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Commentary

Beyond *Hobby Lobby*: Employer's responsibilities and opportunities to improve network access to reproductive healthcare for employees ☆,☆☆

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ABSTRACT

The majority of United States (US) women age 15–49 have employer-sponsored health insurance, but these insurance plans fall short if employees cannot find providers who meet reproductive health needs. Employers could and should do more to facilitate and advocate for their employees through the insurance plans they sponsor. We conducted interviews with 14 key informants to understand how large United States employers see their role in health insurance benefits, especially when it comes to reproductive health care access and restrictions in religious health systems. Our findings suggest that large employers wish to be responsive to their employees' health insurance priorities and have leverage to improve access to reproductive health services, but they do not take sufficient action toward this end. In particular, we argue that large employers could pressure insurance carriers to address network gaps in care resulting from religious restrictions and require insurers to treat out-of-network providers like in-network providers when reproductive care is restricted.

1. Introduction

In the United States (US), 60% of women age 15 to 49 have employer-sponsored health insurance (either through their own job or as a dependent), 7% have individual private plans, and 19% are covered by Medicaid [1]. Many reproductive health services have long been covered by Medicaid (e.g., prenatal care, contraception, and, in some states, abortion) [2]. Under the Affordable Care Act (ACA) rules, most private insurance plans—both employer-sponsored and individually-purchased—are required to cover prenatal care and a range of contraceptive methods alongside other preventive care. These coverage requirements fit within a broader goal of making preventive health care more affordable and accessible by reducing or eliminating out-of-pocket fees for designated services.

Yet, with health insurance entrenched as an employee benefit in the US, a number of employers have objected to some of these coverage requirements on the basis of religious beliefs. For instance, Catholic-affiliated employers have sought exemptions for insurance coverage of contraceptive, fertility, and abortion services for their employees. In the 2014 case *Burwell v Hobby Lobby,* the US Supreme Court ruled in favor of a privately-held for-profit company whose owners had a religious objection to covering some contraceptive methods in their employees' health insurance plans [3]. However, a focus on employer objections overlooks issues that may arise when an employer does not object to coverage but offers employee health plans without adequate access to reproductive health care.

Even if the costs of a specific health service like contraception are *covered*, people can still experience barriers to reproductive health care because of the limited providers in their insurance network. Many employers, even those who are self-insured, make use of a third-party administrator or an insurance company (or carrier) to create insurance plans for their employees. Often, these insurance plans direct employees to seek care within closed provider networks such as health maintenance organiza-

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tions (HMOs) or exclusive provider organizations (EPOs). To try to ensure that networks offer adequate access to providers, state and federal law have established basic requirements that insurance companies must meet. For instance, the ACA requires that health plans sold on the marketplace maintain provider networks that are sufficient in number and types of providers to ensure that all services are accessible to enrollees without "unreasonable delay" [4]. Some state laws also set criteria that plans must meet—such as an adequate number of providers across specialties and geographic areas or require that insurance companies share lists of their providers searchable by certain criteria [5].

As insurance plans shift toward narrower networks to reduce costs, employees with plans through both religious and nonreligious employers may be required to seek care from providers at religiously affiliated health systems [6]. Catholic health systems make up an increasingly large proportion of hospitals in the US, with saturation of the market in some states upwards of 40% [7]. This means that Catholic-affiliated facilities are increasingly likely to be included in or entirely make up provider networks. Similar to employers citing Catholic beliefs to deny coverage, Catholic health systems adhere to restrictions delineated by the *Ethical and Religious Directives for Catholic Healthcare Services*, which prohibit Catholic health facilities from providing certain fertility treatments, birth control, and abortion [8]. Federal statutes establish legal protections for individuals and entities that object to providing health care that would be contrary to their individual or institutional beliefs [9,10].

