# Federal Law Urged As Culmination of Contraceptive Insurance Coverage Campaign

**By Susan A. Cohen**

On September 10, the day before the terrorist attacks on the United States, the Senate Health, Education, Labor and Pensions Committee held a hearing designed to refocus federal policymakers on the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), which was introduced in Congress over four years ago. The time had come, testified the bill's lead sponsors, Sens. Olympia J. Snowe (R-ME) and Harry Reid (D-NV), for Congress to act.

The next morning, the world changed dramatically, as did the congressional agenda, for the near-term at least. Clearly, it will take some time for attention to turn back to ongoing domestic policy issues, even though the needs of U.S. citizens for such things as basic health care have not changed since September 11. Nor has the fundamental case for contraceptive insurance coverage.

Research conducted by The Alan Guttmacher Institute, published in 1994, found that while virtually all traditional indemnity health plans covered prescription drugs, half did not cover prescription contraceptives at all. Only one-third covered the birth control pill—the most popular reversible method among U.S. women. Coverage of contraceptive services and supplies was more extensive in health maintenance organizations, the original form of managed care in the United States, but even among those plans, only four in 10 covered the full range of methods then approved by the Food and Drug Administration. Coverage in what have become today's most prevalent types of managed care plans, "preferred provider" and "point-of-service" plans, fell somewhere in between but leaned toward the coverage patterns of indemnity plans.

These findings were instrumental in providing the impetus for a multipronged strategy to expand contraceptive insurance coverage, the centerpiece of which was EPICC, which would secure, as a matter of federal law, universal coverage for all women with insurance throughout the United States. Since 1994, one-third of the states have enacted or adopted their own versions of EPICC, the U.S. Equal Employment Opportunity Commission (EEOC) has determined that an employer's failure to include contraceptives in its prescription drug plan constitutes gender discrimination under Title VII of the Civil Rights Act and a U.S. district court has ruled likewise. In addition, the federal government in its role as an employer has required that contraceptive coverage be available throughout the Federal Employees Health Benefits Program (FEHBP) since 1999.

Meanwhile, EPICC itself—first introduced in 1997 by Snowe and Reid, along with Reps. James Greenwood (R-PA) and Nita M. Lowey (D-NY) in the House—still languishes on the national legislative agenda. At the September 10 Senate hearing, Committee Chairman Edward M. Kennedy (D-MA) said action should come soon so that "*all* women *throughout* the nation have access to the family planning services they need and want." While passage will no longer occur this year, the groundwork has now been laid for advancing the legislation in the near future.

## In the States and the Courts

The states have been leading the way in the drive to ensure contraceptive coverage (see box). Their laws, and in a few cases administrative policies, are similar to each other and to the federal legislation. They do not aim for "special treatment of contraceptives," says Reid, "only equitable treatment within the context of an existing prescription drug benefit." State policies simply require, as would EPICC, that insurance plans provide the same level of coverage for all FDA-approved prescription contraceptives and related outpatient services as is provided for other prescription drugs and outpatient preventive care. While the question of how to accommodate religious employers with objections to contraception has not yet been confronted in the context of EPICC, here again the states have already grappled with this complex issue and arrived at a range of often-creative solutions (see box, page 12).

In addition to the ongoing legislative and policy activity, a litigation strategy to advance the cause of contraceptive coverage commenced in July 2000, when Planned Parenthood of Western Washington and Planned Parenthood Federation of America went to court to argue that exclusion of contraceptive coverage amounts to illegal sex discrimination. The lead plaintiff in the case was Jennifer Erickson, a Washington State pharmacist, who was dismayed to discover that her employer, Bartell Drug Company, did not provide insurance coverage for prescription contraceptives.

In June 2001, the U.S. District Court for the Western District of Washington issued a landmark decision in Erickson's favor. The court held in *Erickson v. Bartell Drug Co.* that excluding prescription contra-

ceptives from an otherwise comprehensive prescription drug plan is illegal. "The law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception," the court said. "The special or increased healthcare needs associated with a woman's unique sex-based characteristics must be met to the same extent, and the same terms, as other healthcare needs."

**STATE LAWS REQUIRING COMPREHENSIVE INSURANCE COVERAGE OF PRESCRIPTION CONTRACEPTIVES**

| | |
|---|---|
| **1998** | **2000** |
| Maryland | Delaware |
| **1999** | Iowa |
| California | Rhode Island |
| Connecticut | **2001** |
| Georgia | Missouri* |
| Hawaii | New Mexico |
| Maine | Texas* |
| Nevada | Washington*,† |
| New Hampshire | |
| North Carolina | |
| Vermont | |

**Takes effect in January 2002. †By regulation.*

The court's decision in *Erickson*, which technically applies only to Bartell, was to a large extent based on an EEOC policy statement issued in December 2000. The EEOC, which had been asked by two nurses to consider a discrimination charge against their respective employers, concluded that the employers' failure to provide contraceptive coverage, as a component of prescription drug coverage, constituted illegal gender discrimination under Title VII of the Civil Rights Act. As the federal agency charged with interpreting and enforcing civil rights law with regard to all affected employers (those with 15 or more employees), the EEOC's statement, although technically applying to the two specific employers, constitutes formal agency policy, serves notice to employers of their legal obligations and alerts employees to their legal right to coverage.

In order to avoid Title VII violations in the future, the EEOC has instructed the employers to

- cover prescription contraceptives to the same degree as other prescription drugs and devices used for preventive care are covered;

- ensure that outpatient services related to contraceptive care are included on the same basis as other outpatient services;

- offer the full range of prescription contraceptive choices; and

- guarantee that such coverage is available in all health plans available to their employees.

## Need for a National Policy

As important and encouraging as these developments are, insurance coverage for prescription contraceptives, both in principle and in practice, remains a patchwork, and a limited one at best.

