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Insuring Contraceptive Equity

Jennifer Hickey*

ABSTRACT

The United States is in the midst of a family planning crisis. Approximately half of all pregnancies nationwide are unintended. In recognition of the social importance of family planning, the Affordable Care Act (ACA) includes a “contraceptive mandate” that requires insurers to cover contraception at no cost. Yet, a decade after its enactment, the ACA’s promise of universal contraceptive access for insured women remains unfulfilled, with as many as one-third of U.S. women unable to access their preferred contraceptive without cost.

While much attention has been focused on religious exemptions granted to employers, the primary barrier to no-cost contraception is the profit motivation of private insurance companies. This Article fills a crucial gap by providing an in-depth examination of the insurance practices that burden contraceptive access for the vast majority of reproductive-aged women on both public and private insurance. Private insurers are afforded substantial discretion in the products they choose to cover and the costs they set, and this causes significant disparities in the availability and affordability of various contraceptive methods. Arguments for equitable and enhanced contraceptive access are traditionally grounded in claims of constitutional rights to reproductive freedom. Unfortunately, this rhetoric of individual rights, rooted in privacy jurisprudence, focuses only on restraining the state from interfering with a woman’s reproductive decisions. This absolves the state of responsibility for family planning and allows women to shoulder the burden of unintended pregnancy as a matter of individual choice and responsibility.

This Article instead applies vulnerability theory to establish state responsibility for just and fair distribution of contraception. A vulnerability approach imposes positive obligations on the state to provide contraception as a form of resilience, rather than allowing the state to abdicate responsibility to the private insurance market and individual women under a limited “consumer protection” role. This approach requires the state to monitor and regulate the discretion afforded to insurance companies in making public decisions regarding coverage of various contraceptive methods. This includes examining inequitable insurance practices and policies and assessing power imbalances between insurers, providers, and pharmaceutical companies and patients. In this manner, the United States can move beyond its narrow consumer-oriented approach to contraception and recognize that contraception is vital to fulfillment of important social obligations, not an individual choice made by empowered consumers.

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Keywords: contraception, insurance, vulnerability theory, reproductive rights, Affordable Care Act, family planning, public health, state responsibility, equity, COVID-19

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INTRODUCTION

The United States is in the midst of a family planning crisis. For decades, approximately half of all pregnancies in the nation have been unintended, despite almost universal willingness among women to use contraception.¹ Meaningful access to contraception is critical to improving public health and reducing poverty.² In recognition of the social importance of family planning, the Affordable Care Act (ACA) includes a “contraceptive mandate” that requires insurers to cover contraception at no cost.³ A decade

¹ 99% of sexually active U.S. women between the ages of 19 and 44 have used contraception at some point in their lives. Kimberly Daniels, William D. Mosher & Jo Jones, *Contraceptive Methods Women Have Ever Used: United States, 1982-2010*, 62 NAT'L HEALTH STAT. REP. 1, 1 (2013), <http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf>.

² See *infra* Part I.A.

³ 42 U.S.C. § 300gg-13(a)(4) (2018).

after enactment, its promise of universal contraceptive access for insured women remains unfulfilled. As many as one-third of U.S. women⁴ are not able to access their preferred contraceptive without cost.⁵ Because of the powerful relationship between contraceptive preference and efficacy,⁶ public responsibility for family planning cannot be fulfilled without granting access to a wide range of contraceptive options. Yet there are significant disparities in the availability and affordability of various methods.

Much scholarly and political attention focuses on religious exemptions granted to those employers who object to covering contraception. However, the primary reason U.S. women cannot access no-cost contraception is, quite simply, the profit motivation of private insurance companies. This Article fills a crucial gap by providing an in-depth examination of the insurance practices that burden contraceptive access for the vast majority of reproductive-aged women on both public and private insurance.⁷ Public responsibility for contraception did not have to be delegated to private for-profit corporations. Through decades of legislation, the state⁸ essentially created the for-profit health insurance industry and cemented the now-dominant model of managed care, which pits cost considerations against health considerations in a battle that often favors insurers. As a result, private insurers impose a number of restrictions on contraceptive access that undermine public health goals. Women and their families are abandoned to the marketplace, where they face the almost impossible tasks of choosing a health plan that provides optimal contraceptive coverage, fighting a lonely battle against improper insurance claim denials, and shouldering the extreme consequences of unintended pregnancy when their ill-fated efforts to procure contraception ultimately fail.

Adoption of the contraceptive mandate was an important and necessary step in realizing state responsibility for contraception. Unfortunately, the state has attempted to fulfill its obligation by emphasizing individual marketplace choice and minimally regulating insurers under the guise of individual consumer protection. This consumer protection focus absolves the state of responsibility for family planning, placing the burden of access and enforcement on individual women and their families while targeting only the most flagrantly abusive behaviors of insurance companies. Traditional arguments for equitable and enhanced contraceptive access, grounded in claims of individual rights and choice and rooted in privacy jurisprudence, serve to reinforce this approach by focusing only on restraining the state from interfering with a woman's reproductive decisions.

This Article instead applies vulnerability theory to firmly establish state responsibility for just and fair distribution of contraception. Vulnerability theory

⁴ "Women" is used throughout this article as a proxy term for all individuals who may become pregnant. The arguments in this article apply with equal force to persons of all gender identities.

⁵ See *infra* Part I.C.

⁶ *Id.*

⁷ Approximately one in ten women in the U.S. remain uninsured and thus unable to access contraception through insurance. While this is a significant inequity, it will not be the focus of this Article. See *Women's Health Insurance Coverage*, KAISER FAM. FOUND. (KFF) (Nov. 8, 2021) [hereinafter KFF, *Women's Health Insurance Coverage*], <https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/>.

⁸ This Article uses the term "the state" as used conceptually in political theory. While there is no single definition of "the state," it is used here to generally refer to a politically organized community living under a single system of government. The term is not intended to represent a particular state of the union or governance structure, though the federal government more closely aligns with a conception of the state under vulnerability theory.

recognizes that we are universally vulnerable by nature of our embodiment and envisions a state that responds to its citizens' vulnerability by providing the resources needed for resilience.⁹ A vulnerability approach thus imposes positive obligations on the state to provide contraception as a form of resilience, rather than allowing the state to abdicate responsibility to individual women under a limited “consumer protection” role. The state cannot simply delegate responsibility for implementation of the law to the private insurance market without additional oversight. The state is obligated to closely monitor and regulate the discretion afforded to insurance companies in making public decisions regarding coverage of various contraceptive methods. Further, the state is obligated to act where insurance companies are in clear violation of existing law. The delegation of public contraceptive policy to private insurance companies also implicates concerns of democratic accountability and transparency that must be addressed by the state. However, it is not enough to simply increase enforcement or enact stricter regulation. Insurers' institutional vulnerabilities must be addressed if we continue to make them responsible for meeting public goals.

This Article proceeds in four parts. Part I provides an overview of the social importance of contraception and the current state of contraceptive access in the U.S. Part II explores the history of managed care and its impact on contraceptive access. Part III discusses the numerous burdens the state has imposed on individual women by abdicating its family planning obligations to the marketplace. Part IV then concludes by applying vulnerability theory to establish a better approach to state responsibility that obligates the state to address profit-motivated barriers to contraceptive access.

I. THE STATE OF CONTRACEPTIVE ACCESS

There is significant social need for greater access to contraception in the U.S., particularly amid a global pandemic. For decades, the state has recognized the social importance of family planning. Yet, a decade after enactment of the ACA's contraceptive mandate, its promise remains unfulfilled.

A. *The Social Importance of Contraception*

Despite both sides of the political aisle framing contraception as a private issue,¹⁰

⁹ See generally Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008) [hereinafter Fineman, *The Vulnerable Subject*].

¹⁰ Some Republicans oppose public funding of contraception because they consider procreation and contraception private matters. See, e.g., *Haley claims women 'don't care about contraception'*, The Rachel Maddow Show (Apr. 4, 2012, 9:32 AM EDT), <https://www.msnbc.com/rachel-maddow-show/haley-claims-women-dont-care-about-con-msna32359> (quoting Republican governor Nikki Haley regarding contraception: “All we're saying is we don't want government to mandate when we have to have it or when we don't.”); Ricardo Alonso-Zaldivar, *Trump health pick Seema Verma says maternity coverage should be optional*, CHI. TRIB. (Feb. 16, 2017), <https://www.chicagotribune.com/lifestyles/health/ct-trump-health-pick-says-maternity-coverage-should-be-optional-20170216-story.html> (discussing Trump appointee's testimony to Senate Finance Committee that women, not government, should choose maternity coverage). Democrats often argue for full support of individual reproductive choice and respect for private decisions made between women and their healthcare providers. See, e.g., FORA.tv, *Rep. Tammy Duckworth Slams GOP: 'Stay Out of My Uterus.'* YOUTUBE (Jul. 29, 2013), <https://www.youtube.com/watch?v=OWp588lk-v0>; Tom Joyce, *Democrats Should Take Note on Andrew Yang's Abortion Policy*, WASH. EXAM'R (Apr. 12,

there are undoubtedly few things more public. The shockingly high unintended pregnancy rate in the U.S. poses a significant public health crisis. Almost half of all pregnancies in the U.S. are unintended, a figure that has held relatively steady for decades.¹¹ The rate of unintended pregnancy in the U.S. substantially exceeds that of many other developed countries.¹² This is cause for concern, especially when coupled with our extremely high rate of maternal mortality relative to other developed nations.¹³

Unintended pregnancy imposes significant physical, social, and financial costs on women, their families, and our society as a whole. Unintended pregnancy is associated with poor health outcomes for women, including maternal mortality, increased pregnancy complications, perinatal depression, and increased rates of physical abuse.¹⁴ Unintended pregnancy impacts children as well. Short spacing between births increases the risk of premature birth and low birth weight.¹⁵ Unplanned births are associated with delayed and less frequent prenatal care visits, decreased likelihood of breastfeeding, and shorter duration of breastfeeding.¹⁶ Unintended pregnancy especially harms teens. Teenage mothers drop out of high school at alarming rates, often beginning an inter-generational cycle of teenage pregnancy and poverty.¹⁷ Additionally, unintended pregnancy imposes a significant financial burden on the public. The Brookings Institute has estimated that the public pays an average of \$11 billion annually for the medical costs and infant expenses associated with unplanned pregnancy.¹⁸

Contraception plays a pivotal role in addressing this family planning crisis. There is little doubt that correct and consistent usage of contraception prevents unintended pregnancy. Indeed, 95% of all unintended pregnancies result from not using contraception or using it inconsistently.¹⁹ A recent study correlated a global decrease in unintended

2021), <https://www.washingtonexaminer.com/opinion/democrats-should-take-notes-on-andrew-yangs-abortion-policy> (reporting former City Council Speaker’s statement that “I have sole authority in all that pertains to my body INCLUDING choosing NOT to have children.”).

¹¹ *Unintended Pregnancy in the United States*, GUTTMACHER INST. 1, 2 (Jan. 2019),

<https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf>.

¹² *Id.*

¹³ The maternal mortality rate (MMR) in the U.S. is higher than most developed countries, with 19 out of every 100,000 mothers dying from pregnancy and childbirth complications. WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 2000 TO 2017: ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE U. N. POPULATION DIV., EXEC. SUMMARY 1, 11 (2019),

<https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?sequence=13&isAllowed=y>.

¹⁴ See Naomi Cahn, *Contraception Matters: Rights, Class and Context Symposium Keynote*, 24 WASH. & LEE J. CIV. RTS. & SOC. JUST. 529, 541, 547–48 (2018) (noting that unintended birth is associated with both perinatal depression and increased rates of domestic violence); Agustin Conde-Agudelo, Anyeli Rosas-Bermúdez & Ana Cecelia Kafury-Goeta, *Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis*, 295 JAMA 1809, 1809 (2006) (finding pregnancy complications and poor neonatal outcomes increase with shorter intervals between pregnancy).

¹⁵ Conde-Agudelo, Rosas-Bermúdez & Kafury-Goeta, *supra* note 14.

¹⁶ Cahn, *supra* note 14, at 541.

¹⁷ *Id.* at 556 (discussing study indicating that teenage girls are twice as likely to finish high school if they do not give birth and children of teenage mothers are more likely to become teenage mothers and face unemployment).

¹⁸ Emily Monea & Adam Thomas, *Unintended Pregnancy and Taxpayer Spending*, 43 PERSP. SEXUAL & REPROD. HEALTH 88, 88 (2011).

¹⁹ Adam Sonfield, Kinsey Hasstedt & Rachel Benson Gold, *Moving Forward: Family Planning in the Era of Health Reform*, GUTTMACHER INST. 4, 9 (2014),

pregnancies with increased access to contraception.²⁰ Additionally, studies have demonstrated that access to contraception significantly reduces child and adult poverty rates.²¹ The ability to better plan pregnancies gives families the resources necessary to invest in career and education, which ultimately benefits society.²² Contraception use also reduces abortion rates. Multiple studies have demonstrated that access to free contraception, particularly long-acting reversible contraception (LARC), significantly lowers the rate of unintended pregnancies and abortions.²³

The COVID-19 pandemic heightens the social importance of contraception. The pandemic and resulting economic recession may increase demand for contraception, as more families seek to delay or avoid pregnancy due to financial constraints.²⁴ In a recent survey, more than one-third of women reported a desire to delay pregnancy or have fewer children because of the pandemic.²⁵ At the same time, the pandemic has created additional barriers to contraceptive access. The United Nations Population Fund has estimated that over 50 million women globally could lose access to contraception during the pandemic, resulting in up to 15 million unintended pregnancies.²⁶ The social consequences of such an increase, particularly at a time when the pandemic imposes an enormous strain on resources and significant threats to maternal health,²⁷ could be devastating. Against this backdrop, there should be little doubt that unintended pregnancy is a public health issue that requires a social solution. Equitable and widespread access to contraception is a key component of that solution.

https://www.guttmacher.org/sites/default/files/report_pdf/family-planning-and-health-reform.pdf.

²⁰ Jonathan Bearak, Anna Popinchalk, Bela Ganatra, Ann-Beth Moller, Özge Tunçalp, Cynthia Beavin & Leontine Alkema, *Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates From a Comprehensive Model for 1990–2019*, 8 THE LANCET GLOB. HEALTH 1152, 1152 (2020).

²¹ Cahn, *supra* note 14, at 537.

²² Mary Tschann & Reni Soon, *Contraceptive Coverage and the Affordable Care Act*, 42 OBSTETRICS & GYNECOLOGY CLINICS N. AM. 605, 606 (2015).

²³ See Cahn, *supra* note 14, at 558–59 (discussing studies in Colorado and St. Louis associating increased access to long acting reversible contraceptives (LARC) with significant reductions in abortion rates, approximately five times lower than national averages in St. Louis and 34% lower in Colorado); Karen Mulligan, *Contraception Use, Abortions, and Births: The Effect of Insurance Mandates*, 52 DEMOGRAPHY 1195, 1195 (2015) (predicting 25,000 fewer abortions annually because of ACA contraceptive mandate).

²⁴ *Issue Brief: Access To Contraceptives During The COVID-19 Pandemic And Recession*, NAT'L WOMEN'S LAW CTR. 1, 2–3 (Jul. 2020), https://nwlc.org/wp-content/uploads/2020/08/NWLCIssueBrief_BCandCOVID-19.pdf [hereinafter NWLC, *COVID Issue Brief*].

²⁵ Laura D. Lindberg, Alicia VandeVusse, Jennifer Mueller & Marielle Kirstein, *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences*, GUTTMACHER INST. 3, 4–5 (Jun. 2020), https://www.guttmacher.org/sites/default/files/report_pdf/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.pdf.

²⁶ U. N. FUND FOR POPULATION ACTIVITIES, IMPACT OF THE COVID-19 PANDEMIC ON FAM. PLANNING AND ENDING GENDER-BASED VIOLENCE, FEMALE GENITAL MUTILATION AND CHILD MARRIAGE 3 (Apr. 27, 2020), https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf.

²⁷ Hospital restrictions and resource constraints resulting from the pandemic have negatively impacted birth experiences and maternal health in several ways. See Jennifer Hickey, *Nature is Smarter Than We Are: Midwifery and the Responsive State*, 40 COLUM. J. GENDER & L. 245, 300–05 (2021).

B. State Recognition

For decades, the state has acknowledged the social importance of contraception and accepted at least a limited responsibility for its provision. Currently, the government facilitates access to contraception through a patchwork of state and federal laws and programs that vary depending on insurance status.

Uninsured women may access contraception through federally funded “Title X” clinics. Title X is a federal grant program established in 1970 to provide affordable contraceptive and sexual wellness care, particularly to those with low incomes, regardless of health insurance status.²⁸ In establishing Title X, Congress recognized explicitly the pivotal role that contraception plays in improving the physical and financial health of families and addressing the harm of unfettered population growth.²⁹ Ideally, Title X clinics would primarily serve women without access to insurance. Unfortunately, uninsured patients now comprise less than half of those utilizing Title X clinics.³⁰ This is due in large part to chronic underfunding,³¹ which forces clinics to prioritize insured patients because they will be reimbursed for care. Ongoing political attacks also threaten the security of the Title X program.³² As a result, those least equipped to handle an unplanned pregnancy face significant barriers to contraceptive access.

The vast majority of U.S. women access contraception through Medicaid and private insurance.³³ Since 1972, no-cost family planning benefits have been a mandatory part of the joint federal-state Medicaid program, though states vary in the types of services and contraceptive methods that they provide.³⁴ Private insurers are subject to the Affordable Care Act’s (ACA) “contraceptive mandate,” which requires them to cover contraception and related counseling and other services at no out-of-pocket cost.³⁵ Federal guidance has clarified that the mandate requires insurers to cover “at least one form of contraception in each of the methods (currently eighteen) that the Food and Drug Administration (FDA) has

²⁸ INST. OF MED., A REVIEW OF THE HHS FAM. PLANNING PROGRAM: MISSION, MGMT., AND MEASUREMENT OF RESULTS 71–72 (Butler A. Sith & Clayton E. Wright eds., 2009).

²⁹ *Id.* at 22–23.

³⁰ Christina Fowler, Julia Gable, Beth Lasater & Kat Asman, *Family Planning Annual Report: 2019 National Summary*, OFF. OF POPULATION AFFAIRS, OFF. OF THE ASSISTANT SECRETARY FOR HEALTH, DEP’T OF HEALTH AND HUMAN SERVICES A-18 (Sept. 2020), <https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf> (reporting 41% of Title X patients were uninsured in 2019).

³¹ INST. OF MED., *supra* note 28, at 10–11.

³² NWLC, *COVID Issue Brief*, *supra* note 24, at 3 (discussing the impact of Trump administration regulations on Title X clinics, including “slashing the Title X program’s capacity by at least 46% nationally, and up to 100% in some states”).

³³ A significant majority (69%) of the 97.3 million U.S. women aged 19-64 are privately insured, 11% are uninsured, and 17% are on Medicaid (public insurance). KFF, *Women’s Health Insurance Coverage*, *supra* note 7.

³⁴ Adam Sonfield, *A Fragmented System: Ensuring Comprehensive Contraceptive Coverage in All U.S. Health Insurance Plans*, 24 GUTTMACHER POL’Y REV. 1, 3 (2021) [hereinafter Sonfield, *Fragmented System*], <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf>.

³⁵ 42 U.S.C. § 300gg-13(a)(4) (2018) (requiring most group and individual health insurance plans to cover women’s preventive services “provided for in comprehensive guidelines supported by the Health Resources and Services Administration” without cost-sharing).

identified for women in its current Birth Control Guide” without cost sharing.³⁶ The mandate applies to all commercial group and individual health insurance plans, excepting those plans that were “grandfathered” in at the time of ACA implementation.³⁷ The mandate also applies to plans offered to state and federal government employees³⁸ and Medicaid recipients who were made eligible by ACA’s expansion of Medicaid to those with incomes at or below 138% of the federal poverty level.³⁹ Additionally, twenty-nine states and the District of Columbia have their own contraceptive mandates for private insurers, many of them implemented long before the ACA.⁴⁰

The ACA recognized the importance of providing no-cost coverage of a wide array of contraceptive methods. Prior to its implementation, numerous studies confirmed that cost was a major barrier to contraceptive access.⁴¹ To address this, the Department of Health and Human Services adopted the recommendation of the Institute of Medicine (IOM) that the ACA cover without cost “the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.”⁴² The IOM recommendations emphasized that even small costs have been shown to prevent use of contraception.⁴³ Thus, “[t]he elimination of cost sharing for contraception therefore could greatly increase its use, including use of the more effective and longer-acting methods, especially among poor and low-income women most at risk for unintended pregnancy.”⁴⁴

³⁶ FAQs About Affordable Care Act Implementation (Part XXVI), DEP’T OF LAB., HEALTH & HUM. SERVS., & TREASURY at 4 (May 11, 2015), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf>; Women’s Preventive Services Guidelines, HEALTH RES. & SERV. ADMIN. (2019), <https://www.hrsa.gov/womens-guidelines-2019>.

