

HEALTH CARE

PUBLIC POLICY IN-DEPTH



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HEALTH CARE

INTRODUCTION



On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA), commonly known as Obamacare. This piece of legislation, the most significant overhaul of the health care system since the passage of Medicaid and Medicare in 1965, renewed a long-standing debate over the appropriate role of government in health care. In this chapter, we will consider several enduring tensions in health care policy and examine two current controversial issues:

- Should Congress repeal Obamacare?
- Should the government require employers to provide contraceptive coverage for their workers?

“The health of American children, like their education, should be recognized as a definite public responsibility.”

—Harry Truman

Why Is Health Care Policy Controversial? Perhaps no issue affects citizens as deeply and personally as access to health care. When Americans give birth, seek treatment for physical or mental illnesses, or require surgical procedures or emergency care, the affordability and the quality of the health care services they receive can have sweeping effects on their well-being.

But good-quality health care services can be expensive, due to the high costs of medical administration, medical testing, pharmaceutical development, and technological innovation.¹ According to data compiled by the International Federation of Health Plans, a hospital visit in the United States cost an average of \$5,220 per day in 2015.² In order to help pay for such costs, most Americans obtain health insurance—a contract with an insurance company which agrees to pay some or all of a patient’s medical bills according to the terms of his or her policy. In return, the patient pays a fee (also known as a premium) to the insurer on a regular basis. Depending on the insurance plan, some patients also pay annual deductibles (an amount the patient must pay for health care services before the insurer begins to contribute) and copayments (fixed fees at the time of service).

“Only true free market competition will put pressure on the providers and force them to lower their costs to remain in business.”

—Ron Paul

For most insured people, the cumulative cost of premiums, deductibles, and copayments is much less than they would pay if they became ill and had to pay out of pocket for health care. Therein lies the mechanism on which health insurance operates—even though most people will not become significantly ill in a given year, their premiums, deductibles, and copayments help pay for those who do. Health insurance allows groups of people to share the risk of contracting a serious—and expensive—illness.

How does health insurance work?

In the U.S. health care system, the role of government has been deeply controversial for years. Some policymakers believe the government should guarantee all Americans access to affordable health care, regulate medical costs, mandate that all patients be insured, or oversee a single, government-run health care system funded with taxpayer dollars. Other policymakers view such a role as a vast overreach and insist that the government has no right to order Americans to purchase health insurance, to determine which procedures must be covered by private health insurance, to manipulate health care costs, or to interfere with patient choice in the health care system.

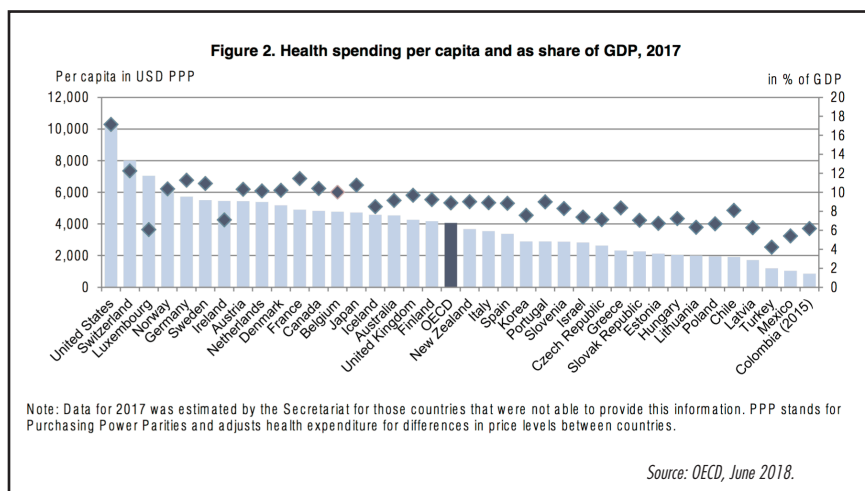
Why Is Health Care Policy So Complicated? Determining the appropriate role of government in the health care system is complicated by the fact that nations around the world use a variety of different models. Many other developed countries—including 32 of the 35 member nations of the Organisation for Economic Co-operation and Development (OECD)—provide citizens with universal (or near-universal) coverage of costs for core health care services, such as consultations with doctors, medical tests, and surgical procedures. Some of these countries provide a basic level of public health care coverage but allow citizens to purchase supplemental insurance privately.³ Others, such as Canada and Taiwan, use a single-payer system, in which one government organization collects all health care fees and pays all health care costs.⁴ In general, universal health care systems are financed by taxation.⁵

