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A Matter of Necessity: The Case for Mandating Health Insurance for Contraception

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Abstract

This paper examines the recent judicial, administrative, and federal and state legislative efforts to mandate contraceptive coverage. The paper analyzes the reasons why historically contraception has been excluded from health insurance plans and then concludes that to end gender discrimination, increase women's power in the workforce, reduce unintended pregnancies and encourage pharmaceutical research and development, Congress should pass the Equity in Prescription and Contraceptive Coverage Act.

I. Introduction

“We allow our insurance companies to be biased against women. If men were the ones who got pregnant, you know it would be different.”¹

“Instituting insurance coverage for contraception that is adequate and fair, even and equal, is a minimum requirement for ensuring reproductive health care for American women and is a sensible private-sector as well as public-sector policy goal.”²

On September 10, 2001 Congress's Health, Education, Labor and Pensions (HELP) Committee held a hearing on S.104, the Equity in Prescription and Contraceptive Coverage Act of 2001 (EPICC).³ If enacted, EPICC would require that health plans or issuers providing health insurance coverage may not “exclude or restrict benefits for prescription contraceptive drugs or devices approved by the Food and Drug Administration [FDA].”⁴ In other words, EPICC would mandate by federal law that all private health insurers and employers that offer prescription drug coverage in their plans, include coverage for prescription contraceptives, such as oral contraceptive pills, Depo-Provera, Norplant, intrauterine devices (IUDs), diaphragms and cervical caps.

This introduction of the EPICC legislation was quite timely, in that it followed a recent Equal Employment

¹ANDREA TONE, DEVICES AND DESIRES: A HISTORY OF CONTRACEPTIVES IN AMERICA 291 (2001) (quoting Dr. Mitchell Creinin, Director of Family Planning at the University of Pittsburgh).

²James Trussell, Jacqueline Koenig, Felicia Stewart and Jacqueline Darroch, *Medical Care Cost Savings from Adolescent Contraceptive Use*, FAMILY PLANNING PERSPECTIVES, Nov./Dec. 1997, at 15.

³*Equity in Prescription and Contraceptive Coverage Act of 2001: Hearings on S. 104 Before the Senate Committee on Health, Education, Labor and Pensions*, 107th Cong. (2001).

⁴S. 104, 107th Cong. § 714 (2001).

Opportunity Commission (EEOC) administrative decision, which ruled that the exclusion of prescription contraceptives from otherwise comprehensive insurance plans was a violation of Title VII of the 1964 Civil Rights Act's antidiscrimination laws⁵ and a ruling by a Washington State district court that an employer's exclusion of prescription contraceptives did indeed violate Title VII.⁶ In addition, EPICC was introduced in the U.S. Congress as many states had their own legislation pending, or had recently passed legislation that would mandate insurance coverage of contraceptives.⁷ Unfortunately for American women, EPICC's hearing took place the day before the worst national tragedy in decades. On September 11, 2001, the nation's focus shifted immediately and dramatically from this and other important issues of domestic policy, to the international conflict posed by terrorist organizations across the globe. Instead of debating family planning issues, Congress was quickly forced to pass legislation aiding the airlines and the victims of the World Trade Center and Pentagon attacks and work with the President to declare a war on terrorism. The partisanship that characterized the 107th Congress until September 11 subsided in a show of national unity and strength. Both the Congressional and Executive domestic agendas were shelved, put on hold until the immediate national emergency was abated. Thus, EPICC went no further than the September 10 HELP hearing. Although its introduction was timely, given that the issue of contraceptive coverage had recently arisen in the judicial, administrative and state legislative realms, the timing of the hearing was most unfortunate. This paper will examine in some detail each of the judicial, administrative and legislative efforts to mandate contraceptive coverage and then argue that although the EEOC opinion, Erickson ruling, and state legislative enactments are important steps in the direction of treating contraception and thus, women, equally in the context of insurance coverage and employment, federal legislation in the form of EPICC is necessary. The paper will question why so many insurance providers choose not to cover prescription contraceptives and

⁵See Wendy Netter, *Insurance: Exclusion of Contraception Found Discriminatory by EEOC*, J.L. MED. & ETHICS, Spring 2001 at 104.