³⁷ A grandfathered health plan is one that has been in place since enactment of the ACA in 2010 and not undergone significant change. 45 C.F.R. § 147.140f.

³⁸ State and local government employee plans are subject to the contraceptive mandate. See Public Health Service Act § 2723(b)(1)(B), 42 U.S.C. § 300gg-22(b)(1)(B). The mandate does not apply directly to the Federal Employees Health Benefits program, but the Office of Personnel Management has directed that all plans comply with the ACA. OFF. OF PERSONNEL MGMT., FEHB PROGRAM CARRIER LETTER NO. 2021-02 11; OFF. OF PERSONNEL MGMT., FEHB PROGRAM CARRIER LETTER NO. 2019-01 6.

³⁹ Sonfield, *Fragmented System*, *supra* note 34, at 3.

⁴⁰ *Id.* at 2.

⁴¹ See Jonathan M. Bearak & Rachel K. Jones, *Did Contraceptive Use Patterns Change after the Affordable Care Act? A Descriptive Analysis*, 27 WOMEN’S HEALTH ISSUES 316, 316 (2017) (collecting the “sizeable literature in the United States” that “suggests that making prescription contraceptives available at no cost leads to increases in contraceptive use”); Cahn, *supra* note 14, at 550–51 (discussing 2010 (pre-ACA) survey finding that “more than one-third of female voters had struggled to afford prescription birth control at some point in their lives and, as a result, had used birth control inconsistently. At that point, birth control payments constituted approximately 30-44% total out-of-pocket expenses for health care”); COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OBSTETRICS & GYNECOLOGY, COMM. OP. NO. 615: ACCESS TO CONTRACEPTION, 125 OBSTETRICS GYNECOLOGY, 250, 252 (Jan. 2015) [hereinafter ACOG, *Access to Contraception*] (finding “[h]igh out-of-pocket costs, deductibles, and copayments for contraception also limit contraceptive access even for those with private health insurance”); Jane Broecker, Joan Jurich & Robin Fuchs, *The relationship between long-acting reversible contraception and insurance coverage: a retrospective analysis*, 93 CONTRACEPTION 266, 270 (2016) (finding that cost was a “significant barrier” to LARC placement for privately insured women utilizing an Appalachian private practice prior to implementation of the ACA and might “remain a barrier for privately insured women who are required to pay some or all of the cost of LARC methods”).

⁴² INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN 108–09 (2011).

⁴³ *Id.*

⁴⁴ *Id.*

In many ways, the ACA's contraceptive mandate has been a tremendous success. Studies suggest that the ACA has significantly improved access to affordable contraception for privately insured women. Several studies show a substantial reduction in out-of-pocket costs.⁴⁵ Other studies confirm an increase in contraceptive use attributed to the ACA, in particular the use of more effective long-term methods.⁴⁶ These findings are supported by studies suggesting that state contraceptive mandates increase contraceptive usage as well.⁴⁷ Recent studies suggest that the contraceptive mandate may be responsible for a decline in unintended pregnancies, particularly among low-income women newly eligible for Medicaid.⁴⁸ Additionally, studies have shown that the ACA's extension of "dependent coverage" to those up to age twenty-six has resulted in decreased fertility among young

⁴⁵ See Amy Law, L. Wen, J. Lin, M. Tangirala, J.S. Schwartz & E. Zampaglione, *Are women benefiting from the Affordable Care Act? A real-world evaluation of the impact of the Affordable Care Act on out-of-pocket costs for contraceptives*, 93 *CONTRACEPTION* 392 (2016) (finding that mean total out-of-pocket expenses for FDA-approved contraceptives decreased approximately 70% from 2011 to 2013 among 2.5 million privately insured women and concluding that "[i]mplementation of the ACA has saved women a substantial amount in out-of-pocket expenses for contraceptives"); Nora V. Becker, *The Impact of Insurance Coverage on Utilization of Prescription Contraceptives: Evidence from the Affordable Care Act*, 37 *J. POL'Y ANALYSIS AND MGMT.* 571 (2018) (analyzing claims data of a large national insurer to find a substantial decrease in out-of-pocket costs of prescription contraceptives following implementation of the ACA); Jonathan M. Bearak, Lawrence B. Finer, Jenna Jerman & Megan L. Kavanaugh, *Changes in out-of-pocket costs for hormonal IUDs after implementation of the Affordable Care Act: an analysis of insurance benefit inquiries*, 93 *CONTRACEPTION* 139 (2016) (finding that the percentage of privately insured women required to pay out-of-pocket costs for IUDs dropped from 58% in January 2012 (pre-ACA) to 13% in March 2014); Laurie Sobel, Adara Beamesderfer & Alina Salganicoff, *Private Insurance Coverage of Contraception*, KAISER FAM. FOUND. (Dec. 2016), <https://files.kff.org/attachment/issue-brief-private-insurance-coverage-of-contraception> ("Since the implementation of the ACA's contraceptive coverage provision, fewer women are paying out of pocket for contraceptives. For example, the share of reproductive age women experiencing out-of-pocket spending on oral contraceptive pills declined from 20.9% in 2012 to 3.6% in 2014. This decline accounts for nearly two-thirds (63%) of the drop in out-of-pocket spending on retail drugs during this time period.").

⁴⁶ See Becker, *supra* note 5 (documenting two studies finding increased usage of contraception after implementation of the ACA and similarly finding "increased use of contraception overall among privately insured women in the United States" and "especially large increases in new use of long-term, more effective methods of birth control," estimating a 2.95% increase in total contraception use among this population); *The Affordable Care Act's Birth Control Benefit: Too Important to Lose*, NAT'L WOMEN'S L. CTR. 1 (Jun. 2018) ("Data on prescription drug use in 2013, after the birth control benefit went into effect, indicate a nearly five percent uptick in filled birth control pill prescriptions. Express Scripts, one of the nation's largest pharmacy benefit management companies, attributed this increase to the birth control benefit fulfilling a previously unmet need.").

⁴⁷ See Danielle N. Atkins & W. David Bradford, *Changes in State Prescription Contraceptive Mandates for Insurers*, 46 *PERSP. SEXUAL & REPROD. HEALTH* 23 (2014) (finding that state contraceptive mandates increased overall usage of prescription contraceptives by 5% among privately insured women).

⁴⁸ Vanessa K. Dalton, Michelle H. Moniz, Martha J. Bailey, Lindsay K. Admon, Giselle E. Kolenic, Anca Tilea & A. Mark Fendrick, *Trends in Birth Rates After Elimination of Cost Sharing for Contraception by the Patient Protection and Affordable Care Act*, 3 *JAMA NETWORK OPEN* 11 (2020) (finding decrease in births in all income groups after implementation of the ACA, most significantly among women in the lowest income group, where estimated probability of birth decreased by 22% from 2014 to 2018, suggesting that "contraception insurance coverage without consumer cost sharing may be associated with decreased income-related disparities in unintended pregnancies"); Colleen L. MacCallum-Bridges & Claire E. Margerison, *The Affordable Care Act Contraception Mandate & Unintended Pregnancy in Women of Reproductive Age: An Analysis of the National Survey of Family Growth, 2008–2010 v. 2013–2015*, 101 *CONTRACEPTION* 34 (2020) (finding "a significant 37% decrease in the odds of unintended pregnancy for women with government-sponsored insurance" in the two years following implementation of the ACA).

adults, possibly due to improved access to contraceptives.⁴⁹ Further, a large majority of Americans support the contraceptive mandate or other laws requiring private insurers to fully cover contraception.⁵⁰ In sum, the ACA's contraceptive mandate has undoubtedly improved access to contraception.

C. A Promise Unfulfilled

Despite the tremendous gains of the ACA, significant barriers to contraceptive access remain. It is not enough simply to provide no-cost access to only some forms of contraception. Research shows that women are more likely to use contraception effectively and consistently when they can use their method of choice.⁵¹ Medical experts have repeatedly recognized the importance of access to preferred contraception.⁵² American College of Obstetricians and Gynecologists (ACOG) has stated that “in the absence of contraindications, patient choice should be the principal factor in prescribing one method of contraception over another.”⁵³ In its recommendations regarding the ACA, the IOM noted that access to a wider range of contraceptives was imperative for increasing consistent and correct usage and correspondingly reducing the rate of unintended pregnancy.⁵⁴

Unfortunately, many publicly and privately insured women are still unable to access their preferred contraceptive. Cost still seems to be a significant barrier, despite the ACA's promise of no-cost contraception. Insured women may be forced to pay for contraception because they are enrolled in one of a small percentage (13%) of legacy plans that are exempt from the ACA.⁵⁵ Some may be on a plan that does not offer contraception due to

⁴⁹ Joelle Abramowitz, *Planning Parenthood: The Affordable Care Act Young Adult Provision and Pathways to Fertility*, 31 J. POPULATION ECON. 1097 (2018) (finding association between the ACA young adult provision and both decreased likelihood of birth and abortion and increased likelihood of long-term hormonal contraceptive use); Bradley Heim, Ithai Lurie & Kosali I. Simon, *The Impact of the Affordable Care Act Young Adult Provision on Childbearing, Marriage, and Tax Filing Behavior: Evidence from Tax Data* 16 (Nat'l Bureau of Econ. Rsch. Working Paper No. 23092, 2017), https://www.nber.org/system/files/working_papers/w23092/w23092.pdf (finding reduction in fertility among unmarried young adults after implementation of the ACA, possibly due to increased access to contraception); Jennifer Trudeau & Karen S. Conway, *The Effects of Young Adult-Dependent Coverage and Contraception Mandates on Young Women*, 36 CONTEMP. ECON. POL'Y 73 (2018) (finding decreased fertility among young women associated with ACA's dependent-coverage and contraceptive mandates).

⁵⁰ A 2015 study found that over 77% of women and 64% of men support laws requiring insurers to fully cover the cost of birth control. Laurie Sobel, Alina Salganicoff & Caroline Rosenzweig, *The Future of Contraceptive Coverage*, KFF (Jan. 9, 2017), <http://kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage>. See also *Contraceptives + Policy Through a Gender Lens, Results from a National Survey Conducted by PerryUndem*, PERRYUNDEM RSCH./COMMC'N 1, 17 (Mar. 2017), <https://www.scribd.com/document/342699692/PerryUndem-Gender-and-Birth-Control-Access-Report> (finding that over 77% of women want continuation of the ACA's contraceptive mandate).

⁵¹ Caroline Moreau, Jean Bouyer, Fabien Gilbert, The COCON Group & Nathalie Bajos, *Social, Demographic and Situational Characteristics Associated with Inconsistent Use of Oral Contraceptives: Evidence from France*, 38 PERSP. SEXUAL & REPROD. HEALTH 190 (2006); J. Noone, *Finding the Best Fit: A Grounded Theory of Contraceptive Decision Making in Women*, 39 NURSING F. 13 (2004).

⁵² See, e.g., AMERICAN COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR WOMEN'S HEALTH CARE: A RES. MANUAL 183 (3d ed. 2007); INST. OF MED., *supra* note 42, at 108–09.

⁵³ AMERICAN COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 52, at 183.

⁵⁴ INST. OF MED., *supra* note 42, at 108–09.

⁵⁵ 2019 *Employer Health Benefits Survey*, KFF (Sept. 25, 2019), <https://www.kff.org/report-section/ehbs->

their employer's religious or moral objections. The ACA has long exempted churches and some religious nonprofits from the contraceptive mandate.⁵⁶ Recent Supreme Court decisions and regulations promulgated by the Trump administration have expanded the availability of the religious or moral objection exemption to any employer other than a publicly traded corporation.⁵⁷ The government estimated that these new exemptions would affect between 31,700 and 120,000 women,⁵⁸ less than 1% of the 64.3 million women who currently have private insurance coverage subject to the contraceptive mandate.⁵⁹

Studies suggest that the number of insured women facing cost barriers far exceeds the small number subject to legacy insurance plans or religious exemptions. A recent women's health survey conducted in 2020 by the Kaiser Family Foundation found that one in five women (18%) are not using their preferred method of contraception and 25% of these women cited cost as the reason.⁶⁰ Numerous studies confirm that a large percentage of insured women, as many as one-third, are still paying out-of-pocket for contraception after enactment of the ACA⁶¹ and these costs preclude them from accessing their preferred method.⁶² For example, one study found that, of the 33% of insured women paying some

2019-section-1-cost-of-health-insurance/.

⁵⁶ See Laurie Sobel, Alina Salganicoff & Caroline Rosenzweig, *New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women*, KFF (Nov. 2018), <https://files.kff.org/attachment/Issue-Brief-New-Regulations-Broadening-Employer-Exemptions-to-Contraceptive-Coverage-Impact-on-Women> (discussing regulations issued by the Trump administration in 2018 and the Supreme Court cases brought by religious employers challenging the contraceptive mandate, *Zubik v. Burwell* and *Burwell v. Hobby Lobby*).

⁵⁷ *Id.* at 1.

⁵⁸ Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47821, 47823–24 (2017).

⁵⁹ KFF, *Women's Health Insurance Coverage*, *supra* note 7.

⁶⁰ Brittini Frederiksen, Usha Ranji, Alina Salganicoff & Michelle Long, *Women's Sexual and Reproductive Health Services: Key Findings from the 2020 KFF Women's Health Survey*, KFF (Apr. 21, 2021) [hereinafter Frederiksen et al., *Women's Sexual and Reproductive Health Services*], <https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2020-kff-womens-health-survey/>.

⁶¹ See Bearak & Jones, *supra* note 41, at 319 (finding that about one-third of insured women in 2015 study had a copayment for prescription contraceptives); Adam Sonfield, Athena Tapales, Rachel K. Jones & Lawrence B. Finer, *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 CONTRACEPTION 44 (2015) (finding that approximately 33% of privately insured women in national survey paid some out-of-pocket costs for oral contraceptives); Emily M. Johnston, Brigitte Courtot & Genevieve M. Kenney, *Access to Contraception in 2016 and What It Means to Women*, URB. INST. (Jan. 2017), <https://www.urban.org/sites/default/files/publication/87691/2001113-access-to-contraception-in-2016-and-what-it-means-to-women.pdf> (finding just under one-third (31.4%) of women at risk of unplanned pregnancy (uninsured and insured) paid some out-of-pocket cost for prescription birth control); Law, Wen, Lin, Tangirala, Schwartz & Zampaglione, *supra* note 45, at 395 (finding that approximately 30% of commercially insured women still have cost-sharing for contraceptives after enactment of the ACA). Note: these studies were conducted before or shortly after the FDA adopted the "category rule" to clarify that insurers must cover one method of contraception from each of the FDA-approved birth control categories without cost-sharing. Implementation of this rule likely did have some effect on cost-sharing. However, a very recent study found that twenty-one percent of privately insured women still paid some out-of-pocket costs for birth control in 2020. Frederiksen et al., *Women's Sexual and Reproductive Health Services*, *supra* note 60.

⁶² See Kristen L. Burke, Joseph E. Potter & Kari White, *Unsatisfied Contraceptive Preferences Due to Cost Among Women in the United States*, 2 CONTRACEPTION: X 1 (2020) (finding that 22% of a large nationally representative sample of women at risk for unplanned pregnancy would use a different method of

amount for prescription contraception, “40% agreed that [eliminating] the copayment [would] help them to afford and use birth control, 32% agreed this would help them choose a better method, and 30% agreed this would help them to contracept consistently.”⁶³ The COVID-19 pandemic has only exacerbated the situation. In a recent survey, 27% of women reported increased concern that they could not afford contraception during the pandemic.⁶⁴

The primary reason women cannot access no-cost contraception is the profit motivation of insurance companies. As detailed in the next Part, insurers employ several profit-generating techniques, many of them technically legal, that create significant barriers to contraceptive access. While cost is the primary roadblock, private insurers are responsible for many other barriers related to the accessibility and availability of contraception. These restrictions impact public insurance as well due to the significant involvement of private insurers in Medicaid. As a result, the vast majority of U.S. women are subject to numerous constraints on contraceptive access that contravene public health goals and undermine the social importance of family planning.

II. THE BUSINESS OF FAMILY PLANNING

Private insurers have become the gatekeepers to affordable contraception. This Part explains how the state allows and even encourages private insurers to limit contraceptive access in order to maximize their profits. It was not inevitable that private for-profit corporations should fulfill public responsibility for contraception. However, the rise of the private health insurance industry and the advent of managed care cemented the role of private insurers in health care delivery. As a result, contraception is distributed in accordance with standard business principles of profit and efficiency, allowing only a narrow consideration of individual medical need.

A. *The Rise of Managed Care*

To understand the privatization of contraception, it is necessary first to examine the history of health insurance in the United States. The market-based approach to the financing of health care, which necessarily involves trade-offs between cost and health, is now “simply dominant in policymaking in the United States.”⁶⁵ However, for-profit insurers and employers have not always acted as mediating institutions in health care provision. History shows that the state, perhaps inadvertently, essentially created the for-profit health insurance industry and has cemented its dominant role in the fulfillment of public health goals, including family planning.

Private health insurance in the U.S. was born less than a century ago. During the Great Depression, economic instability rendered patients unable to seek health care from newly burgeoning hospitals and medical centers.⁶⁶ In response, the American Hospital Association and other physician associations created private health insurance for individual

contraception if cost was not a concern).

⁶³ Bearak & Jones, *supra* note 41, at 316.

⁶⁴ Lindberg, VandeVusse, Mueller & Kirstein, *supra* note 25, at 5.

⁶⁵ Matthew B. Lawrence, *The Social Consequences Problem in Health Insurance and How To Solve It*, 13 HARV. L. & POL’Y REV. 593, 621 (2019).

⁶⁶ Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL’Y 1, 7–8 (2005).

patients: first, the Blue Cross plan which covered hospitalization and later, the Blue Shield plans to cover non-hospital medical expenses.⁶⁷ Importantly, these “Blue” plans were non-profit.⁶⁸

The pervasive union of employment and health insurance also came about fairly recently. After World War II, government-enacted wage and price freezes caused employers to begin offering health insurance plans to attract employees.⁶⁹ While this may have been an “accidental” result of government policy, it gained support as an alternative to the national public health insurance scheme being debated at the time.⁷⁰ Further, this employer sponsorship model was codified in 1954 with the development of tax exemptions for employer contributions to health insurance plans.⁷¹

As employer-sponsored insurance rapidly gained popularity, new insurance companies formed to supply the necessary coverage.⁷² Many of these for-profit insurance companies had a competitive advantage over the Blues because they were able to minimize risk by offering lower premiums (the amount individuals pay for an insurance policy) to healthier groups through the use of “experience rating,” which ties an individual’s premium amount to the likelihood that the individual or her group will need medical care.⁷³ In contrast, the nonprofit Blues used “community rating,” which ensures that all individuals in the same geographic area pay the same premium regardless of their health status.⁷⁴ As commercial entities moved to insure the healthiest groups, the Blues were forced to raise premiums to account for the increased “risk” of insuring less-healthy individuals.⁷⁵ Ultimately, the Blues in most states were forced to convert to for-profit entities and adopt experience rating to remain solvent.⁷⁶ Thus, health insurance shifted from a voluntary, nonprofit “community service” model that functioned as social insurance by redistributing costs from high- to low- risk groups, to a competitive, for-profit model that focuses on not “penalizing” healthy people with higher costs, conflating equity with the “logic of competition.”⁷⁷

By the early 1970s, the health insurance industry was seemingly in crisis.⁷⁸ At the time, health insurers reimbursed patients for medical costs almost without question on a fee-for-service basis.⁷⁹ Thus, physicians and patients had little incentive to control costs.⁸⁰ As technology advanced and expenses accumulated at “alarmingly rapid” rates, insurance companies struggled to pay the costs and threatened to buckle under the strain.⁸¹ In response, the state acted to usher in the now-dominant system of managed care by passing

⁶⁷ *Id.*

⁶⁸ *Id.* at 9.