In the United States, most citizens purchase health insurance in the private market, allowing consumers to choose their own insurer and their desired level of coverage.⁶ The largest share of Americans receive health insurance through their jobs, meaning their monthly premiums are deducted from their paychecks and their employers pay additional insurance costs. In 2017, the National Center for Health Statistics found that approximately 69 percent of U.S. adults (aged 18 to 64) had private health insurance and 20 percent had some form of public insurance.⁷

This structure of the U.S. health care system has drawn both praise and criticism. Between 2005 and 2009, the United States was the world leader in five-year survival rates of prostate cancer (97 percent) and female breast cancer (89 percent), and was among the leaders in treating cancers of the colon and rectum.⁸ The United States is a significant innovator of medical technologies and pharmaceuticals, having accounted for 43.7 percent of new active pharmaceutical ingredients developed between 1992 and 2004.⁹ Patients in the United States also face much shorter waiting periods for elective surgeries than patients in many other developed countries. In 2015, for example, the median waiting period for hip replacement surgery was 100-150 days in Australia, Norway, Portugal, and Spain, and more than 200 days in Chile, Estonia, and Poland.¹⁰

That said, public and private health-related spending in the United States reached 17.2 percent of gross domestic product (GDP) in 2017, dwarfing the 8.9 percent average among OECD nations. Also in 2017, the United States spent more than \$10,000

per person on health care, more than twice the OECD average of \$4,069. Despite these levels of spending, U.S. life expectancy stood at 78.8 years, almost two years less than the OECD average.¹¹ And among the major causes of death



in comparable developed countries, the United States had lower than average mortality rates for cancer, but higher than average mortality rates for circulatory diseases, respiratory diseases, diseases of the nervous system, mental disorders, and endocrine and nutritional diseases.¹²

Yet for years, U.S. lawmakers have disagreed over the root causes of these health care successes and failures, as well as whether—and how—to reform the health care system.

THE ONGOING DEBATE



What is the appropriate role of government in providing access to health care?

As the health care system has developed and grown over the last century, policymakers have intensely debated the appropriate role of government. In 1945, President Harry Truman unveiled a landmark proposal to create a national health care plan—one with an insurance fund to be operated by the federal government and open to all Americans. But as the Korean War erupted in 1950 and critics such as the American Medical Association decried the plan as “socialized medicine,” President Truman abandoned the proposal.¹³

In the following decade, the price of hospital care increased, making it more difficult for non-working, elderly, and disabled Americans to gain access to affordable health care. In response, President Lyndon Johnson signed Medicaid and Medicare into law in 1965, significantly expanding the role of government in the health care system.¹⁴

Medicaid. Medicaid is a health and medical services program for low-income Americans and qualified pregnant women and children. It is the single largest source of health care coverage in the United States, serving nearly 69 million people in 2017. Medicaid is a joint federal-state program, meaning the federal government sets certain coverage requirements that states can build upon.¹⁵ Under the program, states make payments to health care providers and the federal government reimburses the states for a sizable share of those payments. Federal reimbursement rates typically range from 50 percent to 82 percent, depending on the state’s per capita income and several other factors.¹⁶

Medicare. Medicare is a health insurance program for people aged 65 or older, as well as for people under the age of 65 with certain disabilities or end-stage renal disease.¹⁷ The program, which is operated by the federal government, served 58.4 million people in 2017.¹⁸ It is financed through two trust funds. The first trust fund collects payroll taxes—2.9 percent of workers’ wages, split by workers and their employers—that the government uses to reimburse doctors and hospitals for health care services. The second trust is funded from the government’s budget, which is approved by Congress, and goes toward prescription drug benefits, among other services.¹⁹