⁶See *Erickson v. Bartell*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

⁷See *NARAL Report: States Failing to Provide Adequate Access to Contraception: Some Progress Made, Many Barriers Still Exist*, U.S. NEWSWIRE, Sept. 13, 2001.

what the economic, social and moral implications of this lack of coverage are. Finally, the paper will establish that access to affordable contraception is essential for four main reasons: 1 - to save insurance companies, employers, and the public the exorbitant economic and social costs of unintended pregnancies; 2 - to increase women's equality and power in society and the workforce by allowing them to control the number and timing of their pregnancies; 3 - to encourage pharmaceutical companies to research and develop new, more effective contraceptive technology by insuring there is a predictable market for new contraceptive products; and 4 - to end the historic gender discrimination present in many prescription drug plans.

Currently, there are sixty million women in the United States in their childbearing years – between the ages of fifteen and forty-four.⁸ Contraception is an essential part of their basic health care. The federal government can no longer leave it up to individual employers and insurers to decide whether to cover contraceptives because those entities have failed women by excluding contraception from many insurance plans. Congress should act now to pass EPICC and send a message that contraception is a basic health need that insurance companies and employers cannot opt out of providing.

II. Legal Setting

The Equal Employment Opportunity Commission

One of the first indications that the tide was turning toward requiring health insurance coverage for contraception was the December 14, 2000 decision of the Equal Employment Opportunity Commission (EEOC), ruling that two employers who failed to offer insurance coverage for the cost of prescription contraceptive

⁸See *Get the Facts*, (visited Mar. 13, 2002) www.covermypills.org.

drugs and devices had violated Title VII of the Civil Rights Act of 1964 (Title VII),⁹ as amended by the Pregnancy Discrimination Act of 1978 (PDA).¹⁰ These employers were forced to reimburse employees for the costs of their prescription contraceptives for the applicable back pay period.¹¹ Although the agency's decision was not binding on courts and only applied to the two women who filed charges with the EEOC against their employers, it did provide guidance for both Congress (in its EPICC hearings) and the Erickson court as to how Title VII should apply in this context.

The EEOC was careful to note that the reasons *why* a woman utilized contraceptives is irrelevant to the Title VII question. In this sense, whether a prescription such as an oral contraceptive is used to prevent pregnancy or to reduce menstrual cramps cannot factor into the decision to cover contraceptives. Because prescription contraceptives are available and used only by women, excluding them from an otherwise comprehensive prescription drug benefit plan is *facially* discriminatory even though the exclusion of prescription contraceptives may not explicitly distinguish between men and women. "Because one hundred percent of the people affected by [employer's] policy are members of the same protected group – here, women – [employer's] policy need not specifically refer to that group in order to be facially discriminatory."¹² Resting the Title VII violation on the fact that prescription contraceptives are used only by women raises an interesting question as to whether employers and insurance companies could exclude all contraceptive coverage should a viable male prescription contraceptive be developed in the future.¹³

Women's health and advocacy groups such as Planned Parenthood and the National Women's Law Center (NWLC) were particularly pleased with the EEOC decision, and after its release proclaimed that until Congress passed legislation requiring employers to offer prescription contraceptive coverage, they would con-

⁹42 U.S.C. §2000e.

¹⁰42 U.S.C. §2000e(k).

¹¹EEOC Decision on Coverage of Contraception, Dec. 14, 2000, (visited on Mar. 20, 2002) www.eeoc.gov/docs/decision-contraception.html.

¹²See *id.* at 5.