⁶⁹ *Id.* at 10.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.* at 11.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ PAUL STARR, *SOCIAL TRANSFORMATION OF AMERICAN MED.* 329–30 (1982).

⁷⁸ Jennifer M. Jendusa, *The Denial of Benefits Quandary and Managed Care: McGraw v. Prudential Insurance Company*, 3 DEPAUL J. HEALTH CARE L. 115, 121 (1999).

⁷⁹ *Id.* at 120–21.

⁸⁰ *Id.* at 121.

⁸¹ *Id.*

the Health Maintenance Organization Act in 1973. The Act propelled managed care into “the mainstream insurance industry,” primarily by offering funding and support to Managed Care Organizations (MCOs).⁸²

MCOs are concerned foremost with cost containment.⁸³ They are structured via contractual relationships with health care providers to control costs by offering patients a limited number of providers from which to choose.⁸⁴ Additionally, they employ a number of techniques often referred to as “utilization management” to monitor patient care in an attempt to control costs.⁸⁵ For example, MCOs commonly require physicians to seek approval prior to administering a particular treatment, a technique known as prior authorization.⁸⁶ Managed care has been rightfully criticized for commercializing medicine by forcing physicians to consider costs in treatment and denying necessary care to patients to maximize profits.⁸⁷

Regardless, managed care rose to dominance after the 1973 adoption of the Health Maintenance Organization Act. MCOs grew in number throughout the 1980s⁸⁸ and began to dominate the market by the mid-nineties.⁸⁹ By the late 1990s, 85% of insured employees were on managed care plans instead of fee-for-service.⁹⁰ By 2003, that number had risen to 95%.⁹¹

While helping to usher managed care into the private insurance market, the state also gave it a prominent role in public insurance. In 1965, the government created Medicare and Medicaid to provide insurance for groups with traditionally limited access to employer-sponsored health plans.⁹² Medicare and Medicaid were originally based on the same fee-for-service model established by the nonprofit Blues.⁹³ However, as health care costs escalated, for-profit insurers increasingly obtained contractor positions to administer these plans.⁹⁴ Now, managed care is the dominant model for Medicaid delivery. In 2018, 69% of total state Medicaid enrollees were on managed care plans.⁹⁵ As early as 2011, 77% of

⁸² *Id.* at 121; Janet L. Dolgin, *Unhealthy Determinations: Controlling “Medical Necessity”*, 22 VA. J. SOC. POL’Y & L. 435, 464 (2015).

⁸³ Jendusa, *supra* note 78, at 122–23.

⁸⁴ *Id.*

⁸⁵ See John P. Little, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1407–10 (1997).

⁸⁶ *Id.*

⁸⁷ Jendusa, *supra* note 78, at 116, 120 (noting that MCOs have “come under increased scrutiny for denying coverage to claims that would provide necessary treatment to an ailing patient” and discussing the historical concerns of doctors and medical associations that insurers would make medical decisions in their own interests and not those of the patients); Dolgin, *supra* note 82, at 445 (“The industry’s economic motives can privilege considerations about cost over those about quality of care”); Hermer, *supra* note 66, at 23 (discussing physician opposition to managed care).

⁸⁸ Dolgin, *supra* note 82, at 464.

⁸⁹ Hermer, *supra* note 66, at 15.

⁹⁰ Christine Gorman, *Playing the HMO Game*, TIME, Jul. 13, 1993, at 23.

⁹¹ Hermer, *supra* note 66, at 26 n.186.

⁹² *Id.* at 13.

⁹³ *Id.* at 13–14.

⁹⁴ See *id.* (discussing the rise in health care costs); Dolgin, *supra* note 82, at 454–55 (detailing the involvement of for-profit insurers in Medicare claims administration).

⁹⁵ *Total Medicaid MCO Enrollment*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/> (last visited Jul. 9, 2021).

reproductive age women enrolled in Medicaid were on managed care plans.⁹⁶

The ACA further cemented cost-containing private insurance as the means of financing public health care. While political opposition largely disallowed serious consideration of a universal public health care system, it was not inevitable that the ACA would leave intact the dominant role of private insurers. By focusing predominantly on expanding access to insurance while regulating against only the “worst abuses perpetrated by insurance companies on consumers,”⁹⁷ the ACA continued the tradition of conflating access to quality health care with market-based access to health insurance. As a result, “the vast majority of all Americans experience rationing of their health care, despite the fact that we have a private, ostensibly ‘choice’-based, system.”⁹⁸

While dramatically escalating health care costs did necessitate state response, it is not at all clear that enlisting for-profit insurers as cost-containment gatekeepers was the appropriate move. Scholars have questioned whether traditional corporations, obligated by law to maximize shareholder value as their primary objective, could ever effectively meet public health needs.⁹⁹ It is particularly hard to reconcile increasingly poor healthcare outcomes in the U.S. with the record profit growth enjoyed by companies in the healthcare industry, including insurers.¹⁰⁰ Nonetheless, private insurers are now deeply rooted in our health care system and have been tasked with fulfillment of a number of public health goals, including distribution of contraception.

B. Managed Care Burdens Access to Contraception

As a result of the state coupling contraceptive provision to managed care, insurance cost-containment techniques routinely threaten access to contraception. Health insurance companies and Pharmacy Benefit Managers (PBMs), collectively “insurers,” use a number of techniques to control the cost of prescription drugs, including contraception. PBMs manage the prescription benefits for over 90% of covered Americans.¹⁰¹ They are essentially middlemen that negotiate drug sales and reimbursement between health insurance plans, drug manufacturers, and pharmacies.¹⁰² Health insurance companies either contract with PBMs or have their own PBM operations in-house.¹⁰³ Thus, PBMs play a large role in restricting access to prescription contraceptives through cost-cutting measures.

The ACA explicitly allows insurers to use these utilization management techniques to determine the quantity and method of contraception covered, but only within each of the

⁹⁶ Usha Ranji, Yali Bair & Alina Salganicoff, *Medicaid and Family Planning: Background and Implications of the ACA*, KAISER FAM. FOUND. 5 (Feb. 3, 2016), <https://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca>.

⁹⁷ Mariah McGill, *The Struggle to Achieve the Human Right to Health Care in the United States*, 25 S. CAL. INTERDISC. L. J. 625, 630 (2016).

⁹⁸ Hermer, *supra* note 66, at 30.

⁹⁹ See generally Yaniv Heled, Liza Vertinsky & Cass Brewer, *Why Healthcare Companies Should Be(come) Benefit Corporations*, 60 B.C. L. REV. 73 (2019).

¹⁰⁰ *Id.* at 75.

¹⁰¹ Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs*, 38 YALE L. & POL'Y REV. 360, 361 (2019).

¹⁰² *Id.*

¹⁰³ *Id.* at 364.

FDA-defined method categories.¹⁰⁴ This means, for example, if a woman was prescribed a vaginal contraceptive ring, the insurer may seek to employ any of the cost-containment measures described below to restrict coverage to certain brands of vaginal ring but could not require that the woman use oral contraceptives instead. Nonetheless, utilization management techniques can still delay or restrict access to contraception in a number of ways, contravening public family planning goals.

Recognizing that “[utilization] management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods,”¹⁰⁵ nine states and D.C. have adopted laws prohibiting insurers from imposing “restrictions or delays” on contraceptive coverage.¹⁰⁶ However, some of these laws still allow the usage of utilization management techniques in certain circumstances.¹⁰⁷ New York’s Comprehensive Contraceptive Coverage Act, enacted in 2019, is one of the most expansive state laws, requiring no-cost coverage of virtually all contraceptives, ensuring access to emergency contraception, and prohibiting restrictions or delays in coverage.¹⁰⁸ Still, there is no law that truly prohibits the application of utilization management to contraception in all circumstances.

The following sections outline the most common utilization management restrictions placed on contraception and the burdens they impose.

1. Step Therapy

The practice of step therapy, requiring a patient to try less expensive drugs and experience failure or contraindication before covering the prescribed drug, is pervasive in the insurance industry.¹⁰⁹ For those suffering from serious illness, this requirement can be outright cruel. Step therapy requires patients to bear the physical, emotional, and sometimes financial toll of suffering through potentially inadequate treatment.¹¹⁰ Their physical health may deteriorate, sometimes fatally, as they wait for coverage of the drug recommended by their physicians.¹¹¹ They may experience side effects and adverse reactions from the cheaper drugs they are forced to try first.¹¹² This physical suffering also damages their social, economic, and psychological health.¹¹³ Additionally, they may ultimately have to pay exorbitant out-of-pocket costs for their preferred drug because they simply cannot suffer through the imposed waiting period.

¹⁰⁴ FAQs About Affordable Care Act Implementation (Part XXVI), *supra* note 36, at 4 (referring to utilization management techniques as “reasonable medical management techniques”).

¹⁰⁵ Contraceptive Coverage Equity Act of 2014, CA. S.B. 1053 (2014).

¹⁰⁶ *Insurance Coverage of Contraceptives*, GUTTMACHER INST., [hereinafter Guttmacher Inst., *Insurance Coverage of Contraceptives*], <https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives> (last visited Jul. 9, 2021).

¹⁰⁷ For example, California law explicitly allows insurers to use utilization management procedures when a therapeutic equivalent of a prescribed drug is not available. CAL. HEALTH & SAFETY § 1367.25(b)(2)(B)–(C) (2019).

¹⁰⁸ Comprehensive Contraceptive Coverage Act of 2019, N.Y. S.B. S659A (2019).

¹⁰⁹ Sharona Hoffman, *Step Therapy: Legal, Ethical, and Policy Implications of a Cost-Cutting Measure*, 73 FOOD & DRUG L.J. 38, 39 (2018).

¹¹⁰ *Id.* at 38–40.

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

Step therapy acts as a significant barrier to contraceptive access as well.¹¹⁴ Requiring a particular contraceptive to “fail” before covering the preferred method seems absurd. What would failure look like? Must a woman actually conceive a child before her insurance will cover the preferred method? At least one woman has been told exactly that. The National Women’s Law Center has reported that a caller to their CoverHer contraceptive coverage hotline was told she would first have to “show that the birth control covered by the plan had led to ‘therapeutic failure(s)’ (meaning that the contraceptive failed to work—that is, that she became pregnant) or ‘adverse event(s)’” before they would cover the contraceptive she needed.¹¹⁵ Surely such a blatant inducement to unintended pregnancy runs counter to the intention of the contraceptive mandate. And this requirement contravenes public health goals in other ways. As discussed previously, the risk of unintended pregnancy is higher when a woman is forced to use an unwanted contraceptive method, let alone several. Furthermore, side effects from unwanted drugs may cause women to forego contraception entirely.¹¹⁶ Studies have shown that step therapy generally worsens medication adherence.¹¹⁷ Additionally, changing insurance plans may disrupt step therapy, thus interrupting contraceptive use, because new plans may not have access to medication history.¹¹⁸

2. Prior Authorization

Insurers also force providers to obtain a determination that a recommended drug is necessary for a specific patient before it is prescribed, a technique known as prior authorization.¹¹⁹ This process can delay care, sometimes for weeks, while a provider waits for the insurer’s determination.¹²⁰ As with step therapy, this type of delay in treatment can have serious consequences for patients.¹²¹

¹¹⁴ See Michelle Andrews, *Contraception Is Free To Women, Except When It's Not*, NPR (Jul. 21, 2021), <https://www.npr.org/sections/health-shots/2021/07/21/1018483557/contraception-is-free-to-women-except-when-its-not> (reporting that one insurer requires women to try eight other contraceptive methods before covering the newer contraceptive method Phexxi); ACOG, *Access to Contraception*, *supra* note 41, at 252 (“Some insurers, clinic systems, or pharmacy and therapeutics committees also require women to ‘fail’ certain contraceptive methods before a more expensive method, such as an IUD or implant, will be covered.”); Mia R. Zolna, Megan L. Kavanaugh & Kinsey Hasstedt, *Insurance-related Practices at Title X-funded Family Planning Centers under the Affordable Care Act: Survey and Interview Findings*, 28 WOMEN’S HEALTH ISSUES 21, 25 (2018) (finding that 12% of surveyed Title X clinics reported that Medicaid required their clients to “use certain [contraceptive] methods before ‘stepping up’ to more costly ones” and 18% of clinics reported the same requirement imposed by private insurers).

¹¹⁵ *Issue Brief: Exception Policies: Advocating for No-Cost Coverage of Noncovered Contraceptives*, NAT’L WOMEN’S LAW CTR. at 2 (Mar. 2021) [hereinafter NWLC, *Exception Policies*], <https://nwlc.org/wp-content/uploads/2021/03/Exceptions-Guide.pdf> (citing BCBS Federal Employee Program Formulary Tier Exception Member Request Form on file with National Women’s Law Center).

¹¹⁶ Daniels, Mosher & Jones, *Contraceptive Methods Women Have Ever Used*, *supra* note 1, at 8.

¹¹⁷ Linda M. Sobeski, Christine A. Schumacher, Nancy A. Alvarez, Keri C. Anderson, Bridget Bradley, Susie J. Crowe, Jessica R. Merlo, Adowoa Nyame, Kelley S. Rivera, Nancy L. Shapiro, Dustin D. Spencer & Elizabeth Van Dril, *Medication Access: Policy and Practice Opportunities for Pharmacists*, 4 J. AM. COLL. CLINICAL PHARM. 113, 115 (2021) [hereinafter Sobeski et al.].

¹¹⁸ *Id.*

¹¹⁹ Stacey L. Worthy, Daniel C. McClughen & Shruti Kulkarni, *Now or Never: The Urgent Need for Action Against Unfair Coverage Denials for Quality Health Care*, 48 LOY. U. CHI. L.J. 1041, 1064–65 (2017).

¹²⁰ *Id.*

¹²¹ *Id.* (“Even a short-term delay in access to medications for conditions such as HIV, cancer, and seizures

Prior authorization, like step therapy, has been shown to negatively affect medication adherence.¹²² Patients may simply forego medication entirely after an initial rejection or even while waiting for a determination. And a significant number of requests are rejected. In a 2010 survey conducted by the AMA, over half of the 2,400 physicians surveyed reported 20% overall rejection of their initial authorization requests for drugs.¹²³ In such cases, the burden is on the patient to undertake a lengthy and cumbersome appeal or pay for the medication out-of-pocket.

Prior authorization requirements are undoubtedly burdening access to preferred contraception.¹²⁴ As with step therapy, delays in receipt of preferred contraception increase the risk of unintended pregnancy and could result in non-use. This is particularly true with long-acting reversible contraception (LARCs) such as IUDs and implants, where prior authorization prevents same-day insertion, requiring multiple trips to a provider.¹²⁵ Requiring multiple provider visits imposes additional economic and social burdens on women and may substantially lower the likelihood of them returning to obtain contraception at all. Indeed, studies shows that the requirement of an additional provider visit is one of the most common reasons women seeking LARCs do not receive them.¹²⁶ Further, prior authorization may be invisibly limiting the contraceptive options a woman is even presented with. Frequent rejections, cumbersome and plan-specific administrative requirements, and vague or outdated information regarding which drugs are required for prior authorization have caused over three-quarters of providers to “switch[] treatments at least once to avoid the prior authorization process.”¹²⁷ This subtle manipulation of provider behavior only further obscures the role that insurance cost-containment plays in restricting contraceptive access.

3. Quantity Limits

Insurers routinely attempt to control costs by limiting the number of prescriptions or services covered within a given time period. According to ACOG, “Insurance plan restrictions prevent 73% of women from receiving more than a single month’s supply of contraception at a time, yet most women are unable to obtain contraceptive refills on a timely basis.”¹²⁸ In a recent survey, nearly one-third (31%) of hormonal contraceptive users

poses a serious risk to the health and safety of plan enrollees, including permanent damage or death.”).

¹²² Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117, at 115.

¹²³ AM. MED. ASS’N, STANDARDIZATION OF PRIOR AUTHORIZATION PROCESS FOR MEDICAL SERVICES WHITE PAPER 5 (Jun. 2011).

¹²⁴ *See, e.g.*, Zolna, Kavanaugh & Hasstedt, *supra* note 114 (finding that prior authorization was the second most common coverage restriction reported by Title X clinic administrators).

¹²⁵ Caitlin M. D. Parks & Jeffrey F. Peipert, *Eliminating Health Disparities in Unintended Pregnancy with Long-Acting Reversible Contraception (LARC)*, 214 AM. J. OBSTETRICS & GYNECOLOGY 681, 685 (2016).

¹²⁶ Neko M. Castleberry, Lauren Stark, Jay Schulkin & Daniel Grossman, *Implementing Best Practices for the Provision of Long-Acting Reversible Contraception: A Survey of Obstetrician-Gynecologists*, 100 CONTRACEPTION 123, 126 (2019).

¹²⁷ Worthy, McClughen & Kulkarni, *supra* note 119, at 1065–66; *see also* Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117, at 115 (noting the additional time and resources required for providers to complete the prior authorization process and acknowledging that “significant variations” and frequent changes in utilization management criteria among insurers creates a barrier to medication access).

¹²⁸ ACOG, *Access to Contraception*, *supra* note 41, at 252.

reported having missed taking their birth control because they were not able to get their next supply of pills.¹²⁹ For this reason, ACOG recommends that insurers support the provision of a 3–13 month supply of hormonal contraceptives.¹³⁰ Quantity limits impact LARC usage as well. Multiple LARC placements are sometimes necessary if insertion is performed incorrectly or the device is expelled. In a 2015 survey, over one hundred LARC researchers identified insurance company limitations on the number of LARC devices prescribed to women in a three-to-five-year period as a significant barrier to LARC usage.¹³¹

The COVID-19 pandemic has only exacerbated the harm caused by quantity limits. A recent survey of women’s health during the pandemic revealed that “Nearly one in ten women ages 18–25 (8%) and 7% of women ages 26–35 say they delayed or were not able to get birth control due to the COVID-19 pandemic.”¹³² In general, approximately 18% of women in fair or poor health said they had “either not filled a prescription, cut pills in half or skipped doses of medicine because of the COVID-19 pandemic.”¹³³ Certainly, quantity limits played a role in this restricted access, where office closures, stay-at-home mandates, and concerns about virus transmission greatly increased the burden of multiple visits to pharmacies or providers.

Several states have responded to this problem. Currently, twenty states and D.C. have enacted laws requiring insurers to cover an extended supply of contraceptives.¹³⁴ Unfortunately, insurers do not always comply with these laws. For example, in April 2020, the New York Attorney General’s office released a statement demanding that three health insurance companies comply with state law requiring that they cover 12-month supplies of contraception after receiving “multiple complaints” of coverage denial.¹³⁵

4. Other Prescription Limitations

Women face several other restrictions on coverage of prescription contraceptives. Insurers, typically PBMs, develop a drug formulary, or preferred drug list, specifying the availability and coverage amount of a specific drug.¹³⁶ Initially, they may deny coverage of a contraceptive that is not on the formulary, leading to delays and possible

¹²⁹ Frederiksen et al., *Women’s Sexual and Reproductive Health Services*, *supra* note 60. *See also* ACOG, *Access to Contraception*, *supra* note 41, at 252 (“data show that provision of a year’s supply of contraceptives is cost effective and improves adherence and continuation rates.”).

¹³⁰ ACOG, *Access to Contraception*, *supra* note 41, at 251.

¹³¹ Diana Greene Foster, Rana Barar, Heather Gould, Ivette Gomez, Debbie Nguyen & M. Antonia Biggs, *Projections and Opinions from 100 Experts in Long-Acting Reversible Contraception*, 92 *CONTRACEPTION* 543, 546–47 (2015).

¹³² Brittni Frederiksen, Usha Ranji, Alina Salganicoff & Michelle Long, *Women’s Experiences with Health Care During the COVID-19 Pandemic: Findings from the KFF Women’s Health Survey*, KAISER FAMILY FOUND. (Mar. 22, 2021), <https://www.kff.org/womens-health-policy/issue-brief/womens-experiences-with-health-care-during-the-covid-19-pandemic-findings-from-the-kff-womens-health-survey/>.