President Lyndon Johnson signs Medicare into law

But by the early 2000s, many policymakers were calling for significant reforms to the health care system. Health care spending was growing rapidly, and the impending retirement of the “Baby Boomer” generation augured a dramatic increase in Medicare spending. In 2010, 48.6 million Americans were also living without health insurance—either because they could not afford it or because they did not want to purchase it.²⁰

Obamacare. In March 2010, following a year of intense drama and debate, the Democrat-controlled Congress passed, and President Obama signed, the ACA (which became known as Obamacare). The central tenet of Obamacare is a controversial provision known as the individual mandate—a government requirement for almost every American to purchase health insurance. Under Obamacare, Americans have the option of obtaining private insurance through their employer, purchasing their own policy, or enrolling in a public program such as Medicaid or Medicare. If individuals fail to purchase health insurance by the annual open enrollment deadline, they are subject to the higher of two penalties—either 2.5 percent of their annual household income above the tax filing threshold (the income level that triggers the requirement to file a federal tax return) or a flat fee, which stood at \$695 per adult and \$347.50 per child in 2017.²¹

The individual mandate was only one provision of Obamacare, which enacted several other sweeping changes to the

health care system. Under the law:

- Americans who do not have access to private, employer-based insurance or public programs such as Medicaid or Medicare can buy insurance through new online marketplaces called exchanges. Each state has an exchange (operated by the state or the federal government), in which consumers can purchase a range of plans from competing private insurance providers.²²
- Americans who purchase insurance through an exchange are eligible for government subsidies to help pay their premiums if they earn less than four times the federal poverty level (the income level below which households are considered poor).²³
- States were initially required—and later given the option (following a 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius*)—to expand eligibility for Medicaid to include adults who earn 133 percent of the federal poverty level.²⁴ As of July 2018, some 33 states and the District of Columbia have chosen to adopt the Medicaid expansion. The federal government paid all costs for newly eligible Medicaid recipients through 2016; that share will phase down to 90 percent by 2020 and remain at that level.²⁵



Has your state expanded Medicaid eligibility?

- All insurance plans offered in an exchange must cover an array of “essential” services, including emergency services, hospitalization, maternity and newborn care, mental health care, substance use disorder services, prescription drugs, and preventive care.²⁶



Which health services must be covered by Obamacare insurance plans?

- An individual cannot be denied health insurance or charged a higher rate because of a preexisting medical condition.²⁷
- Young people are permitted to remain on their parents’ insurance plans until they turn 26.²⁸
- Companies that employ at least 50 full-time workers are required to provide affordable health insurance for their employees or else face fines.²⁹
- Undocumented immigrants may not use the exchanges, sign up for federal public health benefits, or receive government subsidies to help pay for health care costs.³⁰



How does Obamacare work?