Yet when patients seek care in Catholic facilities, they often arrive unaware of the hospital's religion and the associated restrictions or possible denials [11–14]. Religious affiliation or restrictions is not a search-criteria by which insurance consumers can filter when selecting providers. Patients delivering at Catholic hospitals face reduced access to postpartum contraception and may face limited treatment options for pregnancy complications [15,16]. Physicians working in Catholic hospitals have described situations in which patients' insurance plans only covered the Catholic facility, and this caused patients to defer or be denied family planning services at the time of birth [17]. In plain terms, an employee may have *coverage* for a health service through their employer's insurance plan, but may not be able to use that coverage due to a lack of providers in network who offer the health service.

With the majority of reproductive-age women covered by employer-sponsored health insurance in the US, employers play an outsized role in health care access, and they currently do too little to assure meaningful access to comprehensive reproductive care. We sought to explore how large secular US employers view their role in brokering employee access to reproductive health care and provider networks. We conducted interviews with health insurance decision-makers within or serving large US employers to explore the ways in which access to reproductive health care arises and is negotiated within employer-sponsored benefits and networks.[1] We spoke with benefits managers, health care consultants, and brokers serving both fully-insured (those who pay fees to an insurance company to facilitate plans) and self-insured organizations (those that use their own funds and contract services to provide insurance coverage). Interviewees described each of these roles as follows: benefits managers oversee insurance and other employee benefits, consultants advise companies on employee benefits, and brokers can serve as third parties who help companies assemble and purchase insurance products to offer employees. Findings from these interviews also informed the development of a nationally representative, cross-sectional survey of employees at Standard and Poor's (S&P) 500 companies who receive health insurance through their employer [13,18]. We conducted interviews between January and May 2019 by trained researchers and recorded for transcription, allowing for qualitative data analysis of thematic content [19].

The purpose of this commentary is both to describe what we learned about employer attitudes and beliefs and share our recommendations for employer action. Specifically, from key informant interviews, we identified 4 possible reasons why employers do not currently take adequate action to assure employees' reproductive health care access: (1) While employers do care about employee experience, it is hard for employees to understand and report their reproductive care denials; (2) employers assume access to reproductive care, and they see religious provider-based restrictions as the insurance carrier's responsibility; (3) when it comes to how much responsibility employers should take on this issue, employees and employers may have differing expectations; and (4) employers do not use their leverage equally for all reproductive services. To take concrete actions forward, we recommend the following changes that employers can make: (1) collect employee experience data about access to reproductive care; (2) assure true adequacy in provider networks, including ready access to non-Catholic facilities; (3) treat out-of-network reproductive care as equivalent to in-network care when it comes to employee cost-sharing; and (4) advocate for other employers to do the same.

2. Why do employers not do more to ensure employee access to reproductive care?

2.1. Identifying religious barriers to care is difficult

Benefits managers and employers often do care about employee satisfaction with benefits, but they believe that if employees are dissatisfied with benefits, the employer is likely to hear about it from existing feedback mechanisms. If so, they would make relevant changes to respond to employees and remain competitive with other employers.

However, as previous research has demonstrated, patients seeking care at religiously affiliated health centers are often unaware of religious restrictions or are uncomfortable complaining to their employers about sensitive topics [12,14,20]. We know that denials due to religious restrictions occur, based on reports from providers as well as survey findings showing employees experience care denials at religious facilities [13,15,17]. Employees may be hesitant to address reproductive health issues with their employer, especially if the desired service is private or carries greater stigma, such as contraception or abortion care [21]. It could be that employees themselves are not aware care has been restricted because of religion [11–14]. Or perhaps the employee was eventually able to receive the care due to workarounds used by providers [15,22]. It may also be that employees believe there is little the employer could or would do to address the situation, even if the employer was informed [13].