¹³³ *Id.*

¹³⁴ Guttmacher Inst., *Insurance Coverage of Contraceptives*, *supra* note 106.

¹³⁵ Attorney General James Demands Health Insurance Providers Obey the Law, Protect Women’s Access to Birth Control, N.Y. ATT’Y GEN. (Apr. 19, 2020), <https://ag.ny.gov/press-release/2020/attorney-general-james-demands-health-insurance-providers-obey-law-protect-womens>.

¹³⁶ Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117, at 114.

nonadherence.¹³⁷ This is particularly true for newer contraceptives where formulary update often lags behind the publishing of new clinical evidence¹³⁸ and insurers may have a “new-to-market” policy that delays the addition of any new drug to their formularies.¹³⁹ Additionally, insurers may significantly alter their formularies after the start of the plan year, sometimes even forcing patients to switch to therapeutically equivalent drugs without provider knowledge.¹⁴⁰ Further, ever-changing, complex, and plan-specific formularies can be difficult and time-consuming for providers to navigate, leading to drug recommendations that may not always be in the best interest of the patient.¹⁴¹ As with prior authorization, the hidden impact of these insurance practices is deeply concerning. This is especially true because provider recommendations may frequently run counter to

¹³⁷ See *id.* (noting negative effect of delays and initial coverage denial on medication adherence); Tracey Wilkinson, *Obamacare Was Supposed to Make All Birth Control Free. As a Doctor, I See It's Not Happening.*, VOX (Sept. 6, 2016) (relating provider experiences with contraceptive coverage denials causing nonadherence among patients: “There is one patient I remember clearly who wanted to begin taking oral contraceptive pills. We discussed the different types of pills and how we would start with a low-dose estrogen pill given that this was her first time using contraception. I saw her during a follow-up a month later and learned that she hadn’t received the prescription that I sent to the pharmacy. When I called the pharmacy to figure out what happened, the pharmacist explained that the insurance company formulary didn’t cover the specific contraception I had prescribed. The health plan did cover one with a slightly higher dose of estrogen, and the pharmacy had tried to contact our office to substitute the prescription but had been unsuccessful in reaching us.”).

¹³⁸ See Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117, at 114 (“Ideally, formulary and benefits decisions should be based on the most up-to-date clinical evidence. However, the lag time required to review the evidence, develop criteria, and secure contracts with drug manufacturers may result in the publication of outdated formularies. In addition, clinical guideline updates are not synchronized, further expanding discrepancies between clinical guideline recommendations and medication formularies.”).

¹³⁹ See Martha M. Rumore & F. Randy Vogenberg, *PBM P&T Practices: The HEAT Initiative is Gaining Momentum*, 42 P&T 330, 330–31 (2017) (noting that PBMs frequently exclude new-to-market drugs from their formularies); CVS CAREMARK, FORMULARY DRUG REMOVALS (Jul. 2021), https://www.caremark.com/portal/asset/Formulary_Exclusion_Drug_List.pdf (describing PBM policy that “[n]ew-to-market products and new variations of products already in the marketplace will not be added to the formulary immediately.”).

¹⁴⁰ Worthy, McClughen & Kulkarni, *supra* note 119, at 1059 (discussing a 2015 study in which half of insurers revised their formularies after the beginning of the plan year).

¹⁴¹ THE KENNEDY FORUM, A CONSUMER GUIDE TO DRUG FORMULARIES: UNDERSTANDING THE FUNDAMENTALS OF BEHAVIORAL HEALTH MEDICATIONS 1 (Aug. 2017), https://pjk-wp-uploads.s3.amazonaws.com/www.thekenedyforum.org/uploads/2017/09/170824-KF-Consumer-Guide-Drug-Form-Issue-Brief-0817_4.pdf. See also Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117 at 115 (“Navigating online formularies is time-consuming and requires that providers have accurate drug plan information and working knowledge of UM tools in order to identify the most up-to-date information.”); Brittany Cogdill & Jean Nappi, *Assessment of Prescribers’ Knowledge of the Cost of Medications*, 46 ANNALS PHARMACOTHERAPY 200 (2012) (finding that the majority of surveyed prescribers “rarely asked about a patient’s prescription insurance coverage or consulted a discounted drug list before writing a prescription.”); *Utilization Management: Barriers to Care and Burdens on Small Medical Practices: Hearing Before the Comm. on Small Bus.*, 116th Cong. 8 (2019) (describing a small town family physician’s experience working with thirty-five different insurers “each of which has its own system of prior authorization and drug formularies, and which change on a regular basis. I often do not know in advance which medications in which class will be covered, and this often means that when I wrote a prescription, my patient has to take it to the pharmacy to find out if it is covered. And if it is not, then I need to find an alternative often by writing a new prescription and the process gets repeated.”).

contraceptive preferences. A significant percentage of participants in a recent study indicated that they were not using their preferred contraceptive because their provider recommended an alternative.¹⁴²

Formularies designed to cover only the minimally required contraceptive drugs and devices still impose substantial burdens. As discussed previously, insurers are only obligated to cover one method in each of the eighteen FDA-defined categories of birth control without cost-sharing. Even assuming strict adherence to this federal guidance, there are many reasons why a woman might prefer a particular method within a category. There are often significant differences between the methods in a category. For example, the various brands of progestin IUDs have different replacement rates and are differently sized.¹⁴³ One brand may be better suited for smaller women and there are myriad reasons, such as family spacing, that women may prefer a device that requires replacement in three years rather than five.¹⁴⁴ Further, providers are not likely to know which specific method is covered by a patient's insurance plan when prescribing, particularly in the case of oral contraceptives, where there are over one hundred different types of pills and only three categories.¹⁴⁵ Pharmacies may fail to inform providers when coverage is rejected, leaving patients to seek an alternative prescription on their own, significantly increasing the risk of non-adherence.¹⁴⁶ Additionally, requiring the usage of a generic drug may burden contraceptive access. A brand name contraceptive may be preferable for certain patients at risk of non-adherence even when not medically necessary. Some patients may be confused by different packaging of generics, fear that they received the wrong medication, or generally distrust generic medications.¹⁴⁷ Further, a single covered contraceptive within a method category may not be available at pharmacies, particularly in rural or hard-to-reach areas.¹⁴⁸

Additionally, women face coverage denials of new contraceptive methods that have not yet been incorporated into the FDA birth control guide. For example, many insurers have refused to cover Phexxi, a hormone-free vaginal gel that was approved by the FDA in 2020.¹⁴⁹ According to Phexxi's manufacturers, insurers frequently deny coverage

¹⁴² Frederiksen et al., *Women's Sexual and Reproductive Health Services*, *supra* note 60.

¹⁴³ Erin Armstrong & Agata Pelka, *Medical Management and Access to Contraception*, NAT'L HEALTH LAW PROGRAM (Mar. 15, 2016), <https://healthlaw.org/resource/medical-management-and-access-to-contraception/>.

¹⁴⁴ *Id.*

¹⁴⁵ Wilkinson, *supra* note 137. *See also* Sobeski, Alvarez, Bradley, Merlo, Shapiro, Van Dril, Schumacher, Anderson, Crow, Nyame, Rivera & Spencer, *supra* note 117, at 115 (discussing the barrier to medication access resulting from providers' inability to access or navigate patient-specific formulary information).

¹⁴⁶ Wilkinson, *supra* note 137 ("Sometimes I will get a call from a pharmacy asking to change the birth control I prescribed—and that's if the pharmacy happens to get ahold of me during business hours. Sometimes I will get a fax requesting insurance-specific paperwork to be completed to justify why a method was chosen over another. But most frequently, it isn't until the patient returns to tell me what happens that I find out she wasn't able to get her birth control. This means she never started to use it and has been at risk for an unplanned pregnancy for the days, weeks, and months that have passed since I last saw her.")

¹⁴⁷ *See* S.S. Dunne & C.P. Dunne, *What do people really think of generic medicines? A systematic review and critical appraisal of literature on stakeholder perceptions of generic drugs*, 13 BMC MED. 1, 22–24 (2015).

¹⁴⁸ NWLC, *Exception Policies*, *supra* note 115, at 4. *See also* Wilkinson, *supra* note 137 (noting possibility that a patient's pharmacy may not stock a prescribed contraceptive).

¹⁴⁹ Andrews, *supra* note 114.

because the product is missing from the FDA chart, which has not been updated since the category rule went into effect.¹⁵⁰ This lack of guidance allows insurers total discretion in determining the birth control category to which new contraceptives like Phexxi belong. Consequently, many insurers incorrectly classify Phexxi as a spermicide and refuse full coverage because they are already covering one method from the spermicide category without cost-sharing.¹⁵¹

Sixteen states and D.C. have responded to these issues by requiring insurers to cover at least one therapeutic equivalent of every contraceptive drug or device, regardless of category.¹⁵² In these states, if a particular contraceptive has no therapeutic equivalent, it *must* be covered without cost-sharing. Additionally, some states require insurers to cover an alternative therapeutic equivalent when a particular covered contraceptive is not available to a patient.¹⁵³

5. Narrow Networks

Narrow network insurance policies have become increasingly widespread after the enactment of the ACA.¹⁵⁴ In order to contain costs, insurers keep their networks “narrow” by contracting only with a small number of hospitals and doctors, paying them a discounted fee for their services in exchange for funneling in new patients.¹⁵⁵ Naturally this limits the options available to patients and may result in the “surprise” usage of out-of-network care. Network adequacy typically requires “reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.”¹⁵⁶ “For a network to be considered adequate, it must offer access to adequate care, at the appropriate time, and without requiring an unreasonable amount of travel.”¹⁵⁷ Technically, a network could meet this definition but still burden contraceptive access.

Women may not seek care or receive the optimal contraceptive method if they are unable to access a preferred provider or pharmacy in-network. A 2014 Kaiser survey found

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² Guttmacher Inst., *Insurance Coverage of Contraceptives*, *supra* note 106 (reporting that sixteen states plus D.C. prohibit cost-sharing of contraceptives). Each state law specifically requires coverage of all FDA-approved contraceptive methods without cost-sharing unless there is a therapeutically equivalent drug or device. The FDA considers drug products to be therapeutically equivalent “if they are pharmaceutical equivalents for which bioequivalence has been demonstrated, and they can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling.” See also FOOD AND DRUG ADMIN., APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS (ORANGE BOOK) Preface (41st Ed. 2021), <https://www.fda.gov/drugs/development-approval-process-drugs/orange-book-preface>.

¹⁵³ See NWLC, *Exception Policies*, *supra* note 115, at 4 (quoting Nevada law: “If a covered therapeutic equivalent . . . is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.”); CAL. HEALTH & SAFETY § 1367.25(b)(2)(B)–(C) (“If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by the enrollee’s provider, a health care service plan shall provide coverage, subject to a plan’s utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing.”).

¹⁵⁴ Janet L. Lerman & Frank E. Stepnowski, *The Narrow-Network Nightmare*, 103 ILL. B.J. 32, 32 (2015).

¹⁵⁵ *Id.*

¹⁵⁶ NAT’L ASS’N INS. COMMISSIONERS, *Network Adequacy*, https://content.naic.org/cipr_topics/topic_network_adequacy.html (last visited Jul. 9, 2021).

¹⁵⁷ Worthy, McClughen & Kulkarni, *supra* note 119, at 1076.

that 23% of women in marketplace plans could not get appointments with their chosen provider and 20% were told that their chosen provider did not take their insurance.¹⁵⁸ These restrictions may be especially significant if a woman has switched insurance plans and can no longer see her existing provider.¹⁵⁹ Additionally, younger women on their parents' insurance plans may not be able to access in-network contraceptive care if they have moved away from home.¹⁶⁰ And women may not be able or willing to drive a "reasonable" distance to an in-network pharmacy to obtain contraception, particularly if they are also subject to quantity limits.

Out-of-network restrictions may also burden postpartum LARC or sterilization procedures. Even if a woman uses an in-network hospital, she may receive services from out-of-network specialists, such as anesthesiologists.¹⁶¹

6. Other Restrictions

Insurers may impose other restrictions that necessitate multiple visits to providers or pharmacies. For example, some insurers require clinics to order contraceptive devices directly from them once prescribed to a patient, necessitating multiple visits for IUD insertion because the provider cannot keep the devices in stock.¹⁶² As discussed previously, studies have shown that women are much less likely to use contraception if they are required to make multiple visits to a provider or pharmacy. For this reason, ACOG recommends same-day provision.¹⁶³ Additionally, insurers may require a prescription for contraception that is available over-the-counter (OTC), such as spermicide, female or male condoms, the contraceptive sponge, and even emergency contraception.¹⁶⁴ This requirement forces women to undergo a burdensome and unnecessary provider visit to obtain a prescription, contravening the intent of OTC status.¹⁶⁵

Additionally, insurers do not always cover all related contraceptive services. The ACA requires insurers to cover clinical services related to contraception, such as contraceptive counseling and device insertion and removal. Yet insurers have failed to consistently provide this coverage.¹⁶⁶ This non-compliance may be due to a lack of clarity

¹⁵⁸ Alina Salganicoff & Laurie Sobel, *Women, Private Health Insurance, and the Affordable Care Act*, 26 WOMEN'S HEALTH ISSUES 2, 4 (2016).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ Mary C. Politi, Adam Sonfield & Tessa Madden, *Addressing Challenges to Implementation of the Contraceptive Coverage Guarantee of the Affordable Care Act*, 315 JAMA 653, 654 (2016).

¹⁶² Jaclyn J. Serpico, JaNelle M. Ricks, Wendy G. Smooth, Catherine Romanos, Daniel L. Brook & Maria F. Gallo, *Access to Single-Visit IUD Insertion at Obstetrician-Gynecology Practices in Ohio: An Audit Study*, 102 CONTRACEPTION 190, 192 (2020).

¹⁶³ ACOG, *Access to Contraception*, *supra* note 41, at 253.

¹⁶⁴ ELIZABETH McCAMAN, NAT'L HEALTH LAW PROGRAM, CONTRACEPTIVE EQUITY IN ACTION: A TOOLKIT FOR STATE IMPLEMENTATION 6 (2019), <https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/> [hereinafter McCaman, *Contraceptive Equity in Action*].

¹⁶⁵ Elizabeth McCaman, *Model Contraceptive Equity Act: Legislative Language and Issue Brief*, NAT'L HEALTH LAW PROGRAM, at 7 (Jan. 31, 2019), <https://healthlaw.org/resource/model-contraceptive-equity-act-legislative-language-and-issue-brief/>.

¹⁶⁶ See NAT'L WOMEN'S L. CTR. *The Biden Administration Must Ensure the Affordable Care Act Contraceptive Coverage Requirement is Working for All* 8 (Oct. 2021), https://nwlc.org/wp-content/uploads/2021/10/NWLC_BC_AffordCareAct-Oct_2021.pdf [hereinafter NWLC, *ACA Working for All*] (reporting insurance coverage denials of services related to tubal ligation and IUD placement); NAT'L

on the federal guidelines or because providers are unaware of the correct way to bill for such services.¹⁶⁷

Thus, having insurance does not guarantee adequate access to contraception. This non-exhaustive catalog of possible restrictions on contraceptive access demonstrates the degree to which private profit conflicts with public responsibility for family planning in managed care.

C. Profit-Driven Medical Necessity

While the ACA permits insurers to use the above cost control techniques to limit access to contraception, they are *required* to cover a particular contraceptive without cost-sharing if a physician determines that the product is medically necessary.¹⁶⁸ In this way, insurers seem to be more tightly regulated in the distribution of contraceptives than a great deal of other medical products and services. However, insurers, rather than providers, typically have the final word on medical necessity. They may improperly exercise this authority to burden contraceptive access.

The concept of medical necessity has been dubbed the “primary gatekeeper for the utilization of health care services” in the United States.¹⁶⁹ Insurers routinely deny coverage, and thus prevent treatment, based on in-house determinations that a product or service is not medically necessary. Through the well-known practice of utilization review, insurance companies attempt to control costs by reviewing claims and rejecting those they deem not medically necessary.¹⁷⁰ This rejection may occur during or after a patient is undergoing treatment or it may act as a barrier to recommended treatment, as in the case of prior authorization requirements.¹⁷¹

As scholars have noted, medical necessity is a fluid concept which has no standard industry or federal statutory definition and is subject to varying economic and ideological interpretations.¹⁷² A number of principles may underlie an insurer’s determination of medical necessity, including whether the recommended treatment aligns with customary medical practice, is “effective,” and is not provided merely “as a convenience to the patient or provider.”¹⁷³ Regardless, the insurer’s overarching profit motivation ensures that cost

WOMEN’S LAW CTR, *State of Birth Control Coverage: Health Plan Violations of the Affordable Care Act* 8-9 (2015), <https://nwlc.org/wp-content/uploads/2015/04/State-of-Birth-Control-Coverage-Health-Plan-Violations-of-the-ACA.pdf> [hereinafter NWLC, *State of Birth Control Coverage*] (reporting insurer refusal to cover IUD removal). *See also* Andrews, *supra* note 114 (reporting woman’s successful appeal of insurer charge of \$248 for an ultrasound accompanying IUD insertion).

¹⁶⁷ Politi, Sonfield & Madden, *supra* note 161, at 653–54.

¹⁶⁸ DEP’T OF LAB., HEALTH AND HUM. SERVS., AND THE TREASURY, *supra* note 36, at 4.

¹⁶⁹ Daniel Skinner, *Defining Medical Necessity Under the Patient Protection and Affordable Care Act*, 73 PUBLIC ADM. REV. S49, S49 (2013).

¹⁷⁰ Jendusa, *supra* note 78, at 123–25; *see also* Dolgin, *supra* note 88, at 444 (“In the United States, almost all medical necessity determinations, both for patients with private coverage and for those covered through government programs, are made by insurance company employees.”).

¹⁷¹ Jendusa, *supra* note 78, at 123–25.

¹⁷² *See* Dolgin, *supra* note 88, at 438–46 (discussing “Medical Necessity — A Term in Search of an Agenda”); Skinner, *supra* note 169; John V. Jacobi, Tara Adams Ragone & Kate Greenwood, *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN ST. L. REV. 109, 129–31 (2015) (discussing the “inherent indeterminacy” of medical necessity judgments).

¹⁷³ Jacobi, Adams Ragone, and Greenwood, *supra* note 172, at 130 (quoting Linda A. Bergthold, *Medical*

plays a role in this determination. Indeed, utilization review has been the subject of a great deal of controversy over the years, as insurers are necessarily financially incentivized to override the medical judgment of providers, causing patients to suffer through delay or denial of care.¹⁷⁴ While it may be difficult to determine the degree to which medical necessity determinations are driven by profit motive, there is certainly reason to believe that cost concerns often override concern for patient health. Examples abound of coverage denials that flagrantly disregard the medical needs of a patient.¹⁷⁵ Further, while medical necessity determinations are meant to be made by nurses or physicians employed by the insurance company, providers have reported that these reviews are “often” conducted by insurance company representatives with no medical training.¹⁷⁶

The federal government has done little to limit the discretion generally afforded to insurers in medical necessity determinations. The ACA only further codified this discretion by explicitly granting insurers the “flexibility to employ appropriate medical review and determination of medical necessity.”¹⁷⁷ The ACA does not define medical necessity or limit the manner of its determination in any significant way, even within the Medicare or Medicaid programs.¹⁷⁸ Further, shortly after passage of the ACA, the IOM considered implementing a standardized definition of the term and an accompanying set of implementation guidelines.¹⁷⁹ However, the IOM ultimately could not reconcile the divergent views of various stakeholders.¹⁸⁰ Unsurprisingly, providers and the public generally supported national standardization, while private insurers opposed the move.¹⁸¹

While the ACA requires insurers to defer to a provider’s judgment that a particular contraceptive is medically necessary, it is doubtful that they will just accept a provider’s determination when “medical necessity” is such an amorphous term. Indeed, the concept of medical necessity does not seem entirely applicable to preventive care like contraception. In other contexts, medical necessity often means that there is a physiological need for a certain treatment. However, there are several non-medical reasons why a particular contraceptive may be indicated, including possible side effects, personal

Necessity: Do We Need It?, 14 HEALTH AFFS. 180, 182–83 (1995)).