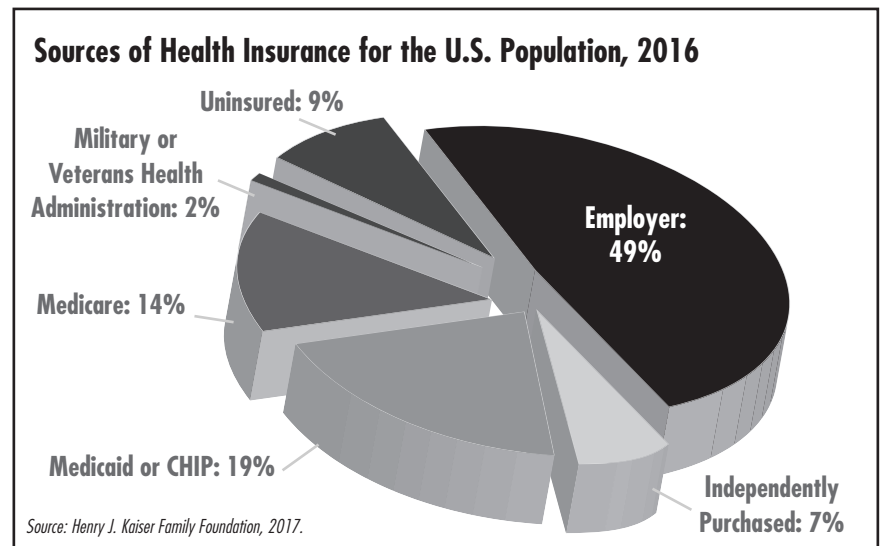
Obamacare represented a significant expansion in the role of the federal government, and in a testament to the law’s controversial nature, it passed Congress without a single Republican vote.³¹ Shortly after President Obama signed the law, 26 states, the National Federation of Independent Business, and several individual plaintiffs sued, arguing that certain provisions—including the individual mandate—were unconstitutional. In 2012, the case made it to the Supreme Court, which ruled in *National Federation of Independent Business v. Sebelius* that the individual mandate amounted to a tax and is therefore a legal exercise of the power of Congress.³²



Should Congress repeal Obamacare?

Obamacare became law in 2010, but it took several years for its central provisions to take effect. By 2017, the law had produced several measurable outcomes.

- Between 2010 and 2016, 20 million Americans gained health insurance, reducing the uninsured population from 48.6 million (16 percent of the population) to 28.6 million (nine percent of the population).³³ Of the newly insured, a majority—14.5 million people—gained their insurance from the government, through Medicaid or the related Children’s Health Insurance Program (CHIP).³⁴
- When Obamacare took effect, some insured Americans had their policies discontinued because they did not meet the new coverage standards. It is estimated that insurers cancelled the policies of approximately 2.6 million Americans, despite President Obama’s promise in 2009 that “if you like your health care plan, you’ll be able to keep your health care plan, period.”³⁵
- According to 2015 estimates by the Congressional Budget Office (CBO), Obamacare expenditures are expected to total \$1.207 trillion between 2016 and 2025—including \$849 billion in federal subsidies to assist enrollees with their premiums.³⁶
- Approximately 84 percent of customers in the exchanges qualified for subsidies in 2016 and 2017.³⁷
- Between 2016 and 2017, the average premium for an exchange insurance plan rose by 25 percent—the largest single-year increase since the exchanges opened in 2013. Some national insurers, including Aetna and UnitedHealth Group, withdrew from the exchanges for 2017, citing high patient costs and lower-than-anticipated enrollment.³⁸ As a result, five states—Alabama, Alaska, Oklahoma, South Carolina, and Wyoming—had only one insurer in their exchanges in 2017. The average number of insurers per state exchange was 3.9, down from 5.4 in 2016.³⁹



What are the criticisms of Obamacare?

As Obamacare has reshaped the health care system, Republican opposition to the law has remained constant. Between 2011 (when the party gained control of the House of Representatives) and 2015, Republicans voted more than 50 times to repeal, defund, or curtail the law, although none of the bills made it through the Democrat-controlled Senate.⁴⁰ But in the aftermath of the 2016 election, when voters elected President Donald Trump and gave Republicans majorities in Congress, the party managed to make significant changes to Obamacare. In December 2017, President Trump signed into law a sweeping tax reform bill which repealed the individual mandate, effective in 2019. President Trump also ended billions of dollars in subsidy payments that the government was making to insurers to lower deductibles and out-of-pocket costs for patients.⁴¹

Thus, Obamacare faces an uncertain future. Some 10.6 million people were enrolled in the program's plans in February 2018, a three percent increase from the year prior. But looking ahead, the White House is considering new regulations that could allow consumers to purchase less comprehensive, short-term insurance plans or association plans, which could attract young, healthy people away from Obamacare exchange plans. Some states continue to struggle to attract insurers. And Republicans are still debating whether to reform Obamacare, repeal it, or leave it in place.⁴²

Supporters of repeal argue that Obamacare is fiscally irresponsible and unsustainable in an era when the national debt has surpassed \$21 trillion.⁴³ They argue that the law is failing to bring down health care costs and making too many Americans dependent on the government. But opponents of repeal note that Obamacare has helped millions of Americans gain access to health insurance. They believe Obamacare represents the appropriate and necessary role of government—to help improve the general welfare and assist citizens in need.



