertilized egg not yet implanted in the uterus.[202]

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.[203] The rule, however, allowed a pharmacy to accommodate a pharmacist's religious objections by having another pharmacist available in the store.[204] 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.[205] 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.[206] However, in July 2015, the Ninth Circuit overturned this decision, holding that the 2007 rule does not violate the religious liberty of businesses.[207] Since the law was generally applicable, the court reasoned that the state need only prove it had a rational interest in implementing the rule.[208] 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."[209]

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.[210]

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200. ARIZ. REV. STAT. ANN. § 36-2154(B) (West, Westlaw through legis. of the 2024 2d Reg. Sess.); ARK. CODE ANN. § 20-16-304(5) (West, Westlaw through acts effective May 3, 2024, of the 2024 Fiscal Sess. of the 94th Arkansas Gen. Assemb.); GA. COMP. R. & REGS. 480-5-.03(n) (West, Westlaw through 2024); IDAHO CODE ANN. § 18-611(2) (West, Westlaw through the 2d. Reg. Sess. of the Sixty-Seventh Idaho Legis.); MISS. CODE ANN. § 41-107-5(1) (West, Westlaw through 2024 Reg. Sess.); S.D. CODIFIED LAWS § 36-11-70 (West, Westlaw through 2024 Reg. Sess. & Sup. Ct. R. 24-04).

201. S.D. CODIFIED LAWS § 36-11-70.

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

203. *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).

204. *Id*. at 966–67.

205. *Id*. at 967.

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

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

208. *See id*. at 1084.

209. *Id*.

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

The amendment included a provision stating that states could exclude or restrict coverage of certain outpatient drugs, including non-prescription drugs.[211] When the FDA approved Plan B in July 1999, it was considered a prescription drug,[212] 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.[213] States vary greatly in their Medicaid policies for over-the-counter Plan B coverage.[214] Six states, for example, cover over-the-counter EC, while other states provide partial or no coverage of over-the-counter EC.[215] Those enrolled in Medicaid programs are particularly burdened by cost, especially in states that provide no coverage of over-the-counter EC;[216] 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.[217] 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 health care law will extend contraception insurance coverage to EC.

In 2016, Maryland implemented its own form of comprehensive contraception coverage,[218] and New York has since followed suit. The New York State Assembly passed a bill entitled the Comprehensive Contraception Coverage Act

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211. *Id.*

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

213. *See Emergency Contraception: Barriers to Access*, NAT'L WOMEN'S L. CTR. (Apr. 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).

214. *See id.*

215. 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. 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 Covered OTC Contraceptive List*, WASH. STATE HEALTH CARE AUTH., https://perma.cc/AH2B-3ZE3; *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.

216. *NWLC Barriers*, *supra* note 213.

217. *Contraceptive Coverage in the Health Care Law: Frequently Asked Questions*, NAT'L WOMEN'S L. CTR. (Aug. 2016), https://perma.cc/X8NW-22FC [hereinafter *NWLC Contraceptive Coverage FAQ*].

218. *See supra* notes 178–179 and accompanying text.

that requires insurance companies to pay for nearly twenty different forms of FDA-approved contraception.[219] The legislation, which was signed into law on April 12, 2019,[220] 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."[221] Ultimately the bill is intended to create more guidance on the contraceptive equity that the ACA seeks to accomplish.[222]

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.[223] 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 or emergency contraception.[224] 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.[225] 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.[226] The doctor must also obtain a signed patient agreement before distributing the medicine.[227] Beyond these federal requirements, each state may dictate its own requirements for doctors dispensing RU-486.[228] Despite the FDA's approval, the legal

219. 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).

220. S.A. 659, 242d Leg., 2019–2020 Reg. Sess. (N.Y. 2019), https://perma.cc/93S6-KN44.

221. *Id.*

222. *Id.*

223. *Id.*

224. *Legislative Memo: Comprehensive Contraception Coverage Act*, AM. C.L. UNION OF N.Y., https://perma.cc/U58Q-2DWU.

225. 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.

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

227. *Id.*

228. *See, e.g.*, ARK. CODE ANN. § 20-16-1504 (Westlaw, West through the 2023 Reg. Sess. and the 2023 First Extraordinary Sess. of the 94th Arkansas Gen. Assemb.) (requiring physicians to sign contracts with other physicians who agree to handle complications); OKLA. STAT. tit. 63, § 1-729a (Westlaw, West current with legislation of the First Reg. Sess. of the 59th Leg. (2023) and the First Extraordinary Sess. of the 59th Leg. (2023)) (requiring physicians to report to the drug manufacturer any serious event or adverse reaction experienced by the patient within one year after use).

guidelines for regulation of RU-486 in the U.S. remain unresolved, and have been hotly contested following the overturn of *Roe v. Wade*.[229]

RU-486 poses particularly difficult regulatory questions because it has the potential to function as a contraceptive, an EC, or an abortifacient.[230] 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."[231] 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.