¹⁷⁴ Jendusa, *supra* note 78, at 125; *see also* Skinner, *supra* note 169, at S50 (“[T]he seemingly arbitrary and decentralized nature of medical necessity decision making within managed care contexts gave rise to debates in the 1990s that raised concerns that HMOs were scrutinizing physicians’ claims about patients’ needs for the purposes of profit rather than sound medical judgment[.]”); Dolgin, *supra* note 88, at 445 (“Gregg Bloche has contended that insurance companies’ reliance on the notion of medical necessity in reviewing medical claims can be an opaque form of rationing, grounded not in concern for the potential advantages of the intervention at issue, but in concern for cost.”).

¹⁷⁵ *See, e.g.*, Jendusa, *supra* note 78, at 129–33 (describing insurer’s denial of coverage of physical therapy to treat multiple sclerosis in which the insurer’s reviewing physician did not review the patient’s medical records, speak to her physicians, examine the patient, or consult any medical literature regarding her condition); Hoffman, *supra* note 109, at 46 (quoting Dr. Benjamin Kopp, a pediatric pulmonologist: “I have prescribed certain pulmonary medications for a toddler, only to have the health insurer insist on a lower cost medication that is designed for a teenager. This shows me the decisions about step therapy requirements do not involved pediatricians, asthma specialists, and pharmacists who know the most about the medications.”).

¹⁷⁶ AM. MED. ASS’N, *supra* note 123, at 21.

¹⁷⁷ CHERYL ULMER ET AL., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 95 (2012).

¹⁷⁸ Dolgin, *supra* note 82, at 441–43.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 442.

¹⁸¹ *Id.* at 442–43.

preference, and ease of use.¹⁸² While federal guidelines have specifically indicated that a medical necessity determination may include these factors,¹⁸³ insurers may be unaware of the non-codified guidelines or may refuse to read into them a more expansive view of medical necessity that considers social and economic factors. Accordingly, some states have enacted laws that use broader terms to define the standard by which a physician's determination should be final, including "reasonable professional judgment," "medically advisable," "medically appropriate", and "medical determination."¹⁸⁴ Further, some states have codified with stronger language the requirement that a provider's determination is final under these circumstances and cannot be overridden by insurers.¹⁸⁵

Regardless, women face significant challenges even requesting a cost-sharing waiver for a medically necessary contraceptive. The ACA requires that insurers have an "easily accessible, transparent, and sufficiently expedient" process for requesting a waiver (also commonly referred to as an "exception") of the cost-sharing requirement when a provider determines that a particular contraceptive is medically necessary.¹⁸⁶ The waiver process must not be "unduly burdensome on the individual or a provider."¹⁸⁷ Nonetheless, many insurers have complicated or non-existent waiver processes. Noting that "many plans do not have an exceptions policy[, m]any insurance companies, birth control users, and providers are not aware of this requirement, and often the state agency does not enforce it," the National Women's Law Center has reported that callers to their CoverHer hotline have been told by their insurers that no exceptions process exists.¹⁸⁸ Additionally, women have reported that insurers are not fully complying with the waiver requirements. In one instance, a woman was charged the difference in cost between the medically necessary contraceptive and the covered one.¹⁸⁹ Providers have also encountered confusing and cumbersome waiver requirements.¹⁹⁰ As with other burdensome utilization management practices, the desire to avoid complicated or ill-defined waiver processes may motivate providers to steer patients towards a sub-optimal contraceptive. Thus, it is difficult to even make it through the initial step of requesting a waiver, much less actually receive one.

The state's placement of responsibility for contraception with the private market has resulted in significant and often inequitable barriers to contraceptive access. Private insurers inject profit considerations into public health through numerous cost-containing

¹⁸² NWLC, *Exception Policies*, *supra* note 115, at 2.

¹⁸³ DEP'TS OF LAB., HEALTH & HUM. SERVS., & TREASURY, *supra* note 36, at 4.

¹⁸⁴ NWLC, *Exception Policies*, *supra* note 115, at 3.

¹⁸⁵ *See id.* (quoting New York law: "If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final.").

¹⁸⁶ DEP'TS OF LAB., HEALTH & HUM. SERVS., & TREASURY, *supra* note 36, at 4–5.

¹⁸⁷ *Id.*

¹⁸⁸ NWLC, *Exception Policies*, *supra* note 115, at 2. *See also* NWLC, *ACA Working for All*, *supra* note 166, at 7–8 (providing examples of reports to CoverHer in 2020 and 2021 of insurers telling women that no exceptions process exists after contraceptive coverage was denied).

¹⁸⁹ Laurie Sobel, Alina Salganicoff, Nisha Kurani, Jennifer Wiens, Kimsung Hawks & Linda Shields, *Coverage of Contraceptive Services: A Review of Health Insurance Plans in Five States*, KAISER FAM. FOUND. 17 (Apr. 16, 2015), <https://www.kff.org/private-insurance/report/coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states/> [hereinafter KFF, *Coverage of Contraceptive Services*].

¹⁹⁰ *See* NWLC, *Exception Policies*, *supra* note 115, at 2 (reporting that health care providers have been required to provide "chart notes to verify past medication trials" as part of the waiver process).

techniques, treating family planning as a business rather than a vital matter of social importance.

III. ABANDONING WOMEN TO THE MARKETPLACE

The state has delegated responsibility for family planning not only to private insurers, but also to individual women. The ACA's treatment of patients as consumers rests on a false assumption that all women are freely able to participate in the market and to take personal responsibility for all aspects of their healthcare. This abdication to the marketplace inappropriately burdens individual women in numerous ways.

A. *The Burden of Choice*

It is glaringly obvious that the ACA's reliance on the market to provide contraception is ill-placed. The state allows insurers to impose profit-motivated constraints on contraception access while abandoning women to the impossible task of "choosing" a plan that provides affordable coverage of their preferred method. In reality, a woman facing restrictions on her preferred contraceptive is rarely, if ever, able to simply choose another health plan that would provide access. Employment status, income, and state of residence almost always dictate health insurance coverage. Even when faced with options, the opacity and complexity of pricing and quality information inherently preclude the informed consumer necessary to a functional market, particularly when combined with the psychological constraints of estimating risk and navigating illness. As a result, women are entirely powerless to regulate contraceptive access through the market, yet the state places enormous responsibility on them to fulfill the contraceptive mandate.

Firstly, most women are significantly constrained in their choice of health plans by their employer. Approximately 61% of U.S. women ages 19-64 are covered by employer-sponsored health plans.¹⁹¹ Employers are not likely to offer a wide array of options because there is less administrative burden and greater financial incentive in contracting with a small number of plans. Yet it is extremely unlikely that a woman would reject an employer-sponsored plan in favor of a marketplace plan that would provide her preferred contraception (assuming such a plan exists) because employer-sponsored plans are often significantly more affordable and provide better overall coverage.¹⁹² Thus, most U.S. women realistically have little to no choice of health insurance plans.

This is especially troubling given that a significant portion of working women are on employer-sponsored plans that are not subject to state contraceptive mandates. Approximately 60% of U.S. workers are unable to take advantage of more expansive state contraceptive equity laws because they are on "self-funded" plans that are exempt from state regulation.¹⁹³ Employer-sponsored plans are still governed by the Employee Retirement Income Security Act of 1974 (ERISA), which was originally developed before

¹⁹¹ KFF, *Women's Health Insurance Coverage*, *supra* note 7.

¹⁹² See John A. Graves & Pranita Mishra, *The Evolving Dynamics of Employer-Sponsored Health Insurance: Implications for Workers, Employers, and the Affordable Care Act*, 94 MILBANK Q. 736, 737 (2016) (discussing lower cost of employer-sponsored plans compared to similar plans on individual insurance market and the historically generous and comprehensive nature of employer-provided health insurance benefits).

¹⁹³ Guttmacher Inst., *Insurance Coverage of Contraceptives*, *supra* note 106.

the advent of managed care, with the primary goal of pension reform.¹⁹⁴ ERISA sought to ease the burden of employers operating in multiple states by exempting them from state insurance law, commonly known as ERISA preemption.¹⁹⁵ Under ERISA, states can regulate a "fully-insured" plan, where an employer buys directly from a state-licensed insurance company.¹⁹⁶ However, states cannot regulate "self-funded" plans in which the employer remains directly liable for fulfillment of insurance claims.¹⁹⁷ Given that most insurance regulation is left to the states, it is unsurprising that ERISA has motivated many employers to self-insure to escape the law.¹⁹⁸ Add to this the 13% of health insurance plans that are still grandfathered and the religious exemptions afforded to employers with objections to contraceptive coverage. The result is a potentially huge segment of the female population confined by their employers to insurance plans that do not provide optimal contraceptive coverage.

The small percentage of women who purchase their own health insurance¹⁹⁹ are no more likely to have meaningful choices. The ACA marketplace in a given state (or the federal marketplace in states that have opted not to run their own) will probably only offer a few plans and the quality of coverage may vary significantly, particularly in states without a more expansive contraceptive mandate.²⁰⁰ Prohibitively high premiums may shrink the list of viable options even further.²⁰¹

Disturbingly, political resistance to federal regulation has weakened the already sparse availability of ACA-compliant health plans. Professor Katherine Vukadin has detailed the "obstructive federalism" crippling the ACA, where some states actively reject their role in its fulfillment due to the political motivations of their leaders, some of whom "actively want the ACA to fail."²⁰² While failure to expand Medicaid is the quintessential example, a new development in Georgia undermines the ACA even further. In November 2020, the Trump administration approved Georgia's application for a Section 1332 Medicaid "innovation" waiver that allows the state to exit the federal health insurance exchange without offering a state exchange in its place.²⁰³ This effectively forces more than 100,000 residents who previously used the exchange to shop directly for non-

¹⁹⁴ Katherine T. Vukadin, *Delayed and Denied: Toward an Effective ERISA Remedy for Improper Processing of Healthcare Claims*, 11 YALE J. HEALTH POL'Y, L. & ETHICS 331, 333, 336 (2011) [hereinafter Vukadin, *Delayed and Denied*].

¹⁹⁵ *Id.* at 336.

¹⁹⁶ *Id.* at 333.

¹⁹⁷ *Id.*

¹⁹⁸ Allison K. Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 1481, 1496 (2014).

¹⁹⁹ 8% of women ages 19–64 were covered by a health insurance plan purchased directly from a non-group market in 2019. KFF, *Women's Health Insurance Coverage*, *supra* note 7.

²⁰⁰ See Daniel McDermott & Cynthia Cox, *Insurer Participation on the ACA Marketplaces, 2014–2021*, KAISER FAM. FOUND. (Nov. 23, 2020), <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/> (documenting average of 5 insurers per state in 2021, with low of 3.5 in 2018 and peak of 6 in 2015, participation variance among states (with several states having only one insurer participating), and significant variance of insurer participation even within a given state).

²⁰¹ Salganicoff & Sobel, *supra* note 158, at 3 (discussing reports of coverage loss due to non-payment of premiums).

²⁰² Katherine T. Vukadin, *Obamacare Interrupted: Obstructive Federalism and the Consumer Information Blockade*, 63 BUFF. L. REV. 421, 445 (2015) [hereinafter Vukadin, *Obamacare Interrupted*].

²⁰³ Complaint at 2, *Planned Parenthood Southeast Inc. v. Azar* (D.D.C. 2021) (No. 1:21-cv-00117).

compliant coverage through private brokers and health insurance companies.²⁰⁴ Reproductive health providers have filed a federal lawsuit challenging the waiver, alleging that it will leave many facing higher premiums and resorting to the purchase of “non-ACA-compliant junk insurance plans with bare-bones coverage” which “often have blanket exclusions for basic health care services such as birth control” and “frequently fail to provide coverage for preventive care such as birth control, cancer screenings, and well-woman exams without out-of-pocket costs to patients.”²⁰⁵ The Trump Administration expanded access to two types of these “junk” plans, association health plans and short-term health plans, in yet another effort to undermine the regulatory protections offered by the ACA.²⁰⁶ The House Committee on Energy and Commerce recently conducted an investigation into short-term health insurance plans and found that they covered three million Americans in 2019, a 27% increase from 2018.²⁰⁷ The investigation concluded that the plans were “simply a bad deal for consumers.”²⁰⁸ They are certainly a bad deal for women. The committee found that “[a] number of insurers exclude coverage of contraception, including birth control pills, implants, injections, supply, treatment device or procedure.”²⁰⁹ One insurer, NHIC, denied a claim for contraceptive services, informing the claimant that “the plan does not include benefits for drugs or devices used directly or indirectly to promote or prevent conception.”²¹⁰ If allowed to stand, Georgia’s Medicaid waiver will only further constrain a woman’s “choice” of contraceptive coverage by forcing more women to purchase these plans and will likely provide a model for further restriction in other states.

Even if a woman had limitless options in an unconstrained insurance market, it would be nearly impossible for her to make an informed decision. Many scholars have pointed out that our market-based solution to healthcare suffers from at least one fatal flaw: imperfect information.²¹¹ Informed consumers are a cornerstone of the free market; the market cannot contain costs through competition if consumers are not making informed choices that provide a meaningful measure of value.²¹² In reality, “consumers” of healthcare rarely even know the price of healthcare products and services or have the necessary information on quality and efficacy to compare alternatives when making health care decisions.²¹³ Additionally, those with more serious health conditions may perceive a

²⁰⁴ *Id.*

²⁰⁵ *Id.* at 64.

²⁰⁶ Dylan Scott, *Trump’s Big New Proposal to Undercut the Affordable Care Act, Explained*, VOX (Jan. 4, 2018), <https://www.vox.com/policy-and-politics/2018/1/4/16849136/trump-association-health-plans-explained>; Dylan Scott, *Trump’s New Plan to Poke Holes in the Obamacare Markets, Explained*, VOX (Feb. 20, 2018), <https://www.vox.com/policy-and-politics/2018/2/20/17031640/short-term-insurance-trump-obamacare>.

²⁰⁷ H.R. COMM. ON ENERGY AND COMMERCE, *SHORTCHANGED: HOW THE TRUMP ADMINISTRATION’S EXPANSION OF JUNK SHORT-TERM HEALTH INSURANCE PLANS IS PUTTING AMERICANS AT RISK 6* (June 2020), <https://www.hsdl.org/?view&did=841078>.

²⁰⁸ *Id.* at 4.

²⁰⁹ *Id.* at 61.

²¹⁰ *Id.* at 73.

²¹¹ See, e.g., Lawrence Singer, *Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It*, 48 LOY. U. CHI. L.J. 703 (2017); Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241 (2010); Heled, Vertinsky & Brewer, *supra* note 99.

²¹² Singer, *supra* note 211, at 710.

²¹³ Heled, Vertinsky & Brewer, *supra* note 99, at 108.

lack of choice or be too incapacitated to make the appropriate decisions.²¹⁴ The health insurance market suffers from similar constraints:

In order to be autonomous market actors, consumers require health plan information that is "publicly available, understandable, and relevant to the decision-making process." In many markets other than health insurance, disclosure around quality occurs voluntarily In the health insurance market, however, important information about products is often not fully disclosed, or is confusing. As a result, consumers are unable to effectively compare health insurance products. And consumers may not buy the products they would have purchased if they had access to better information. The inability of consumers to compare plans skews the pricing of health plans: prices therefore do not reflect true consumer preference, demand, or willingness to pay because consumers do not understand what they are buying.²¹⁵

Further, many are unaware of the protections afforded to them by the ACA or believe the ACA has been repealed, leaving them unable to determine when a plan is non-compliant.²¹⁶ Thus, "consumers" remain uninformed about virtually every aspect of health care financing, yet the state relies on them to regulate the healthcare market.

Contraceptive coverage information is just as difficult to obtain or interpret. Studies in multiple states have found that insurers provide "false or misleading" or contradictory information on contraception coverage.²¹⁷ Coverage information is often difficult to locate or understand.²¹⁸ One study surveyed plan documents across five states and concluded that "[m]any of the publicly available documents do not clearly identify plan coverage rules when it comes to how different contraceptive methods are covered and the limitations of the coverage. This makes it extremely difficult, if not impossible for women in some plans to ascertain their coverage options. This also makes it difficult for women to determine coverage while comparing plans during open enrollment."²¹⁹ Advocates have found that plan documents may be "inappropriately silent regarding contraceptive benefits, such as the ability to obtain an off-formulary contraceptive without cost-sharing when medically appropriate or an OTC product when prescribed, such as the internal condom."²²⁰

While this illustrates a need for greater transparency, subjecting insurers to stricter disclosure laws would only partially solve the problem. A consumer may not know how to access disclosed information or may not be capable of interpreting or processing price and

²¹⁴ *Id.* at 112. See also Singer, *supra* note 211 at 716 (discussing the potentially unreasonable expectation that elderly or "frail" individuals locate and interpret health care cost information).

²¹⁵ Oechsner & Schaler-Haynes, *supra* note 211, at 245–46.

²¹⁶ Vukadin, *Obamacare Interrupted*, *supra* note 202, at 429.

²¹⁷ JoNel Aleccia, *Women Getting Bad Info on Birth-Control Coverage From ACA Insurers*, SEATTLE TIMES (Apr. 17, 2015, 6:52 AM), <https://www.seattletimes.com/seattle-news/health/women-seeking-birth-control-coverage-get-wrong-messages-from-insurers-survey-finds/>; EVERTHRIVE ILL. & U. OF CHI. SECT. OF FAM. PLANNING AND CONTRACEPTIVE RSCH., COVERAGE OF CONTRACEPTION AND ABORTION IN ILLINOIS' QUALIFIED HEALTH PLANS 8 (2015), https://ci3.uchicago.edu/wp-content/uploads/2020/09/Coverage-of-Contraception-and-Abortion-in-Illinois-QHPs_6.24.pdf [hereinafter EVERTHRIVE ILL.].

²¹⁸ EVERTHRIVE ILL., *supra* note 217, at 7–8.

²¹⁹ KFF, *Coverage of Contraceptive Services*, *supra* note 189, at 21.

²²⁰ McCaman, *Contraceptive Equity in Action*, *supra* note 164, at 18.

quality data.²²¹ Studies have shown that many do not understand standard insurance terms such as "deductible," "out-of-pocket spending cap," or "co-pay"²²² and that plan documents are often written at a reading level that is higher than the average person's comprehension.²²³ Many individuals simply find the required balancing between features of insurance plans such as premiums, cost-sharing, and network adequacy too complex and confusing.²²⁴ Choosing a plan requires consumers to predict the types of care that they may need in the future. This requires some knowledge of personal risk, yet studies show that people routinely underestimate their own risk of illness due to lack of understanding of contributing factors and/or general optimism.²²⁵ Simply requiring health insurers to make information available is unlikely to solve these problems.

Nonetheless, as explained above, the ACA recognized at least a minimal state responsibility to educate consumers on the complexities of plan purchase. However, once again, "obstructive federalism" is causing many states to shirk even this most basic duty. Unfortunately, political opposition to the ACA has caused some states to opt out of consumer education obligations and, in some cases, to actively burden federal efforts by imposing restrictions such as additional educational and licensing requirements and prohibitions on information dissemination.²²⁶ In so doing, these states significantly undermine the ACA's recognition of the importance of the informed consumer (albeit an impossible goal).

Thus, even if it were appropriate for the state to delegate such an essential public health matter as family planning to the private market, the "empowered consumer" in this scenario is clearly a myth. Most insured women have little to no choice of health plans and are subject to profit-motivated restrictions on contraceptive access that they cannot escape or "regulate" by simply choosing another insurer. Choice is a fiction that allows the state to shirk its responsibilities and places an impossible burden on individual women.

B. *The Burden of Enforcement*

While the state abandons women to the unrealistic usage of "purchasing power" to regulate contraceptive access, it also forces women to shoulder the burden when an insurer improperly denies a claim for contraceptive care. Insurers generally deny claims at an alarming rate; studies have shown that as many as one out of every six healthcare claims are denied.²²⁷ Under ERISA and ACA, claimants facing a denial must endure a

²²¹ See Singer, *supra* note 211, at 716 ("Even if a consumer wishes to secure price and quality information, however, their ability to appropriately interpret this data may be rudimentary at best."); Oechsner & Schaler-Haynes, *supra* note 211, at 246–47 (discussing difficulties consumers face in understanding health plan information).