[Speaker of the House Paul Ryan, R-Wis., makes the case for repealing Obamacare](#)



[President Barack Obama makes the case for keeping Obamacare](#)



SHOULD CONGRESS REPEAL OBAMACARE?



YES: Repeal this costly, invasive, and poorly formulated law.

“[Obamacare] is bad policy that does not accomplish what it was designed to do,” Representative Paul Ryan, R-Wis., now the speaker of the House, said in 2015. “Instead, the law spends trillions of dollars we don’t have, raises taxes on workers, businesses, and families, and puts the federal government squarely in the middle of health care decisions.”⁴⁴

In an era of more than \$21 trillion in national debt, the government is set to spend \$1.207 trillion on Obamacare between 2017 and 2025.⁴⁵ And as of 2017, an astonishing 84 percent of Obamacare enrollees—even people who earned as much as four times the federal poverty level—were receiving government subsidies to help pay their premiums.⁴⁶ In other words, hardworking taxpayers are helping foot insurance subsidies for strangers—just because an overreaching government decided that all Americans must buy health insurance, no matter if they want it or need it.

Since its passage in 2010, Obamacare has done little more than create a new generation of government dependents. More than 14.5 million of the 20 million newly insured citizens have simply joined Medicaid or CHIP, saddling U.S. taxpayers with the costs of their health care. Yet the government is making Medicaid promises it cannot keep. In 2015, doctors across the country saw a 43 percent reduction in their fees for seeing Medicaid patients (as a temporary Obamacare pay raise expired), making it much harder for doctors to accept Medicaid patients in the future.⁴⁷

Not only does Obamacare represent an enormous government intrusion in private health care matters, but the law is also failing to bring down health care costs. Obamacare allows unhealthy people to wait until they get sick to sign up for private insurance or to simply sign up for Medicaid. With too few young, healthy people enrolling in the exchanges to counteract this behavior, insurers have been hit with high patient costs. This led average premiums to rise by 25 percent between 2016 and 2017, with several major national insurers opting to drop out of the exchanges rather than sustain financial losses.⁴⁸ As of 2017, consumers in 31 percent of U.S. counties had access to an exchange with only one insurer.⁴⁹

In other words, Obamacare is not working. Republicans must pass a commonsense replacement that reduces government dependency, gives more power to the states, and gives patients real choices.

“Over the last five years, Obamacare has revealed the painful consequences of placing our faith in big government,” said Senator Marco Rubio, R-Fla. “Government’s ambitions may be limitless, but its abilities are not.”⁵⁰



NO: This law has already helped millions of Americans.

As Republicans move toward repealing and replacing Obamacare, they should take note that they are acting against the expressed wishes of the American people. In April 2017, an ABC News/*Washington Post* poll found that just 37 percent of respondents wanted Obamacare repealed and replaced; 61 percent said the law should be kept and fixed instead.⁵¹

“Thanks to the law, 20 million more Americans now know the security of health insurance,” said President Obama in 2016. “That includes six million young people who were less likely to be insured before the Affordable Care Act. As many as 129 million Americans with preexisting conditions can no longer be charged more or denied coverage just because they’ve been sick. Almost 140 million Americans who already have private health insurance ... they’re now guaranteed free preventive care as well, and check-ups. Mammograms. You’re getting more for what you’re paying for.”⁵²

Obamacare is hardly a perfect piece of legislation, but it has done an immense amount of good for millions of Americans. And that is not an overreach by government—it is the appropriate role of government. This law has used public funds to enhance the welfare of the public, and to ensure that all Americans—not just the wealthy, the privileged, and the healthy—can afford health insurance.

