The Contraceptive Covenant: Examining the Relationship Between State Religiosity and Contraceptive Policy for Insured Dependents

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Introduction

Religion permeates public life for individuals living in the United States (US), with 70% of US Americans deeming religion an important part of their lives.[1] Involvement with religious institutions shapes individual perspectives on issues related to family planning, including contraceptive policy.[2] While the relationship between religiosity and reproductive health outcomes has been explored, there remains little scholarship investigating the relationship between religiosity and reproductive health policy.[3-5] This research seeks to examine the state legislatures' response to the Patient Protection and Affordable Care Act (ACA) raising the dependent maximum age to 26, creating a new class of older insured dependents facing confidentiality concerns when accessing contraceptive care under existing guidelines that treated dependents as minor children of policyholders.

Research Question

What is the relationship, if any, between religious service attendance and the presence of state legislation safeguarding the confidentiality of insured dependents seeking contraceptive care?

Theoretical Frameworks

Rational Choice Theory provides a framework for understanding the role of personal beliefs, institutional ideology, and socio-cultural influences in shaping behaviors.[6] RCT submits that individuals' self-imposed sanctions (e.g., feelings of guilt, shame, or spiritual distress) are correlated with their degree of religious commitment when contemplating or engaging in contraceptive use.

Social Control Theory complements this understanding by emphasizing the role of religious congregations in regulating behavior. Even if congregants do not hold the same views as faith leaders, those who are strongly bonded to their religious community can internalize ideology as morality and are thus still less likely to engage in behaviors that contradict their community's norms.[7]

Discussion

The self-imposed sanctions that come with strong intrinsic and extrinsic religiosity, as well as extrinsic consequences if the pursuit or receipt of care is disclosed, may dissuade individuals from both publicly and privately engaging in behavior noncompliant with community norms. Accordingly, they may be more likely to consider religious teachings and socialization in not only their own use of contraceptives but also in electing officials who do not support access-oriented policy for insured dependents. Similarly, individuals with low religiosity may be more likely to disregard religious teachings and socialization in their decision-making, thus being more likely to vote for candidates who support access-oriented contraceptive policy. At a demographic level, this variance may translate to differences in policy.

Higher levels of religiosity are associated with certain favorable reproductive health outcomes, including reduced rates of unintended pregnancies.[10] This study suggests that increased religiosity is also correlated with less access-oriented contraceptive policy. While religiosity can positively influence certain health behaviors, its impact on policy may contradictingly simultaneously create barriers to contraceptive access. Understanding the influence of religiosity on contraceptive policy can also help in designing targeted interventions and advocacy strategies. For instance, in states with high religiosity, efforts to increase policy support might focus on reframing the benefits of contraceptive access in ways that resonate with religious values, such as emphasizing family health and well-being.

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References & Acknowledgments