2.2. Employers assume access to providers and see religion-related limits a carrier responsibility

Given the focus on laws placing requirements on insurance carriers to meet network adequacy and reporting requirements, it's not surprising that large employers assume employees would not

[1] The 14 interviewees included benefits managers or health care consultants or brokers, representing 13 organizations. Eleven informants worked as benefits managers or facilitators at large organizations (8 large private companies, 1 large public university, and 1 large regional health system). Industries represented by the companies included financial services, technology, retail, and manufacturing. The 8 large companies had employees in locations across the United States; 4 were headquartered in the Midwest, 3 on the West Coast and 1 in the South. Three informants served as health care consultants or brokers who facilitated or advised on contracts between employers and insurance carriers, working with clients and their employees across the United States.

face barriers to care because of religious restrictions. When evaluating plans offered to employees, employers generally consider network access (e.g., reviewing number of providers in a geographic region, sometimes by specialty) but defer to the insurance carriers or health plan administrators to ensure network adequacy and address complaints regarding provider networks. Significantly, large employers do not consider religious affiliation of providers and hospitals when assessing network adequacy. As a benefits manager at a large retailer explained, "We don't have a lot of influence, necessarily, [on shaping provider networks] other than the fact that we just bring a lot of lives to the table in some areas, so it helps them negotiate better contracts."

Large employers view health center religious restrictions as an unacceptable limitation on care but assume there are other available options for employees in a plan or network. Again, large employers rely on the insurance carrier to address any complaints arising from religious barriers to care. For instance, 1 benefits manager at a large retailer contended there was "never a religious lock" on where people can get care, though went on to describe their response if such a problem arose,

I guess the only way I'd address it is tell the carrier they gotta find somebody to put in network and give the coverage. There's no other option. […]. If there is an area…where there is a religious lock, then the carriers are obligated to find a place for our people to get the care."

2.3. Employee-employer mismatch in expectations

Despite what employers may believe, research suggests that access to reproductive care is important to employees and they view employers as responsible for ensuring access. Women age 16 and over make up just under half (47%) of the US workforce and many women are also insured through a family member's employer [23]. A 2018 survey among employed adults found that more than half (52%) said benefits offering full reproductive care would be a deciding factor between two employment offers. Even more (60%) said they would be more loyal to a company that offers coverage for prenatal care, family planning, and abortion care [24]. Research also demonstrates that women consider benefits as much as salary when comparing employers [25]. Specifically, recent polling found that 83% of women of reproductive age would want their employers' insurance to cover the full range of reproductive health care, including abortion [21]. Furthermore, 86% of women said that being able to control if and/or when to become a parent has been important to their career path.

Findings from our national survey also demonstrate employee expectations around employer responsibility. When presented with the example of a woman being denied access to a tubal ligation immediately following a cesarean-section birth because the delivery occurred in a Catholic hospital and the woman had no other hospital choice, the majority of respondents (60%) felt that something should have been done differently [18]. Within this group, 33% thought the employer should have done something differently. In addition, 79% of all respondents felt that the employer should do something to assist the couple, with 44% believing the employer should ask the insurance company to add a new hospital to the network, 38% thought the employer should ask the insurance company to cover the costs, and 24% thought the employer should cover the extra costs [18].

Examples in large employer settings reinforce the idea that employees have expectations for access, especially when a new benefits plan might reduce access. For instance, employees of a recently acquired company expressed such broad frustration when offered lesser coverage for contraception with their new owner that contraceptive coverage was then expanded for the entire company.

2.4. Employers do not use their leverage equally for all services

Since most reproductive-age women get health care through employer-sponsored health plans, employers have an essential role in assuring access to care. As 1 benefits advisor pointed out, "It's employers [who] pay for 56 to 60% of all health care cost in this country… so really, we're the real payer of health care services." Given this role, large companies and self-insured employers have significant leverage in negotiations with insurance carriers and other health plan administrators to shape benefits offerings. As a benefits manager at a financial services company explained, "I mean the bigger you are the more flexibility you have with the carriers." However, our research and others' suggests that employers feel like they have more leverage to curate covered services but less influence over provider networks [26]. One report points out that companies may not even have access to quality or other metrics from insurance carriers to assess provider networks [19].