²²² Vukadin, *Obamacare Interrupted*, *supra* note 202, at 456.

²²³ Oechsner & Schaler-Haynes, *supra* note 211, at 246–47.

²²⁴ *Id.*

²²⁵ *Id.* at 248. See also Lawrence, *supra* note 65, at 623 (discussing "behavioral biases" such as optimism, myopia, and projection bias identified as health insurance market failures in managed benefits literature).

²²⁶ Vukadin, *Obamacare Interrupted*, *supra* note 202, at 473–74.

²²⁷ Karen Pollitz & Daniel McDermott, *Claims Denials and Appeals in ACA Marketplace Plans*, KAISER FAM. FOUND. (Jan. 20, 2021), <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans> (analyzing required disclosures to determine that, on average, approximately 17% of in-network claims were denied in 2019 across HealthCare.gov issuers with complete data). See also Caroline E. Mayer, *The Claim Game*, AARP MAGAZINE, Nov.–Dec. 2009 (reporting a rate

complicated and burdensome appeals process that highly favors insurers. The state often fails to meet even its minimal obligations to assist during the appeals process or investigate complaints of improper denials. Once again, the regulatory burden falls on individual women.

As an initial matter, an overwhelming majority of healthcare claim denials, upwards of 90%, are never even appealed.²²⁸ This allows improper denials to stand unchallenged and unexposed. Professor Vukadin offers several possible reasons why a claimant may not appeal a claim denial. Initially, there is a “general human tendency” to remain with the default option (no action) even when that option is not beneficial.²²⁹ This is exacerbated in the context of health insurance where insurers may endorse the default option by, for example, using language such as “your responsibility” on bills.²³⁰ Additionally, as with choosing a plan, claimants may not question denials because they are unable to decipher plan documents to determine if the denial was improper.²³¹ They may also have difficulty understanding complex medical bills.²³²

A woman who does challenge improper denial of her claim for contraceptive care is faced with a complex and daunting administrative appeals process. Insurers, both private and Medicaid managed care, are required to maintain an internal appeals process, which must be exhausted before a claimant can file a lawsuit.²³³ Notably, internal appeals must be initiated within a specific time frame after initial denial, 180 days for private insurance and 60 days for Medicaid.²³⁴ While the ACA requires that insurers include information on the appeals process in denial notices,²³⁵ they may not always comply, leaving women to navigate complex procedural requirements and deadlines on their own.

After exhausting the internal appeals process, a claimant may initiate an independent external review through her insurer or her state’s insurance commissioner. The ACA significantly expanded access to this process with the goal of ensuring greater protection of “consumers” facing improper denials.²³⁶ Now, insurers of all private plans, including self-insured plans, must provide access to this type of review.²³⁷ Most states have their own external review processes that are subject to federal guidelines.²³⁸ Independent Review

of one in seven denials of initial claims across 1.4 billion claims submitted annually).

²²⁸ Vukadin, *Delayed and Denied*, *supra* note 194, at 338.

²²⁹ Katherine T. Vukadin, *Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Healthcare Claims*, 47 J. MARSHALL L. REV. 887, 907–08 (2014) [hereinafter Vukadin, *Unfinished Business*].

²³⁰ *Id.*

²³¹ *Id.* at 908–09.

²³² *Id.*

²³³ Luke Kalamas, *Piecing Together the Puzzle: Analyzing the Collision of the ACA and ERISA*, 33 HOFSTRA LAB. & EMP. L. J. 241, 265 (2016) (noting ERISA requirement as applies to employer-sponsored plans); McCaman, *Contraceptive Equity in Action*, *supra* note 164, at 23 (describing appeals process for Medicaid managed care).

²³⁴ McCaman, *Contraceptive Equity in Action*, *supra* note 164, at 21, 23.

²³⁵ CTR. FOR MEDICARE & MEDICAID SERV., INTERNAL CLAIMS AND APPEALS AND THE EXTERNAL REVIEW PROCESS OVERVIEW 9 (2021), <https://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf> [hereinafter CMS, INTERNAL CLAIMS AND APPEALS AND THE EXTERNAL REV. PROCESS OVERVIEW].

²³⁶ Kalamas, *supra* note 233, at 271.

²³⁷ *Id.*

²³⁸ See CMS, INTERNAL CLAIMS AND APPEALS AND THE EXTERNAL REV. PROCESS OVERVIEW, *supra* note 235, at 27 (identifying AL, AK, FL, GA, PA, TX, and WI as the only states that do not currently have their

Organizations (IRO) conduct external reviews and issue decisions that are binding on all parties.²³⁹

Unfortunately, there are several ways in which the external review process may still fail to “protect” “consumers” of contraception. First, external review seems to be geared towards denial of medical treatment rather than preventive care. Per federal regulations, only decisions concerning “medical judgment” or coverage rescission are reviewable by an IRO. “Medical judgment” includes, but is not limited to, medical necessity determinations and “[e]ffectiveness of a covered benefit.”²⁴⁰ As with medical necessity determinations, this narrow focus on medicine seems to preclude a consideration of the many social factors influencing one’s choice of contraception. Further, many states require that the independent reviewer of the claim denial “[b]e an expert in the treatment of the covered person’s medical condition that is the subject of the external review”²⁴¹ It is extremely unclear what type of “medical condition” a healthy woman needing family planning services would be deemed to have, let alone what credentials would qualify an “expert.” Additionally, advocates and scholars have questioned whether external reviewers can be unbiased.²⁴² IROs are private companies hired by the insurers denying the claim at issue.²⁴³ While insurers are required to rotate assignments between at least three reviewers to maintain impartiality, they are allowed to replace companies at will, an arrangement that seems to give insurers the upper hand.²⁴⁴ Lastly, while an arbitration-like external review can be preferable to expensive and time-consuming litigation, IROs are not required to make their decisions public and their decisions carry no precedential value.²⁴⁵ Thus, IROs are shielded from public scrutiny and future claimants are unable to benefit from prior decisions.

Assuming a privately insured woman can make it through this process and muster the necessary resources to file a lawsuit, she still faces serious hurdles in ERISA litigation. Significantly, there is a notable power imbalance between the parties. Insurers and their attorneys are much more familiar with the appeals process and the plan benefits than the average individual. Due to financial constraints, individuals are also much less likely to be represented by counsel.²⁴⁶ Those suffering from serious illness face time constraints that may lead them to accept bad settlements.²⁴⁷ In sum, the entire appeals process is heavily stacked against an individual claimant.

The process also imposes substantial burdens on women seeking contraceptive care. Importantly, it often results in a significant delay that compromises contraceptive care.

own external review processes and are thus subject to federally-administered external review).

²³⁹ Kalamas, *supra* note 233, at 271–72.

²⁴⁰ CMS, INTERNAL CLAIMS AND APPEALS AND THE EXTERNAL REV. PROCESS OVERVIEW, *supra* note 235, at 23.

²⁴¹ Several states have adopted this language from the Uniform Health Carrier External Review Model Act, written by the National Association of Insurance Commissioners and partially adopted by the U.S. Department of Labor. Unif. Health Carrier External Review Model Act § 13(B)(1). *See, e.g.*, 200 Mich. Pub. Acts 251 § 550.1919; Mont. Code Ann. § 33-32-417; LA Rev Stat § 22:2441.

²⁴² Vukadin, *Unfinished Business*, *supra* note 229, at 914.

²⁴³ *Id.*

²⁴⁴ *Id.*

²⁴⁵ *Id.* at 916.

²⁴⁶ *Id.* at 912–13.

²⁴⁷ Gideon Parchomovsky & Alex Stein, *Empowering Individual Plaintiffs*, 102 CORNELL L. REV. 1319, 1338–39 (2017).

Appeals can take several months to resolve.²⁴⁸ Add additional months or even years to this if the claim is litigated. There are significant financial burdens as well. If even feasible, women may pay for preferred contraception out-of-pocket, hoping to be reimbursed upon successful resolution of their appeal. They may also have to pay for attorneys during the administrative phase of the appeal.²⁴⁹ Worse yet, any damages suffered because of initial claim denial are not recoverable because ERISA does not authorize compensatory damages.²⁵⁰ Additionally, women must invest significant time and effort to gather medical records and comply with other evidentiary requirements during each phase of the appeal.²⁵¹

Some have proposed greater provider involvement to alleviate these burdens on individual women. Even if it were acceptable to continue placing responsibility solely on private individuals, there are several obstacles to implementation. Insurers often prohibit the assignment of appellate rights to other parties, preventing healthcare providers from appealing on behalf of their patients.²⁵² It is difficult for providers to even assist with appeals because they “do not have access to” the necessary policy documents or information concerning the appeals process.²⁵³ Even with the necessary knowledge, it is unclear if providers would have the time to provide meaningful assistance.²⁵⁴

Left to shoulder substantial burden alone, it is no wonder that large numbers of claimants drop out of the process at each level of appeal.²⁵⁵ Yet, overall, appeals are largely successful. Approximately half of challenged claim denials are reversed on appeal.²⁵⁶ Some portion of these denials undoubtedly result from mistakes, but given such an astonishing reversal rate, it is hard not to conclude that a significant portion of denials are profit driven. Indeed, evidence suggests that insurers are engaging in a number of bad faith tactics, including rewarding employees for denying claims, replacing employees who do not deny claims, and even engaging in fraudulent behavior like forging signatures on coverage waivers in order to avoid paying claims.²⁵⁷ ERISA does little to deter insurers from improperly denying claims in this manner and “effectively invites” bad faith strategic approaches to claims payment. Insurers have an “enormous” financial incentive to deny claims, yet “[u]nder the current approach, most non-compliance [with claims regulations] is excused under the “substantial compliance” doctrine, and even substantial departures from the claims regulations generally result in no substantive remedy.”²⁵⁸

²⁴⁸ Hoffman, *supra* note 109, at 57–58.

²⁴⁹ See Vukadin, *Delayed and Denied*, *supra* note 194, at 349 (noting that attorney’s fees are not recoverable during the administrative phase of the appeal).

²⁵⁰ *Id.* at 350.

²⁵¹ Jacobi, Ragone & Adams, *supra* note 172, at 134.

²⁵² Robert Armand Perez, Sr., *Defeating Healthcare Plan Denials*, 33 OHIO LAW. 18, 19 (2019).

²⁵³ *Id.* at 21.

²⁵⁴ *Id.*

²⁵⁵ Vukadin, *Unfinished Business*, *supra* note 229, at 910.

²⁵⁶ Vukadin, *Delayed and Denied*, *supra* note 194, at 338 (citing 2010 newspaper article). See also Hoffman, *supra* note 109, at 57 (“According to a 2011 federal government report, insurance denial reversals ranged between 39 and 59 percent on internal appeal, with an additional 23 to 54 percent reversed or revised as a result of external appeals[.]”); Pollitz & McDermott, *supra* note 227 (analyzing required disclosures to determine that Healthcare.gov insurers upheld 60% of appealed in-network claims in 2019).

²⁵⁷ Everett Kimball, *Tricks of the Trade: How Insurance Companies Deny, Delay, Confuse and Refuse*, AM. ASS’N FOR JUST. 2 (Jan. 21, 2010, 9:20 PM),

https://thehill.com/sites/default/files/aaj_insurancetactics_0.pdf.

²⁵⁸ Vukadin, *Delayed and Denied*, *supra* note 194, at 334–35.

Not only is the state abandoning women to a David versus Goliath-style fight against unfair claim denials, but it is also failing to fulfill even the most basic enforcement obligations. Claim denials are appealable to each state’s Department of Insurance (DOI) or the United States Department of Labor (DOL) if the plan is self-insured (due to ERISA preemption).²⁵⁹ This avenue of enforcement should be highly preferable to the individualized appeals process because it alleviates much of the burden on individual women and has the potential to effect mass change. In practice, however, these agencies are failing to adequately investigate complaints. Callers to NWLC’s CoverHer hotline have reported several failures to resolve complaints regarding contraceptive coverage.²⁶⁰ For example, the DOL was unable to resolve women’s complaints when their insurers improperly denied coverage of the vaginal contraceptive ring. Women in several states reported similar coverage issues to their state DOIs and were met with refusal to investigate.²⁶¹ Additionally, “obstructive federalism” has hobbled enforcement in most states. The state consumer assistance centers envisioned by the ACA were intended to aid with appeals as well as provide information on plan choice.²⁶² Twenty-three states have not even put these programs in place, leaving many without even basic government assistance in filing their own appeals.²⁶³ Worse yet, by refusing to put the centers in place, states are missing an opportunity to collect information from consumers for enforcement purposes, hampering their ability to regulate insurers.²⁶⁴

Thus, the state allows and even incentivizes insurers to improperly deny claims while abandoning women to fight these denials alone. This is hardly the sort of enforcement necessary to meet the state’s responsibility for adequate contraceptive access.

C. Bearing the Consequences

Not only are women bearing the burden of enforcement alone, but they are also left to shoulder the extreme consequences of unintended pregnancy when their efforts to procure contraception fail. Because contraception and pregnancy are framed as the products of individual choice, unintended pregnancy is viewed as a personal failure. Rather than holding the state accountable for the myriad ways in which it has failed to meet its family planning obligations by underregulating insurers, the pregnant woman is held entirely responsible for managing the pregnancy and its outcome. When the state does get involved, the response is often punitive and stigmatizing, targeting women who make “bad choices” that may cause harm to the fetus.

Contraception is one of many public health matters that have long been subject to narratives of individual responsibility. Professor Lindsey Wiley has noted that, despite “[o]ur increasingly collective approach to ensuring health care access,” there remains

²⁵⁹ McCaman, *Contraceptive Equity in Action*, *supra* note 164, at 21–22 (describing the process for appeals and complaints with state DOIs); NWLC, *State of Birth Control Coverage*, *supra* note 166, at 11 (stating that DOL regulates self-funded coverage).

²⁶⁰ NWLC, *State of Birth Control Coverage*, *supra* note 166, at 11–12.

²⁶¹ *Id.*

²⁶² Vukadin, *Obamacare Interrupted*, *supra* note 202, at 433–34.

²⁶³ See *Consumer Assistance Program (CAP Grants)*, CTRS. FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/ccio/resources/consumer-assistance-grants> (last visited Aug. 2, 2021) (listing states without Consumer Assistance Programs).

²⁶⁴ Vukadin, *Obamacare Interrupted*, *supra* note 202, at 433–34, 461–62.

“deep disagreement” about whether the root causes of poor health “are a matter of collective responsibility or personal responsibility.”²⁶⁵ Serious illnesses such as cancer and heart disease are framed as individual failure to engage in preventive activities like eating well and exercising.²⁶⁶ Medicaid incentive programs and SNAP restrictions on unhealthy food disproportionately place individual responsibility on low-income people of color.²⁶⁷ Similarly, some states once conditioned receipt of public assistance on the usage of LARCs, a form of “reproductive coercion” that some have likened to sterilization laws of the early twentieth century.²⁶⁸ Additionally, some opponents of the ACA have argued that the public should not have to bear the cost of insuring those with preexisting conditions because they “typically result from irresponsible conduct.”²⁶⁹ Unsurprisingly, contraception as preventive care is subject to the same framing. For example, conservative political commentators are quick to oppose social responsibility for family planning because they view sexuality as a matter of individual choice, and women can simply choose to have sex less frequently if they cannot afford to buy contraception on their own.²⁷⁰

This pervasive focus on individual choice and individual responsibility precludes state responsibility for unintended pregnancy. While the ACA’s contraceptive mandate was an important step in recognizing public responsibility for family planning, a woman is clearly on her own once the state fails to meet this obligation.²⁷¹ Abortion access is constantly threatened with political attack and the need for an abortion is certainly not constructed as a failure of the state to provide appropriate contraception. If an unintended pregnancy is carried to term, women and their families are left to manage the pregnancy and raise the child without adequate support from the state.²⁷²

Instead, the state is confined to a punitive role. In what is, at best, a misguided attempt to improve birth outcomes, the state is increasingly criminalizing pregnancy.²⁷³ A study analyzing data from 1973 to 2005 found 413 women had been subjected to state action due to their behavior during pregnancy, either by criminalization or forced intervention.²⁷⁴ These charges rarely seem justified by actual harm. No adverse pregnancy outcomes were reported in two out of three overall cases in the study and many cases were brought solely on the basis of possible harm.²⁷⁵ A large majority of these criminal cases involved

²⁶⁵ Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL’Y 47, 96 (2014).

²⁶⁶ *Id.*

²⁶⁷ *Id.* at 97–98.

²⁶⁸ NWHN Staff, *Policy Issues: Long-Acting Reversible Contraceptives (LARCs)*, NAT’L WOMEN’S HEALTH NETWORK (May 30, 2019), <https://nwhn.org/larcs/>.

²⁶⁹ Govind Persad, *Choosing Affordable Health Insurance*, 88 GEO. WASH. L. REV. 819, 829 (2020).

²⁷⁰ Skinner, *supra* note 169, at S52.

²⁷¹ For example, the Center for Disease Control and Prevention (CDC)’s “Recommendations to Improve Preconception Health” summarily reflects this total abdication of state responsibility for maternal and fetal outcomes in unplanned pregnancies. The first two recommendations are “Individual Responsibility Across the Lifespan” and “Consumer Awareness.” Kay Johnson, Samuel F. Posner, Janis Biermann, José F. Cordero, Hani K. Atrash, Christopher S. Parker, Sheree Boulet & Michele G. Curtis, *Recommendations to Improve Preconception Health and Health Care — United States*, 55 CDC MORBIDITY & MORTALITY WKLY. REP. 1, 1 (Apr. 21, 2006), <https://www.cdc.gov/mmwr/pdf/rr/rr5506.pdf>.

²⁷² For a discussion regarding privatization of birth and caretaking, see Hickey, *supra* note 27.

²⁷³ Cortney Lollar, *Criminalizing Pregnancy*, 92 IND. L.J. 947 (2017).

²⁷⁴ Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL. POL’Y & L. 299, 299 (2013).

²⁷⁵ *Id.* at 318.

allegations of illegal drug use.²⁷⁶ Pregnant women have been criminally charged for drug use during pregnancy under a number of state laws that essentially grant legal status to the fetus, including assault, chemical endangerment of a child, criminal neglect, delivery of drugs to a minor, and involuntary manslaughter.²⁷⁷ Again, a vast majority of these charges were brought despite no showing of harm to the fetus. Further, these laws do not seem to reflect scientific understanding of the “relatively small and short-term” effects of drug use on fetuses.²⁷⁸

Women are also increasingly facing punishment for miscarriage or stillbirth.²⁷⁹ It is estimated that several hundred U.S. women have been prosecuted for pregnancy outcomes.²⁸⁰ For example, in 2018, an Alabama woman was indicted by a grand jury for manslaughter after losing her 5-month-old fetus to a gunshot wound. While the person who shot her was not criminally charged, she faced a severe prison sentence for being involved in a fight while pregnant.²⁸¹ Similarly, women have faced criminal charges for manslaughter or feticide due to failure to wear a seatbelt during a car accident, attempting suicide, and even accidentally falling down the stairs.²⁸² Women have even faced criminal charges for giving birth to stillborn babies at home, absent any evidence that the fetuses died of unnatural causes, under statutes that criminalize concealing a birth or death.²⁸³

Punitive state responses such as these cause substantial harm to pregnant women and their families. Prison conditions can be harmful to the health of pregnant and birthing women. Incarceration harms the families that these women leave behind. The involvement of child welfare authorities can interrupt crucial maternal-newborn bonding and have devastating effects on the entire family, subjecting them to surveillance and scrutiny that could ultimately lead to removal of the child from the home and termination of parental rights.²⁸⁴ The justifiable fear of punishment creates a harmful deterrent effect. Some women may not seek help for addiction, or even prenatal care at all, for fear that physicians will report drug or alcohol use or other potentially “bad” behavior to the state.²⁸⁵ Lack of prenatal care can cause substantial harm to both mother and fetus. This fact alone should prompt serious reconsideration of punitive approaches.

Thus, the message is clear: it is almost entirely the responsibility of the individual woman to avoid unwanted pregnancy, she is fully to blame for any adverse pregnancy outcome that may result from her failure to properly plan, and she should be punished by the state for this failure. We should expect more from the state, and we must begin by calling for the meaningful fulfillment of its obligation to support family planning.

