EDITORIALS

Contraception at Risk

The Editors

In March 2014, the U.S. Supreme Court will hear oral arguments in two cases, *Sebelius v. Hobby Lobby Stores, Inc.*[1] and *Conestoga Wood Specialties Corp. v. Sebelius*.[2] These cases, which arise from an Affordable Care Act mandate, will have a critical impact on women's health. At issue is whether a for-profit corporation can be required to provide coverage for contraceptive services to its employees. We believe that provision of these services meets a critical public health need and that a woman, regardless of the religious beliefs of her employer, should have access to a full panel of Food and Drug Administration (FDA)–approved methods of contraception as part of a basic package of health services.

In the *Hobby Lobby* case, the plaintiffs' challenge derives from statutory law, the Religious Freedom Restoration Act (RFRA). According to that law, the government may not infringe on religious freedom unless there is a compelling state interest. Hobby Lobby argues that the contraceptive mandate contravenes the RFRA and should be struck down. In the *Conestoga* case, the plaintiff argues not only that the government overstepped the RFRA, but also that it infringed on the free exercise of religion protected by the First Amendment. As part of its examination, the Court will consider whether the protection of women's health is a compelling state interest and whether corporations have religious rights (or whether such constitutional rights are limited to individuals).

In the *Hobby Lobby* case, the Court will consider whether the provision of contraceptive services meets a compelling public health need. We believe, along with an Institute of Medicine committee that reported in July 2011,[3] that it does. First, appropriately prescribed contraceptive services prevent unintended pregnancies without promoting promiscuity.[4] Preventing unplanned pregnancies, more than half of which are currently terminated, averts these induced abortions and their attendant financial, physical, and psychosocial expense. More important, planned pregnancy affords women and their children a better quality of life: it gives younger women the opportunity to complete school, start careers, and establish stable relationships, and older women the ability to add to their families only when they have the capacity to care for them. Finally, a full panel of contraceptive services saves money for the state, as evidenced by gathered data[5] and empirical modeling.[6] Simply put, there is a compelling public health value in preventing unwanted pregnancy.

In working with women to prevent unwanted pregnancy, physicians need the full panel of FDA-approved contraceptive methods. If that panel is limited by a woman's inability to pay — if the method deemed optimal for her is unavailable because her health insurance does not cover it — then the religious freedom of her employer will have interfered with the provision of high-quality medical care to her. In this context, the welfare of the patient must trump the religious convictions of her employer. After all, it is the woman, not her employer, whose health is at risk.

In the *Conestoga* case, the arguments will hinge in part on whether the First Amendment rights of the employer have been infringed. Specifically, the plaintiffs argue that a for-profit corporation should not have to provide coverage for services that it considers unacceptable given

its religious beliefs. This argument is spurious, as can easily be illustrated by potential cases involving recognized religious beliefs and medicine. It would clearly be unacceptable, for example, if an employer who was opposed to blood transfusions offered employees a health insurance policy that did not cover transfusions, thus putting them at high risk for avoidable complications or even death after severe trauma or major surgery. Similar arguments could be made if employers offered health insurance policies that did not cover vaccination, mental health services, or cancer chemotherapy; the employers' religious beliefs would present an unacceptable health risk to their employees. In neither case before the Court is there infringement of personal religious rights; should an employee for religious or other reasons not wish to receive covered services, she is free to make that choice for herself. Accepting the *Conestoga* arguments puts the religious beliefs of an inanimate corporation ahead of the primary health needs of its employees. We do not believe that a for-profit corporation should be able to decide what kinds of health care are available to its employees.

If the full panel of FDA-approved contraceptive services is made available to American women, the public health of the country will benefit. If a woman's religious beliefs compel her to decline such services, she has the right to do so. But to deny coverage for these vital public health services to women who want them but cannot afford them outside their employer-sponsored insurance would be a personal and public health tragedy.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Sebelius v. Hobby Lobby Stores, Inc., No. 13-354 (U.S. Nov. 26, 2013).
2. Conestoga Wood Specialties v. Sebelius, No. 13-356 (U.S. Nov. 26, 2013).
3. National Research Council. Clinical preventive services for women: closing the gaps. Washington, DC: National Academies Press, 2011.
4. Winner B, Peipert JF, Zhao Q, et al. Effectiveness of long-acting reversible contraception. N Engl J Med 2012;366:1998-2007.
5. Thomas A, Monea E. The high cost of unintended pregnancy. CCF [Center on Children and Family at Brookings] report no. 45. Washington, DC: Brookings Institution, 2011.
6. Burlone S, Edelman AB, Caughey AB, Trussell J, Dantas S, Rodriguez MI. Extending contraceptive coverage under the Affordable Care Act saves public funds. Contraception 2013;87:143-8.

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Treatment of Atherosclerotic Renovascular Disease

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If the treatment of renal-artery stenoses can improve blood pressure and renal function,[1] why have clinical trials of renal-artery stenting failed to reduce the rates of renal and cardiovascular events?[2-4] The answer is found by examining the design and results of the Cardiovascular Outcomes in Renal Atherosclerotic Lesions (CORAL) trial, now reported in the *Journal*,[4] which concludes that implanting stents for moderately severe obstructive renovascular disease is no better than medical therapy alone in preventing the primary end point of death from cardiovascular or renal causes, myocardial infarction, stroke, hospitalization for heart failure, progression of renal failure, or the need for renal-replacement therapy.

The CORAL trial replicates the findings of the Angioplasty and Stenting for Renal Artery Lesions (ASTRAL) trial[2] and the Stent Placement and Blood Pressure and Lipid-Lowering for the Prevention of Progression of Renal Dysfunction Caused by Atherosclerotic Ostial Stenosis of the Renal Artery (STAR) trial[3] and establishes beyond a reasonable doubt that renal-artery stenting is futile for the target population enrolled in the study. Patients who have atherosclerotic disease with a mean renal-artery stenosis of 73%, as assessed visually on angiography, in addition to hypertension while receiving two or more antihypertensive drugs or stage 3 chronic kidney disease, should not undergo renal-artery stenting, because the only tangible consequence is the procedure-related risk of bleeding or vascular complications.

The CORAL trial addresses the criticism leveled against earlier randomized trials that they enrolled patients with mild renal-artery stenoses. The current study required patients to have