Still, large employers may have more leverage to influence health insurance networks than they recognize. For example, some large employers pressure insurance carriers for changes or are willing to create exceptions for services like fertility benefits when there is visible demand. This response suggests a willingness among some employers to search for creative and potentially higher-cost solutions to tailor benefits and networks to better suit the reproductive health priorities of employees. For example, benefits managers talked about high demand for access to fertility benefits, citing the large female population of their workforce, the need to remain competitive with peer employers, and a vocal "craving for IVF." Of particular note, employer responsibility for creating access even went beyond covering costs; several large employers added fertility benefits by "carving out" or coordinating directly with a specialty fertility network in addition to their traditional insurance networks in order to make the services available to employees. While this serves as a helpful example of employers' willingness to find creative solutions, it's also worth noting that such focused attention on fertility benefits raises considerations of equity in access to reproductive health care. Research shows that women seeking help to become pregnant tend to be older, white, living on higher-incomes, and privately insured; this population may feel more empowered in the workplace to demand coverage and provider access for fertility-related reproductive care that is less stigmatized than contraception and abortion [27]. However, employers should be leveraging their influence to ensure employee access to the full spectrum of reproductive care.

3. Potential approaches for employer action

A recent report from the Wharton Social Impact Initiative proposes a framework for evaluating companies' impact on the women they employ; one of the core 4 criteria suggests that a good employer for women is one that "supports and protects the health" of the women (and men) it employs, including through health insurance benefits [28]. Given the leverage larger companies have in their relationships with insurance carriers, insurance brokers, and their peers, untapped opportunities exist to assure employee access to care that might otherwise be denied due to network barriers. We propose the following actions for large employers.

3.1. More purposeful data collection

At the very least, employers could consider proactively collecting more nuanced anonymous feedback from employees regarding their experience with reproductive health care access. This should not be confused with merely waiting to hear of employee complaints; expecting employees to disclose personal health informa-

tion in the workplace in order to get reproductive care only reinforces societal pressures on women to carry the emotional and practical burdens of preventing pregnancy, also described as "fertility work", and securing pregnancy-related care [29,30]. Internal audits to identify coverage and network access gaps could also reveal opportunities for action [21].

3.2. Assure true network adequacy

Large employers consider it the insurance carrier's responsibility to ensure networks include a diverse set of providers in the first place. When assessing network adequacy, employers could ask carriers to identify and track religious hospitals in networks and include information about religious affiliations and associated care restrictions for employees comparing plans and providers. A recent survey of US women found that more than 80% feel that it is important to know about a hospital's religious restrictions before deciding where to seek care [20].

3.3. Treat out-of-network as in-network

Large employers could require insurers to treat out-of-network providers like in-network providers for reproductive and other care that is restricted in religious health settings. Large employers already appear to push for this type of response in some individual cases that arise, working to reduce costs for employees who cannot access care within a certain geographic radius, for instance. Establishing a consistent rule across offered plans would help ensure access. One approach would be to press insurance companies to allow employees who are denied care based on religious restrictions the opportunity to seek care elsewhere and have it covered as if it were in-network. However, this practice would only benefit employees who know their care has been obstructed because of religious restrictions and who are willing to make a complaint to their insurance company or employer. Another, more comprehensive approach that acknowledges the difficulty employees may have in identifying barriers to care would be to pre-emptively allow employees to seek reproductive and other care commonly restricted for religious reasons at their preferred providers with a guarantee of coverage. This approach would mimic longstanding requirements in the Medicaid program. Policy rules governing Medicaid acknowledge barriers to reproductive care and make clear that recipients can obtain family planning care from any provider who accepts Medicaid, regardless of any network restrictions that may apply for other care; private insurance could adopt a similar approach to ensure employees are not constrained within inadequate networks [31].

3.4. Set an example for other employers

Large employers have the ability to set industry standards regarding health benefits. We know that benefits managers pay close attention to the benefits offerings among peer employers and many advertise their commitment to gender equality [28]. Detailing plans to ensure employee access to health care, free from barriers imposed by religious restrictions that disproportionately affect female employees, is one way to demonstrate that commitment and encourage other employers to do the same.

4. Conclusions

Research suggests that large employers may have leverage to influence health insurance networks to improve access to reproductive health services. While reproductive health does not receive much attention in benefit design, large employers are willing to respond to employee feedback and priorities regarding reproductive health coverage. In particular, large employers may be able to pressure insurance carriers to address gaps in care resulting from religious restrictions.

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