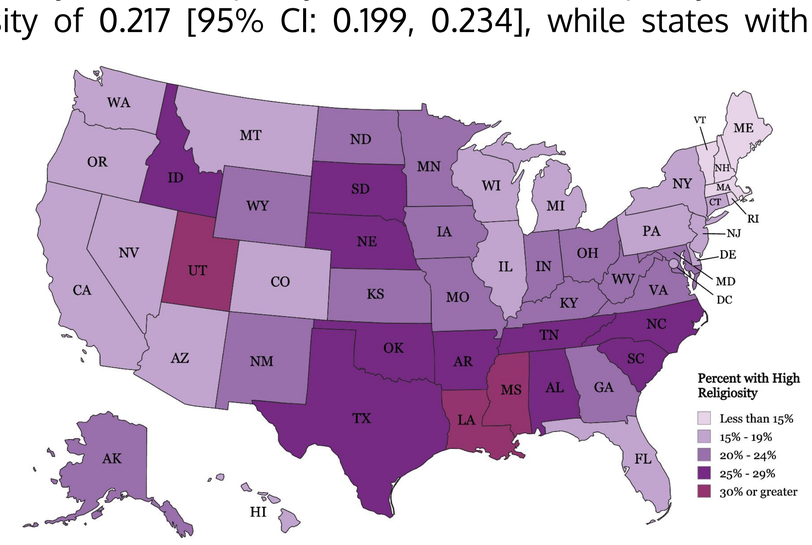
Methodology

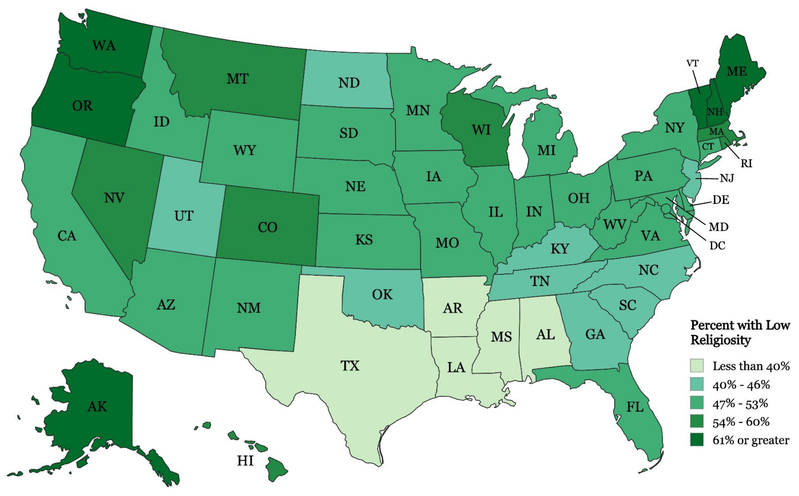
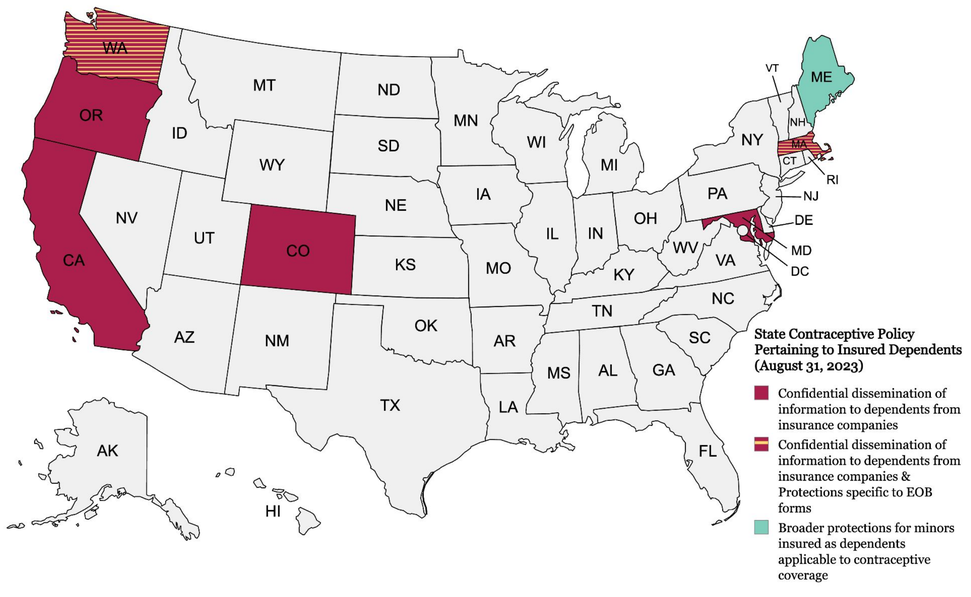
Data from the Guttmacher Institute was used to evaluate which states had legislation that protected the confidentiality of insured dependents seeking contraceptive care as of August 31, 2023.[8] The dataset for religious service attendance was obtained from the US Census Household Pulse Survey, Phase 4.0 Cycle 2 conducted February 6 to March 4, 2024.[9] Low religiosity reflected the percentage of respondents who reported attendance as never or less than once per year. High religiosity reflected the percentage who reported attendance at 12 or more times per year.

A logistic regression analysis was performed using STATA BE 18.0 to assess the relationship between religiosity and state contraceptive policy. Chi-square tests of independence compared state religiosity with and without contraceptive policy present. Statistical significance was set at the 95% level ($p < .05$).

Results

There was a statistically significant difference in the mean religiosity between rates of low and high religiosity and state policy. States with absent policy had a mean rate of high religiosity of 0.217 [95% CI: 0.199, 0.234], while states with present policy had a mean rate of 0.165 [95% CI: 0.137, 0.192] ($p = .0114$). States with absent policy had a mean rate of low religiosity of 0.492 [0.468 to 0.516], while states with present policy had a mean rate of 0.579 [0.524 to 0.634] ($p = .0036$).





The odds of having a policy in place increased by 14.7% with every additional percentage point of low religiosity [OR 1.147 (95% CI: 1.024, 1.284) ($p = .0034$)]. There was a significant relationship between higher rates of low religiosity and the presence of policy [LR $chi^2(1) = 6.89$ ($p = .0087$)]. Conversely, states with high religiosity were 19.3% less likely to have policy in place with every percentage increase in high religiosity [OR 0.807 (95% CI: 0.662, 0.984) ($p = .018$)]. There was a significant relationship between increased rates of high religiosity and the absence of policy [LR $chi^2(1) = 6.02$ ($p = .0141$)].