¹³See Polly F. Harrison & Allan Rosenfield, Eds., *Contraceptive Research and Development: Looking to the Future*, J. AM. MED. ASS'N, 1996 at 9 (recommending that future contraceptive research consider developing methods for males that would expand their contraceptive choices and responsibility).

tinue to file lawsuits on behalf of women that had been discriminated against in this manner.¹⁴ At the time, Jennifer Erickson’s class action complaint was pending in a Washington federal court, and her class was represented in part by attorneys from Planned Parenthood and the National Women’s Law Center.¹⁵

Erickson v. Bartell

On June 12, 2001 the U.S. District Court for the Western District of Washington handed down a landmark decision in a case of first impression, holding that the “selective exclusion of prescription contraceptives from defendant’s [Bartell Drugs] generally comprehensive prescription plan constitutes discrimination on the basis of sex.”¹⁶ The Court found that Bartell’s exclusion of prescription contraception was inconsistent with the requirements of federal law under Title VII,¹⁷ and the Pregnancy Discrimination Act.¹⁸ Under Title VII, it is unlawful for an employer “to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex or national origin.”¹⁹ Furthermore, according to Judge Lasnik, “it is undisputed that fringe benefits, such as the prescription benefit plan at issue here, are part of the employees’ ‘compensation, terms, conditions, or privileges of employment’.”²⁰ For Judge Lasnik, the resolution of this case was relatively straightforward. Defendant Bartell Drugs was an

¹⁴Tamar Lewin, *Agency Finds Many Health Plans Should Cover Contraceptive Costs*, N.Y. TIMES, Dec. 15, 2000 at A1.

¹⁵In addition, the EEOC has subsequently brought at least one Title VII suit against a major corporation – the United Parcel Service (UPS) - alleging that the exclusion of all oral contraceptives, even when prescribed to treat hormonal disorders, from UPS’s health plan but inclusion of treatments for male hormonal disorders was both a case of impermissible disparate treatment and disparate impact. The claim survived UPS’s motion to dismiss. *See EEOC v. United Parcel Service, Inc.*, 141 F. Supp. 2d 1216 (D. Minn. 2001).

¹⁶*See Erickson*, 141 F. Supp. 2d at 1268.

¹⁷42 U.S.C. §2000e.

¹⁸42 U.S.C. §2000e(k).

¹⁹*See* 42 U.S.C. §2000e.

²⁰*See Erickson*, 141 F. Supp. 2d at 1269 and n.3, *citing* *Newport News Dock Co. v. EEOC*, 462 U.S. 669, 682 (1983).

employer subject to Title VII (employers with 15 or more employees are subject to federal antidiscrimination legislation)²¹ offering its employees a self-insured benefit plan that covered all prescription drugs, but specifically excluded from coverage “a handful of products, including contraceptive devices,”²² which were available only to women. This amounted to impermissible Title VII discrimination. Despite the fact that the resolution is both legally and logically correct, it was the first ruling of its kind, because it was the first lawsuit of its kind.²³ Although the PDA amended Title VII in 1978, it was more than twenty years before a lawsuit was brought challenging the ongoing discrimination by employers and health insurers. I will discuss why this is below.

Jennifer Erickson was the perfect plaintiff representative for a class action lawsuit alleging Title VII gender discrimination in the context of employers’ exclusion of contraceptives from insurance coverage. Ms. Erickson is a twenty-seven year old, attractive, white, married woman who works as a pharmacist for the Bartell Drug Company in Washington State. Both she and her husband Scott have full-time jobs. When she testified on September 10 at the Congressional EPICC hearing, Ms. Erickson noted that she and Scott were “working hard to save money.”²⁴ They had recently bought their first house and spent a lot of time fixing it up. Jennifer testified that while she and Scott were “both looking forward to starting a family, [they wanted] to be adequately prepared for the financial and emotional challenges of parenting.”²⁵ Someday, when she and Scott were “ready,” they planned to have one or two children but “could not cope with having twelve to fifteen children, which is the average number of children women would have during their lives without access to contraception.”²⁶

As a middle class woman and as a health professional, Jennifer Erickson was adversely affected by her

²¹42 U.S.C. §2000e(b).

²²See Erickson, 141 F. Supp. at 1268 and n.1.

²³See Julie Hatcher, *Erickson v. Bartell Drug Co: Prescription for Equality in Insurance Coverage*, 25 AM. J. TRIAL ADVOC. 231 (2001).

²⁴See *Hearings on S. 104*, supra note 3, (testimony of Jennifer Erickson).