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.[232] These groups are often impeded by their lower economic status and their lack of protection under U.S. law.[233] 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*,[234] 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 con

229. 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); *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.

230. Kremser, *supra* note 33, at 446–47.

231. *Id*. at 455.

232. *NWLC Barriers*, *supra* note 213.

233. In 2010, 19.9% of immigrants in the U.S. lived in poverty. Steven A. Camarota, *Immigrants in the U.S.: A Profile of America's Foreign-Born Population*, CTR. FOR IMMIGR. STUDIES, https://perma.cc/CJP2-DRBT. 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. 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.

234. Carey v. Population Servicesm, 431 U.S. 678, 685 (1977) (holding minors have a constitutional right to privacy that encompasses decisions about their own use of contraception).

traceptive services,[235] twenty-three states and D.C. explicitly allow all minors to consent, even without parental involvement.[236] 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,[237] the minor is married,[238] the minor is a parent,[239] or the minor has previously been pregnant.[240]

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.[241] 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.[242]

Parental involvement for minors' 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

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235. These states are North Dakota, Ohio, Rhode Island, and Wisconsin. *Minors' Access to Contraceptive Services*, GUTTMACHER INST., https://perma.cc/9QQF-2VZ9 [hereinafter *Guttmacher Minors' Access*].

236. These states are 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 current with ch. 1 of 2023-24 First Extraordinary Sess., and all laws through Ch. 890 of 2023 Reg. Sess.).

237. *Guttmacher Minors' Access*, *supra* note 235. For an example of a state code allowing a minor whose health is in jeopardy to obtain contraception, *see* FLA. STAT. ANN. § 381.0051 (West, Westlaw current with laws, joint and concurrent resolutions and memorials in effect from the 2023 Spec. B and C Sess. and the 2023 First Reg. Sess.).

238. Nineteen states allow married minors to consent. *Guttmacher Minors' Access*, *supra* note 235. For an example of a state code allowing married minors to obtain contraception, *see* ME. REV. STAT. ANN. tit. 22, § 1503 (West, Westlaw current with legis. through ch. 486, Const. Resol. 4, and Initiated Bill 3 of the 131st Legis.).

239. Five states allow minors who are parents to consent. *Guttmacher Minors' Access*, *supra* note 235. 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 2023 Reg. Sess. effective through July 1, 2023).

240. Five states allow minors who were previously pregnant to consent. *Guttmacher Minors' Access*, *supra* note 235. 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 clergy member 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 current through the end of the 2023 First Spec., Reg., and Second Spec. Sess.) (allowing minors fourteen or older to consent to use of contraception).

241. *Parental Involvement in Minors' Abortions*, GUTTMACHER INST., https://perma.cc/8562-WVPD.

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

parent, questioning whether minors can fully understand the reproductive choices they are making.[243] 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.[244] 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."[245] For example, parental notification can have a "significant deterrent effect on a minor's use of Title X clinics."[246] Requiring parental involvement can add another strenuous obstacle to overcome in situations in which minors are already dealing with stringent restrictions.[247] Furthermore, the U.S. has the highest teenage pregnancy rate of the world's most developed countries.[248] 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.[249]

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.[250] 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.[251] Therefore, parental consent requirements create a higher barrier for low-income minors, who are more likely to seek contraception from publicly funded clinics.[252]

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.[253] New York has attempted to mitigate these transportation issues by

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243. 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).

244. *Id*. at 217–218.

245. *An Overview of Consent to Reproductive Health Services by Young People*, GUTTMACHER INST. (Aug. 30, 2023), https://perma.cc/6QVR-DSHW.

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

247. 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 243, at 219.

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

249. *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.