²⁷⁶ *Id.*

²⁷⁷ Lollar, *supra* note 273, at 949.

²⁷⁸ *Id.* at 954.

²⁷⁹ Stillbirth is defined as the loss of a pregnancy after twenty weeks.

²⁸⁰ N.Y. Times Editorial Board, *Opinion: A Woman’s Rights Series: When Prosecutors Jail a Mother for a Miscarriage*, N.Y. TIMES (Dec. 28, 2018), <https://www.nytimes.com/interactive/2018/12/28/opinion/abortion-pregnancy-pro-life.html>.

²⁸¹ Ava B., *When Miscarriage is a Crime*, PLANNED PARENTHOOD ADVOCATES OF ARIZ. BLOG (Jul. 29, 2019), <https://www.plannedparenthoodaction.org/planned-parenthood-advocates-arizona/blog/when-miscarriage-is-a-crime>.

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 747 (2018).

²⁸⁵ Lollar, *supra* note 273, at 991–92.

IV. TOWARDS A RESPONSIVE STATE: A VULNERABILITY APPROACH

How might we achieve meaningful state support for family planning? This Section first provides a theoretical framework for establishing state responsibility for contraception and then suggests several actions that a more responsive state could take to improve equitable access to contraception.

A. *From Restrained to Responsive*

While enactment of the ACA's contraceptive mandate firmly establishes social responsibility for contraception, the implementation is still highly individualistic. The state attempts to fulfill its obligation for family planning by emphasizing individual marketplace choice and minimally regulating insurers under the guise of individual consumer protection. This consumer protection focus absolves the state of responsibility for family planning, placing the burden of access and enforcement on individual women and their families while targeting only the most flagrantly abusive behaviors of insurance companies. Through this abdication of responsibility by the state, women are falsely framed as unencumbered consumers who can freely shape their family planning experiences through market participation and thus do not need the state's support. The concomitant emphasis on individual responsibility justifies a punitive state response when a woman "fails" to navigate the contraceptive market properly and experiences an unintended pregnancy.

Traditional arguments for equitable and enhanced contraceptive access are grounded in claims of Constitutional rights to reproductive freedom.²⁸⁶ Unfortunately, this rhetoric of individual rights, rooted in privacy jurisprudence, focuses only on restraining the state from interfering with a woman's reproductive decisions. It imposes no positive obligations on the state. Instead, rhetorical focus on individual reproductive choice affirms the state's problematic abdication of responsibility for contraception to the marketplace and its placement of blame for unintended pregnancy on individual women. Further, advocating for contraception as a private individual choice fuels political and social arguments against public funding and obscures the widespread social harm that results from inadequate access to contraception.

²⁸⁶ See, e.g., Neil S. Siegel & Reva B. Siegel, *Contraception as a Sex Equality Right*, 124 YALE L.J.F. 349 (2015), <http://www.yalelawjournal.org/forum/contraception-as-a-sex-equality-right> (arguing that the Constitutional "right to contraception" is grounded in the principle of sexual equality as well as liberty); NWLC, *COVID Issue Brief*, *supra* note 24, at 1 ("The right to access birth control is enshrined in the U.S. Constitution and a range of state and federal laws. These legal protections are grounded in the principle that birth control and the ability to determine if and when to have children are inextricably tied to one's wellbeing, equality, and ability to determine the course of one's life."); Sonfield, *Fragmented System*, *supra* note 34, at 1 (arguing for comprehensive coverage of contraception because "[b]irth control is central to people's reproductive autonomy and their ability to control whether and when to become pregnant"); Colleen P. Judge, Tierney E. Wolgemuth, Megan E. Hamm & Sonya Borrero, "Without Bodily Autonomy We Are Not Free": Exploring Women's Concerns About Future Access to Contraception Following the 2016 U.S. Presidential Election, 96 CONTRACEPTION 370, 374 (2017) (finding that concerns of survey participants "centered on the overarching theme that bodily autonomy and reproductive autonomy are fundamental human rights and that access to affordable contraception and abortion is vital to the preservation of these rights.").

A better approach to establishing state responsibility for family planning would reframe state involvement as proactive, positive, and supportive rather than punitive and reactionary. Vulnerability theory offers such an approach.²⁸⁷ Vulnerability theory begins with the recognition that, as embodied beings who are constantly susceptible to changes in our physical and social well-being, we are all universally vulnerable.²⁸⁸ The severely restrained state can play only a limited role in protecting the autonomous, independent, and self-sufficient legal subject from any constraint on the exercise of her autonomy.²⁸⁹ In contrast, vulnerability theory requires a responsive state that affirmatively addresses the vulnerability of its subjects.²⁹⁰ It does so by providing its citizens with the resources needed to maintain resilience in all life stages in a just and equitable manner.²⁹¹

A vulnerability approach thus imposes positive obligations on the state to provide contraception as a form of resilience, rather than allowing the state to abdicate responsibility to individual women under a limited “consumer protection” role. This shifts the focus from providing access to a minimally regulated insurance market to providing holistic support for family planning, including the social and economic support needed to address unintended pregnancy. This recognition allows us to move beyond the myth that contraception is solely the product of private medical decisions made between a woman and her provider and require the state to consider the myriad social and economic factors influencing family planning.

The COVID-19 pandemic illustrates the need for a holistic state response. The pandemic’s enormous financial and social impacts on all aspects of family planning demonstrate the shortcomings of a narrow consumer-oriented approach to contraception. The resulting economic recession has left millions without health insurance due to job loss, particularly women.²⁹² Further, many women have been unable to access a provider or pharmacy to obtain contraception due to pandemic-related closures and transportation difficulties. In a recent national survey, 33% of women experienced a delay or cancellation of reproductive health care during the pandemic.²⁹³ It is not enough to simply ensure that these women can make “informed” choices about health insurance and contraception when their choices are so severely constrained.

The state made a deliberate choice to involve private insurers and cannot simply delegate responsibility for family planning without additional oversight. The ACA certainly did not have to tie distribution of contraception to the for-profit insurance model. Yet rather than reviving direct public funding of contraceptive care through something like the Title X program,²⁹⁴ the ACA further delegated fulfillment of this important public

²⁸⁷ See generally Fineman, *The Vulnerable Subject*, *supra* note 9.

²⁸⁸ Martha Albertson Fineman, *Injury in the Unresponsive State: Writing the Vulnerable Subject into Neo-Liberal Legal Culture*, in *INJURY AND INJUSTICE: THE CULTURAL POLITICS OF HARM AND REDRESS* 50, 58 (Anne Bloom, David M. Engel & Michael McCann eds., 2018).

²⁸⁹ *Id.* at 66–67.

²⁹⁰ *Id.*

²⁹¹ *Id.* at 63–64.

²⁹² NWLC, *COVID Issue Brief*, *supra* note 24, at 2.

²⁹³ Lindberg, VandeVusse, Mueller & Kirstein, *supra* note 25, at 9.

²⁹⁴ The Title X program, the state’s first recognition of the importance of family planning, has increasingly relied on private insurance for funding. Title X funding has declined significantly since its peak in 1980, requiring Title X clinics to rely on public and private insurance reimbursement. INST. OF MED., *supra* note 28, at 10–11. Today, 20% of Title X patients are covered by private insurance, a significant increase from 8% in 2009. Fowler, Gable, Lasater & Asman, *supra* note 30, at A-18.

health responsibility to the private insurance market. So long as private insurers remain involved in fulfilling this public responsibility, the state must closely monitor and regulate the discretion afforded them in making public decisions regarding coverage of various contraceptive methods.²⁹⁵ Further, the egregious lack of transparency in insurance practices is not merely a matter of consumer protection. We must recognize that insurers are making public policy when they decide to impose cost-sharing or other burdensome requirements on a particular contraceptive or to deny medical necessity waivers for a preferred contraceptive. Therefore, lack of enforcement and disclosure requirements inhibits the public accountability and transparency that is crucial to democracy. The state is obligated to act where insurers are in clear violation of existing law and to ensure that the public has enough information to hold insurers accountable for failure to vindicate public values.

B. From Individual to Institutional

The ACA's relentless individualism forecloses a necessary examination of the institutional constraints motivating insurer conduct. Instead, vulnerability theory allows us to expand beyond the autonomous individual and closely examine societal institutions. Institutions are the central way that society provides resources to individuals, allowing them to fulfill social roles and contribute to the healthy reproduction of society.²⁹⁶ Thus, vulnerability theory requires the state to monitor and regulate the ways in which power and privilege may be conferred unequally within social institutions and relationships.²⁹⁷ Under this approach, the state is obligated to closely examine insurance practices and policies that create significant inequities in contraceptive access.

At the same time, it is important to recognize that institutions themselves are vulnerable to internal and external corruption and change and must be actively monitored and updated by the state because of this vulnerability.²⁹⁸ Thus, the state must assess power imbalances between insurers, providers, pharmaceutical companies, employers, and patients. In contrast to an individualistic focus on consumer protection or reproductive rights, a vulnerability approach allows us to consider the interests of all stakeholders, including the insurers. Under this approach, we can examine how the state can and should respond to the institutional, physical, social, and economic conditions that constrain corporate and governmental behavior. It is not enough simply to increase enforcement or enact stricter regulation. Insurers' institutional vulnerabilities must be addressed if we continue to make them responsible for meeting public goals. State vulnerability must also be addressed to pave the way for meaningful solutions.

1. The Vulnerable Insurer

As private corporations, insurers are inherently vulnerable by nature of their dependence upon profit generation.²⁹⁹ While managed care undoubtedly burdens access to

²⁹⁵ See Fineman, *supra* note 288, at 67 (“Because societal institutions are so vitally important, both to individuals and to society, their flaws, barriers, gaps, and potential pitfalls must be monitored, and these institutions must be adjusted when they are functioning in ways harmful to individuals and society.”).

²⁹⁶ See *id.*

²⁹⁷ See *id.*

²⁹⁸ See *id.* at 58–59.

²⁹⁹ *Id.* at 69.

contraception, some amount of cost containment in health insurance is necessary due to the enormous cost of health care in the U.S. This Section provides an analysis of some of the institutional vulnerabilities that also motivate the use of cost-saving techniques.

a. Harm Caused by the ACA

By placing the responsibility for equitable contraceptive access on private insurers, the ACA is asking them to fulfill a fundamental public health goal that is arguably incompatible with the primary corporate obligation to maximize shareholder value. At the same time, the state has crippled their ability to meet either of these obligations in several ways. Scholars have noted the degree to which enactment of the ACA transformed health insurance from a traditional risk-spreading device to a financier of care more akin to social insurance.³⁰⁰ Unfortunately, this transformation was hardly recognized, much less supported, by the state. The ACA imposed enormous public responsibility on insurers while failing to address the many ways in which its corresponding consumer protections threatened insurers' livelihoods.

First, the ACA prohibited long-standing practices of risk classification. Insurance traditionally functions by attempting to spread risk across large groups to keep costs low.³⁰¹ This inherently involves classifying individuals and groups according to risk.³⁰² A major goal of the ACA was to prohibit insurers from denying coverage or increasing premiums based on individual risk classification.³⁰³ As a result, insurers are prohibited from denying or dropping coverage because of preexisting conditions, medical history, or medical status.³⁰⁴ Insurers on the individual and small-group markets are also not allowed to charge higher premiums based on gender or health status and are prohibited from charging significantly higher premiums based on age.³⁰⁵ These prohibitions were important public health gains. They significantly increased access to insurance by disallowing the consideration of preexisting conditions and the practice of charging women higher premiums due to their likely need for reproductive care. However, as a result, insurers were forced to insure a much larger segment of potentially high-risk individuals with less ability to vary premium rates according to risk. And while the ACA imposes no upper limit on premiums, plans cannot expect to remain competitive if they implement significant across-the-board premium hikes.

Second, Congress did not do enough to ensure necessary participation. It is well-recognized that a system requiring insurers to accept anyone who applies regardless of health status requires nearly universal participation.³⁰⁶ Otherwise, young healthy people would only purchase insurance when they became sick or aged, a phenomenon known as adverse selection.³⁰⁷ Self-selection of the riskiest individuals for enrollment in insurance

³⁰⁰ See, e.g., Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 438 (2010).

³⁰¹ *Id.* at 439–41.

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ *Id.*

³⁰⁶ See *id.* at 438; Summer B. Kasem, *The PPACA is Just a Band-Aid: Healthcare Reform Cannot Be a One-Sided Solution*, 42 S. L. REV. 205, 211–13 (2015) (discussing the importance of the individual mandate).

³⁰⁷ Lawrence, *supra* note 65, at 621–22.

plans is considered “adverse” to the insurer and marketplace.³⁰⁸ In such a scenario, insurers are forced to increase premiums and other costs to meet the increased care needs of the riskier pool.³⁰⁹ To combat this, the ACA originally contained an Individual Mandate, which required most individuals to either purchase insurance or pay a penalty.³¹⁰ However, after a protracted legal and political battle, Congress effectively killed the Individual Mandate in 2017 by reducing the penalty amount to \$0.³¹¹ Thus, healthier individuals have significantly less incentive to participate in the insurance market, forcing insurers to spread risk across a smaller pool.

Third, the ACA placed caps on administrative spending that could harm smaller insurers. The ACA effectively capped insurer profits by imposing minimum medical loss ratio (MLR) requirements.³¹² The MLR is the percentage of premium revenue spent on patient care and efforts to improve the quality of patient care.³¹³ If an insurer spends above a certain threshold, typically 15-20% of premium revenue, on anything else (such as administrative costs or salaries), it must issue rebates to its customers. This requirement resulted in significant customer gains. From 2011-2017, insurers refunded \$4 billion to policyholders.³¹⁴ Unfortunately, some insurers resort to unethical tactics to avoid issuing rebates. A recent study found that approximately 14% of insurers strategically over-estimate to avoid rebates, costing policyholders hundreds of millions of dollars.³¹⁵ While there is certainly no excuse for circumventing the law in this manner, the motivation to do so may be understandable. The MLR does not just restrict “windfall profits”³¹⁶ but also restricts arguably legitimate administrative spending. Indeed, opponents of the MLR argued vigorously that the requirement would force many insurers out of the market, particularly small insurers, which tend to have a higher percentage of administrative costs.³¹⁷ This problem is further exacerbated by the increased expense of administering the MLR itself.³¹⁸ Thus, while some insurers may be opportunistically circumventing the law solely to boost profits, others may simply be resorting to drastic measures to remain solvent.

Last, the ACA required insurers to make enormous expenditures by mandating no-cost coverage of preventive services. Naturally, requiring insurers to cover a host of

³⁰⁸ *Id.*

³⁰⁹ *Id.*

³¹⁰ Kasem, *supra* note 306, at 212–13.

³¹¹ Rabah Kamal, Cynthia Cox, Rachel Fehr, Marco Ramirez, Katherine Horstman & Larry Levitt, *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums*, KAISER FAMILY FOUND. ISSUE BRIEF 1 (Apr. 2018), <https://files.kff.org/attachment/Issue-Brief-How-Repeal-of-the-Individual-Mandate-and-Expansion-of-Loosely-Regulated-Plans-are-Affecting-2019-Premiums>.

³¹² Wesley D. Markham, *Healthcare Reform’s Mandatory Medical Loss Ratio: Constitutionality, Policy, and Implementation*, 46 U.S.F. L. REV. 139, 143 (2011).

³¹³ *Id.* at 141.

³¹⁴ Evan M. Eastman, David L. Eckles & Andrew Van Buskirk, *Accounting-Based Regulation: Evidence from Health Insurers and the Affordable Care Act*, 96 ACCOUNT. REV. 231, 232 (2021).

³¹⁵ *Id.*

³¹⁶ Markham, *supra* note 312, at 169 (quoting Representative James R. Langevin: “[The bill] will require all insurers to reinvest more of our premiums back into health coverage through a ‘medical loss ratio’ of at least 80 percent, ensuring that no more than 20 percent of our premiums go toward administrative expenses and windfall profits for insurance executives.”).

³¹⁷ *Id.* at 170–71.

³¹⁸ *Id.*

services, drugs, and devices without cost-sharing could impose an enormous financial strain. While it has been argued that focusing on prevention might ultimately save money, the evidence is mixed as to whether covering preventive services generally saves insurers from the resulting costs of more expensive treatments down the road.³¹⁹ Additionally, our system of employment-based insurance disincentivizes this sort of long-term strategy, as a change in employment status often triggers a change in insurer, such that the insurer funding the preventive care may not reap the long-term benefits.³²⁰ In sum, these requirements are very likely to impose significant profit loss without some sort of compensating measure.

The ACA imposed a significant financial burden upon private insurers. Requiring insurers to cover individuals and services that they would not normally cover forces insurers to either raise premiums, increase cost-sharing, or deny coverage elsewhere.³²¹ Studies support this, showing a modest increase in premiums,³²² significant increase in across-the-board cost-sharing,³²³ and increased narrowing of networks since implementation of the ACA.³²⁴ Insurers can only raise premiums so much if they wish to remain competitive and it may be difficult to reduce administrative costs or payments to providers. Therefore, insurers must primarily rely on cost-sharing and utilization management techniques that limit or discourage the usage of unnecessary or expensive treatments.³²⁵

Additionally, insurers may consider merging to remain solvent, a move that could increase consumer costs and decrease quality of care by reducing market competition.³²⁶ A prominent example of this is the 2015 attempted merger of Aetna and Humana. After the Department of Justice moved to block the merger, the CEO of Aetna sent a letter of intent to withdraw from the health insurance exchanges if the merger was disallowed.³²⁷ While many viewed the letter as a threat, Aetna claimed they were losing money and simply could not afford to remain on the exchanges without additional resources.³²⁸ The merger was ultimately struck down in federal court on antitrust grounds, due to concern that the

³¹⁹ Mariner, *supra* note 300, at 447. However, there is strong evidence that full coverage of contraception saves money compared to the costs associated with unintended pregnancy. See James Trussell, Anjana M. Lalla, Quan V. Doan, Eileen Reyes, Lionel Pinto & Joseph Gricar, *Cost Effectiveness of Contraceptives in the United States*, 79 CONTRACEPTION 5 (2009).

³²⁰ Hoffman, *supra* note 198, at 48.

³²¹ Mariner, *supra* note 300, at 445–46.

³²² Rachel Fehr, Cynthia Cox, Larry Levitt & Gary Claxton, *How Affordable are 2019 ACA Premiums for Middle-Income People?*. KAISER FAM. FOUND. (Mar. 5, 2019), <https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people> (reporting that premiums for those enrolled in marketplace plans “increased significantly” between 2015 and 2018).

³²³ Lawrence, *supra* note 65, at 601 (“The years since the enactment of the ACA have seen a dramatic across-the-board increase in cost-sharing that cannot be explained by abusive practices alone.”).

³²⁴ Sabrina Corlette, JoAnn Volk, Robert Berenson & Judy Feder, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, GEO. UNIV. CTR. ON HEALTH INS. REFORMS & URB. INST. (2014),

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643.

³²⁵ Mariner, *supra* note 300, at 446.

³²⁶ Jacqueline C. Lien, *Bad Behavior: Health Insurance Mega-Mergers*, 15 HASTINGS BUS. L.J. 129, 138–39 (2019). See also Lawrence, *supra* note 65, at 623 (“In the absence of a competitive insurance market insurers have diminished incentive to offer plans that reduce net costs for insureds.”).

³²⁷ Lien, *supra* note 326, at 131–32.