²⁵*Id.*

²⁶*Id.*

own insurer's policy, and her customers' insurance policies, which similarly excluded contraceptive coverage. Contraception was her "most important, ongoing health need" and her monthly prescription of oral contraceptives cost her about \$30.00 per month. She did not realize that Bartell's prescription drug plan didn't cover contraceptives until after she started working there²⁷ (and this lack of information is certainly not unusual, the vast majority of insured persons (even highly educated professionals) do not know the particulars of their coverage until they attempt to use their plan to purchase a prescription or obtain coverage for a medical service and are told their plan doesn't insure for that service or prescription).²⁸ Furthermore, very few people have the luxury of choosing an employer based on the specific coverage its insurance plan offers. At the September 10 EPICC hearing, Jennifer explained how although the expense of her own contraception was far from nominal, as a professional with a husband who also worked full-time, she could afford the cost of purchasing oral contraceptives every month. In contrast, many of the women she served as a pharmacist often could not afford their own contraceptive prescriptions. It was frustrating professionally for Jennifer to have to tell the women at her pharmacy that their insurance plans did not cover contraception; she felt that she was failing in some way in her duty as a health care provider. Sadly Jennifer said, she had "seen women leave the pharmacy empty-handed because they [couldn't] afford to pay the full cost of their birth control pills, and it [broke] her heart."²⁹

Thus, Jennifer became the first plaintiff to challenge this exclusionary practice by bringing a lawsuit against her employer. Title VII civil rights claims are difficult to bring; there's a shortage of lawyers willing to take on such cases and a shortage of willing clients because private civil rights attorneys often ask clients to pay the out-of-pocket costs for litigation.³⁰ Fortunately, this issue was ripe for litigation, given the prior EEOC

²⁷See *id.*

²⁸See Sylvia Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363 at n.132 (1998), for multiple examples of this problem, e.g. Janet Benshoof, President of the Center for Reproductive Law and Policy asked her employer to give her information about coverage for contraception and other reproductive health services. "Even as an employer, she discovered information was still hard to obtain. Eventually, Benshoof learned that her organization's health insurer excluded coverage for all contraception except three generic formulas for birth control pills only available by mail order."

²⁹See *Hearings on S. 104*, *supra* note 3, (testimony of Jennifer Erickson).

³⁰See Law, *supra* note 28, at 388-389.

decision, the pending legislation in various states, and the release of Viagra, which was covered by many insurance plans immediately after being placed on the market, causing a firestorm of controversy about why Viagra should be covered and contraception not.³¹ Finally this lawsuit was brought because Planned Parenthood, a well-funded, reputable reproductive rights organization, was willing to take on Jennifer's case in an effort to effect this important change.³²

Jennifer Erickson had comprehensive health insurance through her employer and thus was not dependent on the government for any sort of public assistance. Yet, Jennifer Erickson's "comprehensive" health insurance did not cover her most important, ongoing health need – contraception. Jennifer represented only a class of similarly situated plaintiffs, and Judge Lasnik's ruling, while certainly influential, did not bind any employer outside of Washington. However, Jennifer's situation is typical for millions of women nationwide. Middle class women with private health insurance often cannot get their prescription contraception covered by their plans. Ironically, low-income women who qualify for Medicaid have better contraception coverage.³³

Bartell's benefit plan covered "all prescription drugs, including a number of preventive drugs and devices, such as . . . drugs to prevent allergic reactions."³⁴ There were no allegations by Erickson that Bartell's exclusion of contraceptives was the result of intentional discrimination. Judge Lasnik noted though that regardless of intent, the mere "exclusion of women-only benefits from a generally comprehensive prescription plan is sex discrimination under Title VII."³⁵ Because there was no evidence that Bartell's choice of health insurance was "intended to hinder women in the workforce or to deprive them of equal treatment in employment or benefits" the Judge surmised that "the exclusion of women-only benefits is merely an unquestioned holdover

³¹ See Sarah E. Bycott, *Controversy Aroused: North Carolina Mandates Insurance Coverage of Contraceptives in the Wake of Viagra*, 79 N.C. L. REV. 779, 779-80 (2001).

³² See Erickson, 141 F. Supp. 2d at 1268 (Eve C. Gartner, Donna Lee, Planned Parenthood Federation of America, New York, NY, Roberta N. Riley, Planned Parenthood of Western Washington, Seattle, for Jennifer Erickson, on behalf of herself and all others similarly situated, plaintiffs.)