Although many Republican lawmakers have decried the high price tag of Obamacare, the anticipated costs of the program are falling. In January 2015, the CBO estimated that the law would cost \$1.35 trillion between 2016 and 2025; by March, that estimate had fallen to \$1.207 trillion. Also in January 2015, the CBO predicted that the government would spend \$1.058 trillion on subsidies in the next decade; by March, that estimate had fallen to \$849 billion.⁵³

But if Congress repeals Obamacare, the consequences will be felt in every state and in every community. Already, with the individual mandate set to end in 2019, the CBO has predicted that four million more people will go without health insurance in 2019 and 13 million will do so after a decade. Insurance premiums could also increase by 10 percent annually. And if President Trump strips Obamacare’s coverage requirements and allows consumers to purchase bare-bones insurance plans, premiums could rise even higher.⁵⁴

In the end, Congress must rethink its mission to repeal and replace Obamacare. “Republicans should look at the numbers and finally end their fixation with repealing this historic law,” said House Minority Leader Nancy Pelosi, D-Calif.⁵⁵



What is the proper balance between government interest and the protection of religious freedom?

Religious freedom—the right to practice any religion or no religion, free from government controls or coercion—has been part of American life since the colonial era. In 1636, Roger Williams established Providence Plantations in present-day Rhode Island, creating a new colony that guaranteed liberty of conscience.⁵⁶ By 1791, the Bill of Rights had enshrined the freedom of religion in the First Amendment, which reads: “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.”⁵⁷



But like many vague constitutional provisions, the definition of “free exercise” of religion has generated frequent debate in the United States. Over the years, the Supreme Court has issued several landmark rulings on the subject, including:

- ***Reynolds v. United States (1878)***. When George Reynolds, the secretary to Mormon leader Brigham Young, challenged a federal law that banned polygamy, the Supreme Court ruled that the law did not violate the religious freedom of Mormons. The Court declared that the First Amendment protects religious belief, but it does not protect religiously motivated criminal acts. Chief Justice Morrison Waite wrote, “To permit this would be to make the professed doctrines of religious belief superior to the law of the land and, in effect, permit every citizen to become a law unto himself.”⁵⁸
- ***Sherbert v. Verner (1963)***. Adell Sherbert sued her employer when she was fired for refusing to work on Saturdays, the Sabbath of her Seventh-day Adventist faith. When South Carolina refused to give her unemployment benefits, the Supreme Court ruled that the state had imposed an unconstitutional burden on the free exercise of Sherbert’s religion and that it lacked a “compelling state interest” in denying the unemployment benefits.⁵⁹
- ***Wisconsin v. Yoder (1972)***. Several Amish parents were convicted of violating Wisconsin’s mandatory school attendance law by declining to send their children to high school, which they said violated their religious beliefs. The Supreme Court held that the free exercise of religion outweighed the state’s interests in mandating school attendance after eighth grade.⁶⁰
- ***Employment Division v. Smith (1990)***. The Supreme Court affirmed Oregon’s right to deny unemployment benefits to two men who were fired for using peyote—an illegal drug in the state—during a Native American religious ceremony. Justice Antonin Scalia wrote that siding with the two men “would open the prospect of constitutionally required religious exemptions from civic obligations of almost every conceivable kind.”⁶¹

The Little Sisters of the Poor, whose suit against the contraceptive mandate was part of *Zubik v. Burwell*, gather at the Supreme Court.

In the wake of the *Employment Division v. Smith* decision, religious groups, civil liberties organizations, Democrats, and Republicans came together to push for passage of the Religious Freedom Restoration Act (RFRA), which was signed by President Bill Clinton in 1993. The RFRA mandated that the government shall not “substantially burden religious exercise without compelling justification,” as well as proof that the burden is the least restrictive means of furthering that interest.⁶²



President Bill Clinton signs the Religious Freedom Restoration Act into law

So, what does religious freedom have to do with health care? In an effort to expand the preventive health care services available to women, Obamacare requires health insurance plans to cover several specific services for female patients—such as mammograms, cervical cancer screenings, and contraceptives—without out-of-pocket costs.⁶³ As a result, nearly all employers who provide health insurance to their workers must offer female employees contraceptive coverage without out-of-pocket costs. This rule applies to emergency contraceptives, intrauterine devices, and all other methods of birth control approved by the Food and Drug Administration. Employers who do not comply with the “contraceptive mandate” are subject to fines of \$100 per day per affected employee.⁶⁴

However, this mandate generated fierce protest from churches and religious employers opposed to the use of artificial birth control, who argued that the government could not force them to provide their employees with free contraceptives.