250. Brandt, *supra* note 243, 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)).

251. Brandt, *supra* note 243, at 219.

252. Bornstein, *supra* note 246, at 42.

253. Brandt, *supra* note 243, at 219.

establishing School-Based Health Centers (SBHCs).[254] There are currently over 387 SBHCs across the five boroughs of New York City located primarily where there is limited access to health care.[255] 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.[256]

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.[257] More than 20% of public health care providers report that most of their clients seeking contraception have difficulty paying for their visit.[258] For insured and uninsured low-income individuals, the cost of accessing contraception can include the cost of transportation to and from pharmacies and clinics.[259] Additionally, these people also face difficulties due to their potentially inflexible work schedules or inability to secure necessary childcare.[260] This reality is even worse for African American, Latina, American Indian, and Alaskan Native people who can become pregnant.[261]

Additionally, the cost of the contraception itself can be prohibitive. In 2020, birth control pills cost up to about $50 a month.[262] 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.[263] The ACA had no apparent effect on the cost of birth control pills for uninsured individuals.[264] Data indicates that the cost of birth control is often higher in low-income areas,[265] and surveys indicate that people who are struggling financially

254. *School Based Health Centers*, N.Y.C. DEP'T OF EDUC., https://perma.cc/QS28-GMTU.

255. *See id.*

256. *See id.*

257. *See Issues: Birth Control*, NARAL PRO-CHOICE AM., https://perma.cc/FP96-EZ8J.

258. 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.

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

260. *Fact Sheet: Understanding Contraceptive Deserts*, POWER TO DECIDE, https://perma.cc/ST4Y-3PBD.

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

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

263. *Id.*

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

265. 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.

are likely to use birth control inconsistently—or stop using it altogether—in order to save money.[266]

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.[267] Before the ACA was passed, most states did not extend Medicaid coverage to low-income people unless they were pregnant;[268] the ACA expanded eligibility to all adults with incomes at or below 138% federal poverty level (FPL).[269] The Supreme Court's 2012 ruling in *NFIB* made this expansion a state option.[270] However, as of March 2023, thirty-six states have set their income eligibility levels to at least 138% FPL.[271] Fifteen states continue to deny Medicaid coverage to childless, low-income adults altogether.[272] 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."[273]

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.[274] 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."[275] 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.[276]

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266. *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/JR22-CNY7.

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

268. *See* Sherry A. Glied & Mark A. Weiss, *Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility*, THE COMMONWEALTH FUND (Sept. 11, 2023), https://perma.cc/9KV7-QWXA.

269. 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*, KFF (Mar. 26, 2020), https://perma.cc/5RTJ-E2ZW.

270. *A Guide to the Supreme Court's Affordable Care Act Decision*, KFF (July 2012), https://perma.cc/W32M-N73H.

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

272. *Id.*

273. *NWLC Contraceptive Coverage FAQ*, *supra* note 217.

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

275. *Private and Public Coverage of Contraceptive Services and Supplies in the United States*, KFF (July 10, 2015), https://perma.cc/T9HR-MJT5.

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

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.[277] Customers must present identification to purchase EC, which may create a barrier for immigrants who lack government-issued identification.[278] 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 contraception to unaccompanied, immigrant minors placed in their care while they await their immigration detention hearings.[279]

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.[280] 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.[281] Mergers between religious and secular hospitals are increasing, and the resulting system may adopt religious restrictions that further hinder access to contraception.[282] This can be problematic for survivors, who often need to obtain the medication immediately.[283] Moreover, some pharmacists still refuse to dispense EC based on their personal beliefs,[284] and survivors may be confronted with criticism or harassment at the pharmacy counter.

IV. CONCLUSION

In the post-ACA world, access to contraception has been greatly improved. In the fourteenth year since the legislation was passed, insured people who can become pregnant are now, more than ever, eligible to obtain contraception with

277. Only 24% were successful in accessing EC. 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: Differences by Language and Region*, 41 PERSPS. SEXUAL & REPROD. HEALTH 110, 113 (2009).

278. 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.

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

280. *See* Singh, *supra* note 278.

281. NARAL: *Refusal Laws*, *supra* note 7; *see also Catholic Health Care in the United States,* CATHOLIC HEALTH ASS'N, https://perma.cc/K9CP-VK5P (emphasizing the prevalence of Catholic hospitals in the U.S.).

282. 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. *See Religious Hospitals, Mergers & Refusal Clauses*, LAW STUDENTS FOR REPROD. JUST. 1, 2 (2012), https://perma.cc/X5RB-AQSY.

283. *Id.* at 1.

284. *Id.* at 3–4.

no out-of-pocket costs. Even those employed by religiously affiliated entities are eligible for the same benefits. Additionally, now that forty-one states and 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.[285] Access to EC has similarly improved and 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 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 health care 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.

285. *See Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Feb. 7, 2024), https://perma.cc/YJB4-5MQ7.