A woman's right to contraceptive coverage today is contingent to a large extent on the state in which she lives. Even then, state contraceptive coverage laws do not apply to those employers who self-insure; nationwide, almost half of all workers who obtain their insurance through their employers work for companies that self-insure.

While the EEOC statement and the federal court ruling in *Erickson* are momentous, making their decisions a reality, at this point, may depend on more women being willing to sue their employers. Even then, Title VII only applies to employers with 15 or more employees. Fewer than one-fifth of all U.S. employers fall into this category, leaving out some 14 million people working for small businesses as well as another 16 million who obtain health insurance through the individual market.

Both the accumulation of state laws and the invocation of Title VII contribute to a consciousness-raising that should encourage more employers to incorporate contraceptive coverage in their health plans. This will take time, though, and may never happen under many policies. For that reason, the purpose of the Senate hearing was to draw attention both to the momentum behind the movement for contraceptive coverage and the need for Congress to finally establish a nationwide policy.

Sen. Barbara A. Mikulski (D-MD), who chaired the hearing and represents the first state to enact its own contraceptive coverage law, opened the hearing with an observation that women pay a "gender tax." EPICC could go a long way toward reducing the extra burden on women, she submitted, pointing out that women of reproductive age pay 68% more in out-of-pocket costs than men of the same age, with expenses related to reproductive health care accounting for much of this difference.

Both Snowe and Reid asserted that the tremendous progress that has occurred so far in the states is all the more reason that Congress should finally step in to make this a national norm. Their call for enactment of EPICC, *because* of the gains that have already been made, were echoed by Jennifer Erickson as well as Marcia D. Greenberger of the National Womens' Law Center, which instigated the EEOC's examination of this issue.

Only the U.S. Chamber of Commerce sent a representative to testify against the idea of the EPICC legislation. In the Chamber's view, contraceptive coverage is yet another "mandate [that] will further increase costs and jeopardize the affordability and availability of health plans for workers."

The Chamber opposes insurance mandates across the board, and in

coalition with other business and insurance interests, it has successfully taken on some, but not all, such proposals over the years. Indeed, it may come as a surprise to many who take insurance coverage of prenatal and delivery services for granted that inclusion of maternity care became industry standard only as the result of a hard-won federal mandate enacted in 1978. Then, as now, added cost and the threat that employers would drop insurance coverage were cited as major reasons to resist adding any new insurance requirements. In the case of contraceptive coverage, though, the costs have been shown to be, at the most, nominal.

The federal government, which is the nation's largest employer, has provided contraceptive coverage through the massive FEHBP since Congress passed a law requiring it to do so in 1998. The federal Office of Personnel Management reported early this year that "there was no cost increase" in premiums due to the contraceptive coverage requirement that took effect in 1999.

A 1998 analysis by The Alan Guttmacher Institute found that, on average, adding contraceptive coverage in the private market would cost employers that currently do not provide any coverage at all just $21.40 per employee per year to cover the full range of FDA-approved methods. Assuming the employer would pay 80% of the cost, this would amount to about $1.43 per month in premium costs for each employee. Naturally, the cost would be even less for those employers already offering at least some coverage ("The Need for and Cost of Mandating Private Insurance Coverage of Contraception," *TGR*, August 1998, page 5).

More recently, the Washington Business Group on Health went further and estimated that "*not* providing contraceptive coverage may in fact cost an employer 15–17% more than providing coverage" (emphasis added). As Sen. Snowe put it plainly, "When we talk about costs, let's talk about the costs of unintended pregnancy."

Finally, beyond the issues of cost and savings, universal contraceptive insurance coverage stands as a key part of Congress's long-term effort to discourage abortion and reduce its incidence. Facilitating access to effective, voluntary contraceptive services in order to reduce the incidence among women of unintended pregnancy in the first place has long been established as the single most effective way to achieve this goal. As Snowe stated at the Senate hearing, "It defies logic why Congress has been reluctant to have a national law."

## Conscience and Contraception

*Debates over contraceptive coverage laws often get embroiled in the highly charged topic of "conscience." The issue centers on whether certain employers (or insurers) should be entitled to claim a conscientious objection to providing contraceptive coverage and, if so, on what grounds. At the same time, these factors must be considered in light of their effects on achieving the goal of the legislation: to guarantee individual employees' access to contraceptive services and supplies.*

*Of the 17 states with contraceptive coverage laws or policies, 12 have incorporated some form of exemption to take into account religious beliefs.* Most allow "religious employers," variously defined, to opt out where the coverage would conflict with the employer's bona fide religious tenets. Missouri's law is the only one that allows employers that are not religious entities to opt out for moral or ethical reasons. The effect of such a compromise, however, even when narrowly drawn, is that employees at these corporations, whether they subscribe to their employer's religious beliefs on the question of contraception or not, are left without coverage. In recognition of this problem, Hawaii's law, for example, goes so far as to provide that affected employees may purchase contraceptive coverage on their own at the same price as the group rate would have been. Missouri's broader exemption includes a similar provision and additional protections for employees ("State Contraceptive Coverage Laws: Creative Responses to Questions of 'Conscience'," TGR, August 1999, page 1).*

*EPICC, as introduced, does not contain any exemptions. It is not hard to imagine, however, that debate over a "conscience clause" could overshadow even the subject of costs and mandates once the legislation begins to move. If so, state precedents could be helpful in addressing this vexing policy issue in ways that seek to respect the conscientious beliefs of women, not just those of corporations, as well as women's legitimate reproductive health needs.*

**California, Connecticut, Delaware, Hawaii, Maine, Maryland, Missouri, Nevada, New Mexico, North Carolina, Rhode Island and Texas.*