THE CURRENT CONTROVERSY



Should the government require employers to provide contraceptive coverage for their workers?

When the Obama administration announced the contraceptive mandate in August 2011, many churches, religious organizations, and religious employers protested, arguing that the law placed an undue burden on their free exercise of religion. Within months, the administration announced that churches, as well as the businesses they administer, would be exempt from the mandate.⁶⁵

But the exemption did not address the concerns of religiously affiliated nonprofit organizations, such as hospitals, schools, and charities. In June 2013, the Obama administration created an accommodation for those religious nonprofits, allowing them to notify their insurers of their objections to the mandate and empowering the insurers to make direct payments to employees for contraceptive services.⁶⁶ The rules of the contraceptive mandate changed again in 2014, when the Supreme Court decided in *Burwell v. Hobby Lobby Stores* that “closely held” for-profit businesses (corporations with a limited number of shareholders) operated on religious principles, such as the craft store chain Hobby Lobby, could not be required to adhere to the contraceptive mandate. Instead, they were entitled to receive the same accommodation as religious nonprofits.⁶⁷

However, various religious groups have objected to the accommodation, as it requires proactive facilitation that they believe tacitly endorses the use of contraceptives. When several legal challenges to the accommodation came together in *Zubik v. Burwell* (2016), the Supreme Court vacated the case and told the Obama administration and the challengers to find a new, acceptable compromise.⁶⁸ The two sides failed to reach an agreement before President Obama left office in 2017.⁶⁹

Since that time, the Trump administration has moved to make sweeping changes to the contraceptive mandate. In October 2017, the Trump administration issued new regulations that exempt any employer from covering contraceptive services if it objects “based on its sincerely held religious beliefs” or has other “moral convictions” against covering such care. Soon after the announcement, the American Civil Liberties Union and several Democratic state attorneys general announced that they would fight the new rules in court.⁷⁰

President Trump's new regulations quickly revived the debate over whether or not the government should be allowed to require employers to provide contraceptive coverage for workers. Supporters of the contraceptive mandate argue that the policy allows women—no matter their wealth or employer—to make the vital health care decisions that most deeply affect their lives. But opponents insist the mandate is a dangerous violation of the religious freedom of many employers, as well as an unnecessary government handout.

 [Georgetown law student Sandra Fluke testifies before Congress about her support for the contraceptive mandate](#)

 [Timothy Cardinal Dolan, archbishop of New York, explains his opposition to the contraceptive mandate](#)



SHOULD THE GOVERNMENT REQUIRE EMPLOYERS TO PROVIDE CONTRACEPTIVE COVERAGE FOR THEIR WORKERS?



YES: Female workers have a right to access their basic health care needs.

“The birth-control coverage benefit in our nation’s health care law was the single greatest advancement in reproductive health care in a generation,” said Kaylie Hanson Long of NARAL Pro-Choice America. “It gave millions of women more control over their own lives by making birth control affordable and accessible.”⁷¹

Prior to Obamacare’s passage in 2010, 22 percent of U.S. women of childbearing age were paying out of pocket for oral contraceptives.⁷² And at that time, there were some forms of birth control that were simply unaffordable for some women. “The cost of an IUD is nearly equivalent to a month’s full-time pay for workers earning the minimum wage,” Justice Ruth Bader Ginsburg wrote in her dissent of *Burwell v. Hobby Lobby Stores*.⁷³ Cecile Richards, president of the Planned Parenthood Federation of America, noted, “A 2010 survey found that more than one-third of women voters have struggled to afford prescription birth control at some point in their lives—but when they have access to it, they can support themselves financially, complete their education, and plan their families and have children when they are ready.”⁷⁴