³²⁸ *Id.*

deal would lessen competition on the individual insurance marketplace and thus allow the combined entity to raise prices or reduce benefits.³²⁹ While this decision may have been best for patients, it is worth considering the motivations of many insurers attempting such mergers shortly after implementation of the ACA.³³⁰ Aetna did in fact pull out of most of the state exchanges in 2017 and completely exited all exchanges in 2018, “projecting around \$225 million in losses from its exchange plan businesses this year following a loss of \$700 million for 2014 through 2016.”³³¹ It is certainly possible that the attempted merger was an effort to save the business.³³²

Thus, while utilization management and premium increases undoubtedly burden contraceptive access, insurers may have to use these cost-containing measures because the state gave them enormous public responsibility without the necessary assistance.

b. Big Pharma

Rising pharmaceutical costs have been the subject of intense academic and political scrutiny.³³³ Pharmacy Benefit Managers (PBMs) especially are receiving increased attention in this ongoing debate. Many have rightfully criticized the conflicts of interest inherent in PBM structure that can lead to higher prices for the consumer. Foremost, PBMs negotiate with drug manufacturers for rebates on drugs rather than negotiating for discounted prices.³³⁴ The retrospective nature of such rebates increases the likelihood that the cost-savings will not be passed onto the consumer.³³⁵ This is exacerbated by a marked lack of transparency.³³⁶ Further, rebates are typically paid as a percentage of a drug’s list price, which incentivizes PBMs to select more expensive drugs for formularies or to encourage increased list prices.³³⁷ Evidence suggests that this incentive is reciprocal, as manufacturers are motivated to increase drug prices to compensate for the expense of rebates.³³⁸ Additionally, PBMs that include pharmacies, such as CVS-Caremark, are incentivized to steer pharmacy customers to higher-cost drugs to maximize profits.³³⁹

While all of this is cause for concern, it is also worth examining the ways in which

³²⁹ Reed Abelson and Leslie Picker, *Judge Blocks Aetna’s \$37 Billion Deal for Humana*, N.Y. TIMES (Jan. 23, 2017), <https://www.nytimes.com/2017/01/23/business/dealbook/aetna-humana-deal-blocked.html>.

³³⁰ *Id.* (reporting the “frenzy of deal making” among insurers after enactment of the ACA).

³³¹ Deena Beasley, *Aetna Fully Exits Obamacare Exchanges with Pull-out in Two States*, REUTERS (May 10, 2017), <https://www.reuters.com/article/us-aetna-obamacare/aetna-fully-exits-obamacare-exchanges-with-pull-out-in-two-states-idUSKBN1862XK>.

³³² One study suggests that insurer profitability on the exchange has improved since 2017, when “insurance company losses led to a number of high profile exits from the market.” McDermott & Cox, *supra* note 200.

³³³ See Nisha Kurani & Cynthia Cox, *What Drives Health Spending in the U.S. Compared to Other Countries*, PETERSON-KFF HEALTH SYS. TRACKER (Sept. 25, 2020), <https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/> (discussing 2018 findings that the United States spends significantly more per capita (\$1,397) on prescription drugs than comparable countries (\$884) and policy proposals to address the high cost of prescription drugs).

³³⁴ Shepherd, *supra* note 101, at 376–78 (2019).

³³⁵ *Id.*

³³⁶ *Id.*

³³⁷ *Id.*

³³⁸ *Id.* at 378; Ralf Boscheck, *Pharmacy Benefit Managers: Fixing Healthcare Market Failures or Straining Regulatory Logics*, 40 WORLD COMPETITION 459, 460 (2017).

³³⁹ Boscheck, *supra* note 338, at 460.

this structure leaves PBMs vulnerable to the profit-maximizing efforts of pharmaceutical companies. First, insurers are undoubtedly impacted by the enormous cost of prescription drugs. The pharmaceutical industry is one of the most profitable in the nation,³⁴⁰ with profit margins that far exceed those of the health insurance industry.³⁴¹ High drug prices are often justified by the need for innovation. However, many have criticized this rationale, particularly where evidence suggests they are spending more on advertising than on research and development.³⁴² Additionally, some companies spend more on stock buybacks, dividends, and executive compensation than research and development.³⁴³ Recently, Congressional committee members questioned a pharmaceutical CEO's rationale for increasing the price of its top-selling drug Humira to a whopping \$77,000 per annual supply.³⁴⁴ Noting the CEO's own \$24 million annual salary and the \$50 billion spent on stock buybacks and dividends in a five-year period, Representative Katie Porter confronted the CEO about the "Big Lie":

You're spending all this money to make sure you make money rather than spending money to invest in [and] develop drugs and help patients with affordable, lifesaving drugs You lie to patients when you charge them twice as much for an unimproved drug, and then you lie to policymakers when you tell us that [research and development (R&D)] justifies those price increases The Big Pharma fairy tale is one of groundbreaking R&D that justifies astronomical prices. But the pharma reality is that you spend most of your company's money-making money for yourself and your shareholders.³⁴⁵

Pharmaceutical companies place additional pressure on insurers by creating patient demand for expensive drugs through a combination of coupon programs and direct-to-consumer advertising. First, drug manufacturers issue coupons to patients to try their products at sharply discounted rates, but unbeknownst to the patient and the prescribing physician, the patient's insurer may not cover the cost of the drug once refills are needed.³⁴⁶ Professor Michelle Mello recounted her story of receiving a coupon from a physician for her son to try Auvi-Q, an alternative to the popular epinephrine product EpiPen, at no cost.³⁴⁷ After learning that the no-cost program was limited to three refills, she contacted her insurer to determine her future out-of-pocket costs.³⁴⁸ With some difficulty, she was able to ascertain that her out-of-pocket costs would be a jaw-dropping \$13,500 for three

³⁴⁰ Michelle M. Mello, *What Makes Ensuring Access to Affordable Prescription Drugs the Hardest Problem in Health Policy?*, 102 MINN. L. REV. 2273, 2282 (2018).

³⁴¹ Markham, *supra* note 312, at 170 ("The health insurance industry profit margin is 2.2%, which pales in comparison to the profit margins in other health-related industries such as pharmaceuticals (19.3%).") (data from 2009).

³⁴² Mello, *supra* note 340, at 2282.

³⁴³ *Id.*

³⁴⁴ Brett Wilkins, 'You Lie': Katie Porter Wields 'Whiteboard of Justice' While Grilling Pharma CEO on Price Hikes, COMMON DREAMS (May 18, 2021), <https://www.commondreams.org/news/2021/05/18/you-lie-katie-porter-wields-whiteboard-justice-while-grilling-pharma-ceo-price-hikes>.

³⁴⁵ *Id.*

³⁴⁶ Mello, *supra* note 340, at 2291–92.

³⁴⁷ *Id.* at 2275.

³⁴⁸ *Id.* at 2276.

packs.³⁴⁹ Because her PBM received only a 2.35% discount on the enormous list price of \$4394.10 per pack (versus \$554.95 for EpiPen), they could not cover Auvi-Q without a physician's determination that cheaper forms of epinephrine were contraindicated.³⁵⁰ Professor Mello noted that these patient coupon programs "have driven a wedge between the perceived interests of patients and those of their health plans. They are highly effective in inducing prescriptions for branded drugs: in one study, they increased branded-drug sales by 60%, with commensurate reductions in sales of generic drugs."³⁵¹ Additionally, pharmaceutical companies engage in direct-to-consumer advertising to induce patients to request certain drugs from their physicians. This type of advertising, legal in only one other country besides the U.S., creates enormous conflict.³⁵² Physicians may prescribe these drugs because they are unaware of drug cost or the details of a patient's insurance coverage³⁵³ or because they fear they will lose the patient to another doctor if they do not comply.³⁵⁴ Insurers, in turn, face pressure from physicians and patients to cover the often-exorbitant cost of these brand-name drugs.

The combination of high drug prices and promotional efforts poses a significant threat to insurers. Insurers face substantial pressure to pay the asking price when confronted with increased consumer demand for an expensive drug. This is particularly true for drugs that have no competition, limiting the ability of insurers to bargain with manufacturers.³⁵⁵ To combat unregulated drug prices, the PBM industry has undergone a series of highly criticized mergers, shrinking the market from "at least ten significant competitors" in 2012 to the top three PBMs controlling approximately 70% of revenues in the PBM market in 2017.³⁵⁶ As PBMs often serve multiple insurance plans, consolidation necessarily increases their ability to negotiate prices with drug manufacturers and pharmacies. Evidence confirms that these negotiations, particularly selective contracting with pharmacies, have lowered drug costs.³⁵⁷

The focus on PBM mega-mergers and perverse incentives to inflate drug prices once again exemplifies the tension between private profit and public health. We cannot delegate responsibility for financing pharmaceutical costs to private insurers and expect them not to engage in profit-maximizing behaviors. Undoubtedly, the state should regulate these behaviors and take significant steps to increase transparency. However, the state must also recognize the enormous financial burden imposed upon PBMs by pharmaceutical companies.

c. Medical Providers

While insurers often look like the villains in frequent disputes with medical providers,³⁵⁸ it is important to remember that insurers are highly dependent upon medical

³⁴⁹ *Id.* at 2275–76.

³⁵⁰ *Id.*

³⁵¹ Mello, *supra* note 340, at 2292.

³⁵² Kasem, *supra* note 306, at 228.

³⁵³ See S. Reichert, T. Simon & E.A. Halm, *Physicians' Attitudes About Prescribing and Knowledge of the Costs of Common Medications*, 160 ARCH. INTERN. MED. 2799, 2802 (2000).

³⁵⁴ *Id.*

³⁵⁵ *Id.* at 227.

³⁵⁶ Shepherd, *supra* note 101, at 370–71.

³⁵⁷ *Id.* at 366.

³⁵⁸ Disputes between providers and insurers often involve allegations of insurers attempting to push

providers to contain costs. Providers can threaten profits in several ways. Providers sometimes inflate costs by engaging in the practice of offensive medicine, providing excess care to maximize reimbursement.³⁵⁹ Further, malpractice insurers and medical institutions may encourage the use of defensive medicine, providing potentially unnecessary care to avoid legal liability.³⁶⁰ According to one source, defensive medicine alone has been estimated to cost as much as \$46 billion each year in the U.S.³⁶¹

Importantly, managed care thrives on the contractual relationship between providers and insurers, wherein providers offer discounted rates in exchange for referrals. Research shows that this selective contracting has lowered the cost of health care for both insurers and patients.³⁶² Insurers may struggle to keep costs low if providers refuse to negotiate reasonable reimbursement rates. For example, USAP, a large group of anesthesiologists, recently filed two state lawsuits against UnitedHealthcare, accusing the insurer of using “unlawful tactics” to divert business from them after an ongoing rate dispute.³⁶³ A UnitedHealthcare spokesperson countered that the lawsuits were an effort to pressure them into agreeing to USAP’s egregious rate demands, which were “double the median rate paid to other anesthesiology groups in Texas and 70% higher than the median for similar groups in Colorado.”³⁶⁴ This case illustrates the continuous tension between profit-driven health care entities. Providers are not always single physicians acting in the best interests of patients. Hospitals and medical practices can be enormous profit-generating machines, employing the same questionable business tactics for which insurers are criticized and threatening insurers’ solvency.

d. The Cost of Transparency

Lastly, it is worth noting that the transparency required to vindicate public values comes at a cost to private entities. First, collecting and preparing information for disclosure increases costs. In the case of PBMs, “[t]he FTC has acknowledged that additional disclosure ‘will increase health care costs, and such costs may be reflected in the price of drug plans that health plans are able to offer . . . , the scope of coverage consumers receive

providers out of business by exclusively contracting with other providers. *See* Lien, *supra* note 326, at 136–37 (discussing instances of dominant insurers partnering with large healthcare providers to limit competition). Other disputes involve allegations of insurers unfairly terminating providers from managed care networks, *see* Little, *supra* note 85, at 1440–52, and failing to properly reimburse providers for services, *see* Vukadin, *Delayed and Denied*, *supra* note 194, at 371–73 (describing class action lawsuits brought by providers against insurers for improper claims processing procedures that, inter alia, reduce provider reimbursement).

³⁵⁹ Ronen Avraham, *Clinical Practice Guidelines: The Warped Incentives in the U.S. Healthcare System*, 37 AM. J.L. & MED. 7, 8–9 (2011) (describing offensive medicine and reporting that costs of offensive medicine are estimated to be higher than the costs of medical errors and defensive medicine combined).

³⁶⁰ *Id.* at 28 (offering example of liability insurers requiring doctors to perform annual mammograms because liability insurers “do not bear the costs of extra mammograms but do bear the costs of malpractice lawsuits arising from the late diagnosis of breast cancer.”).

³⁶¹ Michelle M. Mello, Amitabh Chandra, Atul A. Gawande & David M. Studdert, *National Costs of The Medical Liability System*, 29 HEALTH AFF. 1569, 1570 (2010).

³⁶² Shepherd, *supra* note 101, at 365.

³⁶³ Paige Minemyer, *Anesthesiologists Sue UnitedHealthcare, Say Insurer is Pushing Them Out of Market*, FIERCE HEALTHCARE (Apr. 5, 2021, 10:37 AM), <https://www.fiercehealthcare.com/payer/anesthesiologists-sue-unitedhealthcare-say-insurer-pushing-them-out-market>.

³⁶⁴ *Id.*

under such plans, or the number of consumers who have access to such coverage.”³⁶⁵ Additionally, as with all private entities, public disclosure of sensitive information may reduce bargaining power. For example, PBMs may lose their ability to negotiate with pharmacies and drug manufacturers for discounts if all contract terms are made public.³⁶⁶ In the worst-case scenario, this increased transparency could “foster tacit [price] collusion among drug makers.”³⁶⁷ Similarly, disclosure could harm competition amongst PBMs for contracts with health plans.³⁶⁸ Again, there is an inherent tension in requiring private entities to meet public expectations. This tension must be recognized and addressed by the state.

2. The Vulnerable State

While this Article is focused primarily on regulation of insurers, it should be noted that the state’s current approach to contraceptive access is also highly unjust. The patchwork of contraception laws that vary by insurance status causes vast inequities. Laws vary between those who have insurance and those who do not, those on private versus public insurance, those on Medicaid managed care versus fee-for-service, and those on Medicaid by way of ACA expansion versus “regular” Medicaid. Of course, contraceptive access varies dramatically by state of residence. First, state contraceptive and insurance regulation laws differ significantly. Second, state Medicaid programs vary in the products and services covered. Third, states vary in the amount of information and assistance provided in obtaining insurance through the ACA marketplace. If Georgia’s Medicaid waiver is allowed to stand, states will also vary in whether they even offer a marketplace for private insurance for those not covered by an employer. Fourth, states that have not expanded Medicaid leave millions in the uninsured “Medicaid gap,” burdening contraceptive access. Lastly, state enforcement of improper contraceptive coverage denial varies in both practice and policy.

This fragmented system of regulation is the result of the state’s vulnerability to capture and corruption by corporations and special interest groups. Insurers and pharmaceutical companies exercise enormous lobbying power.³⁶⁹ They were extremely influential in the drafting of the ACA, first launching campaigns to defeat health care reform entirely, then helping to defeat single-payer and public options.³⁷⁰ The pharmaceutical industry spent over \$185 million to prevent the incorporation of drug price controls into the ACA.³⁷¹ State insurance commissioners are also vulnerable to capture. Insurance companies donate to the campaigns of state governors who will appoint commissioners that may serve their interests.³⁷² Many of these state regulators are former

³⁶⁵ Shepherd, *supra* note 101, at 383–84.

³⁶⁶ *Id.* at 384.

³⁶⁷ *Id.*

³⁶⁸ Boscheck, *supra* note 338, at 465–66.

³⁶⁹ McGill, *supra* note 97, at 659–61 (discussing the significant influence of insurance and pharmaceutical lobbyists on drafting and adoption of the ACA); Mello, *supra* note 335, at 2301 (describing the “enormous lobbying presence of the biopharmaceutical industry,” which spent \$247 million on lobbying efforts in 2016).

³⁷⁰ McGill, *supra* note 97, at 659–61.

³⁷¹ *Id.* at 659–60.

³⁷² See Lien, *supra* note 326, at 134 (describing insurer Anthem’s efforts to get their merger with Cigna approved by, inter alia, donating large sums of money to groups supporting campaigns of candidates for

employees of insurers who may return to working with insurers in the future.³⁷³ As a result, state regulators routinely “rubber stamp” policy forms and rarely exercise authority to reject inadequate language in policy documents.³⁷⁴ It is easy to see how this lax enforcement could extend to improper denials of contraceptive coverage.

Additionally, the state is vulnerable to ideological capture. This Article has detailed several ways in which anti-regulatory and federalist ideologies undermine fulfillment of public health obligations. Individual state leaders, motivated by political desire to undermine the ACA, have prevented access to insurance, and thus contraception, in numerous ways, exposing the federal government’s vulnerability to “obstructive federalism.” Actions of the Trump administration to promote health plans that circumvent the ACA and expand religious exemption demonstrate the state’s vulnerability to the ideologies of its leader. In sum, a comprehensive approach to contraception requires us to also recognize our collective responsibility for monitoring and democratically correcting the state.

C. Responsive Solutions

The primary aim of this Article is not to provide concrete solutions but rather to reimagine the theoretical underpinnings of state involvement in family planning. However, there are several possible steps the responsive state could take to better ensure contraceptive equity.

Obviously, decoupling contraception distribution from private insurance coverage would free women from burdensome and inequitable profit-motivated restrictions. This decoupling could be accomplished by offering contraception through a nationalized single-payer public insurance program or a significantly expanded Title X program. Barring that, the federal government should codify firmer protections against restrictive insurer tactics. Ideally, insurers would be prohibited from imposing any cost-sharing or utilization management techniques on a specific contraceptive unless there is a therapeutic equivalent. This would ensure free access to a much wider range of options. At the very least, the “category rule,” which clarifies that insurers must cover at no-cost at least one method in each FDA-defined birth control category, should be codified to ensure that it cannot be easily altered by future administrations. The federal government should also address restrictive quantity limits by requiring insurers to cover a single provision of several months’ supply of contraception. It would also be beneficial to require coverage of male contraceptives as well as OTC and pharmacy prescribed methods. However, it should be clear that the state cannot simply prohibit insurers from using their remaining cost-containing methods without addressing some of their many institutional vulnerabilities. It is beyond the scope of this Article to propose such a holistic solution, but the need must be acknowledged.

The state could take several steps to increase transparency and accountability. The ACA was a good start, imposing promising new disclosure requirements on individual marketplace plans. Importantly, those plans are now required to report the number of claims denied. Expanding these requirements to employer-sponsored plans would be

governors who, in turn, appoint the insurance commissioners responsible for reviewing proposed mergers).

³⁷³ Christopher C. French, *Dual Regulation of Insurance*, 64 VILL. L. REV. 25, 61 (2019).

³⁷⁴ *Id.* at 28–29.

extremely beneficial. Additionally, the state should require insurers to submit more detailed information on cost-sharing and denials of contraception claims (and really all claims involving mandatory coverage of preventive health services). Mandatory reporting of appeals decisions would also help to hold insurers accountable for improper claim denials. The federal government should require insurers to use a standard waiver form and process to expedite waiver of cost-sharing when a physician determines that a particular contraceptive is “medically necessary,” a step that has already been taken in at least one state.³⁷⁵ The state should take further steps to expand this exemption beyond individual medical needs, recognizing the many social and economic factors that influence contraception choice, including physical location. Additionally, there should be greater oversight of state insurance commissions and a mass information campaign to encourage investigation and enforcement of improper claim denials at the agency level. ERISA’s burdensome and piecemeal enforcement process is simply insufficient to ensure mass compliance with such important public health requirements.

CONCLUSION

Unintended pregnancy is a social problem suffering from an individualistic and privatized “solution.” The ACA’s contraceptive mandate made important gains in fulfilling public responsibility for contraception, but too much of the implementation is left to the discretion of private insurers and too much of the enforcement burden is placed on individual women. We must move beyond our narrow consumer-oriented approach to contraception. Contraception is vital to fulfillment of important social obligations, not a choice made by empowered consumers. Unintended pregnancy is not a personal failure but a social one. Rather than continuing to focus on individual choice and individual responsibility, vulnerability theory properly places responsibility with the state to provide contraception as a form of resilience. This responsibility extends to all stages of societal reproduction. The state is obligated to provide economic and social support for adequate family planning as well as for pregnancies that result from their failure to meet this obligation. Further, if the state continues to make private insurers responsible for meeting public health goals, it must also address the institutional vulnerabilities of insurers resulting from the enormous tension between private profit and public health that the state has imposed. Only in this manner will we be closer to achieving true contraceptive equity under our existing market-based approach to public health.

³⁷⁵ At least one state, New York, has required insurers to use a standard, easy-to-understand waiver form developed by a state agency. NWLC, *Exception Policies*, *supra* note 115, at 4.