By 2014, the share of U.S. women paying out of pocket for oral contraceptives had plummeted to less than four percent—thanks to Obamacare.⁷⁵

A woman’s decision to use birth control is a personal one—and one that should not depend on her employer’s beliefs. “For millions of women in this country, the only thing controversial about birth control is the fact that we’re still fighting to have this basic health care covered by insurance—especially given the overwhelming evidence that birth control, when used correctly, has a host of health and medical benefits,” Richards wrote. “It can help relieve painful menstrual cramps, avert infertility by addressing the symptoms of endometriosis, and—shockingly—prevent unintended pregnancy.”⁷⁶

The government has a compelling interest in helping women prevent unintended pregnancies. In 2016, the Guttmacher Institute found that 45 percent of the 6.1 million annual pregnancies in the United States are unintended—accidental pregnancies that having lasting effects on families and cost U.S. taxpayers close to \$21 billion each year.⁷⁷ Even within a single household, a middle-income family with a child born in 2015 can expect to spend more than \$233,000 on child-related expenses before that child turns 18, according to the Department of Agriculture.⁷⁸

“No woman’s health should depend on who she is or where she works or how much money she makes,” said President Obama. “Period.”⁷⁹



NO: The contraceptive mandate is unnecessary and a violation of religious freedom.

“The Religion ... of every man must be left to the conviction and conscience of every man; and it is the right of every man to exercise it as these may dictate,” James Madison wrote in 1785. “This right is in its nature an unalienable right.”⁸⁰

The founding fathers believed religious freedom to be so vital a principle that it is enshrined in the first words of the First Amendment to the Constitution. Yet the Obama administration believed it acceptable to place this liberty at risk—by requiring most employers to provide their workers with access to no-cost contraceptives.

By issuing this blanket mandate with few workable accommodations, the government set a dangerous precedent. “Denmark recently prohibited kosher and halal slaughter methods because they believe they are inhumane,” Justice Samuel Alito said during oral arguments in *Burwell v. Hobby Lobby Stores*. “Now, suppose Congress enacting something like that here. What would a corporation that is a kosher or halal slaughterhouse do? ... They would have no recourse whatsoever.” Justice Anthony Kennedy also pointed out that the government’s argument could force a business to pay for abortions, if such a law was passed by Congress.⁸¹

American women—like all patients—certainly have a right to make their own health care decisions. They also have a right to use birth control if they wish. Yet the idea that women are entitled to birth control without paying any out-of-pocket expenses merely demonstrates how dependent Americans have become on the government. In an era of skyrocketing national debt, it is not the responsibility of taxpayers to foot the bill for contraceptives—especially when women can use generic forms of birth control pills for roughly \$9 per month, condoms for \$12.50 per month, or a diaphragm and spermicide for \$5 per month.⁸²

“Neither before nor after Obama’s [Department of Health and Human Services] imposed this mandate did the Left offer a convincing argument as to why birth control—above all other health-care procedures and treatments—was so essential that the government could compel business owners, regardless of conscience, to provide it for free to their employees,” wrote Alexandra DeSanctis, a fellow at *National Review*.⁸³

President Trump is right to allow any employer to seek a religious or moral exemption from this overly broad rule. “At long last, the United States government has acknowledged that people can get contraceptives without forcing nuns to provide them,” said Mark Rienzi, senior counsel at the Becket Fund for Religious Liberty. “That is sensible, fair, and in keeping with the president’s promise.”⁸⁴



The controversies surrounding Obamacare and the contraceptive mandate are only two examples of the health care debates Americans have engaged in for years. And although the fate and effects of these policies remain far from certain, U.S. policymakers, doctors, insurers, and patients will undoubtedly continue to debate the goals and priorities of the health care system—and which government policies best reflect and achieve them.



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