³³ See SARAH S. BROWN & LEON EISENBERG, EDS., *THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES* 140 ("In contrast to private insurance coverage and HMOs, the Medicaid programs of all fifty states and the District of Columbia provide reimbursement for contraceptive services, as required by law") (1995).

³⁴ See Erickson, 141 F. Supp. 2d at 1268 n.1.

³⁵ See Erickson, 141 F. Supp. 2d at 1272.

from a time when employment-related benefits were doled out less equitably than they are today.”³⁶ Indeed, when Judge Lasnik’s decision was announced, Bartell asserted “it was never our intention to discriminate”³⁷ and since April 2001 (two months before the actual ruling) the company has offered prescription contraceptive benefits in the medical plan for union employees.³⁸ Consistent with Judge Lasnik’s ruling, Bartell claimed it would “take prompt actions to add these benefits to the non-union employees’ plan” (Jennifer Erickson was a non-union employee).³⁹

Bartell argued that its plan also excluded coverage for Viagra, the male impotency drug, in contrast to many other plans, which immediately covered Viagra when it was introduced to the market in 1997, but continued to exclude contraception. In fact, by May 1, 1998, almost fifty percent of all Viagra prescriptions were subsidized by insurance plans.⁴⁰ The Erickson court left open the question (which was not before them) of whether excluding Viagra may later be determined to violate male employees’ rights under Title VII⁴¹ (possibly opening the door for future litigation by male classes against employers that do not choose insurance plans that cover Viagra). Judge Lasnik also briefly addressed the defendant’s contention that the plan’s exclusion of infertility drugs made its exclusion of prescription contraceptive drugs and devices neutral and not discriminatory. He reasoned that an exclusion of infertility drugs,

[A]pplies equally to male and female employees, making the coverage offered to all employees less comprehensive in roughly the same amount and manner. The additional exclusion of prescription contraceptives, however, reduces the comprehensiveness of the coverage offered to female employees while leaving the coverage offered to male employees unchanged.⁴²

³⁶ See *id.* at 1272 n.7.

³⁷ See Press Release, Statement of Jean Bartell Barber, the company’s CFO and granddaughter of the founder, Bartell Drugs, (visited Jan. 21, 2002), www.bartell1drugs.com/press-releases.

³⁸ See *id.*

³⁹ *Id.*

⁴⁰ See Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 172 (1999).

⁴¹ See Erickson, 141 F. Supp. 2d at 1275 and n.12. See also Stephen T. Kaminski, *Must Employers Pay for Viagra? An Americans With Disabilities Act Analysis Post-Bragdon and Sutton*, 4 DEPAUL J. HEALTH CARE L. 73 (2000), for a discussion of possible employer liability under the Americans with Disabilities Act for refusing to provide employees with insurance plans that cover Viagra.

Thus, Bartell's exclusion of other reproduction-related prescription drugs did not cure the discriminatory practice of excluding contraceptives in particular.

Bartell suggested that the issue of contraceptive coverage was best addressed by the legislature but Judge Lasnik rejected this assertion, emphasizing the role of the judiciary in interpreting *existing* laws.⁴³ Since Erickson brought this case as a Title VII claim, it was the province of the federal judiciary to decide whether this specific employer practice violated that statute. Lasnik thought it "interesting to note that Congress and some state legislatures are considering proposals to require insurance plans to cover prescription contraceptives, [but] that fact [did] not alter [the] Court's constitutional role in interpreting Congress's legislative enactments in order to resolve private disputes."⁴⁴

Indeed, it certainly was the Court's role to assess the merits of the Title VII claim in this particular case, but the passage of the federal and state legislation mentioned by Judge Lasnik is essential to give all women access to contraceptive coverage. Title VII's prohibition on discrimination in the workplace applies only to employers with fifteen or more employees, thus millions of women who work for small businesses, or work part-time and thus purchase outside private health insurance, would be still without contraceptive coverage, even if suits such as this one were brought and won in all federal district courts.⁴⁵ In addition, Title VII contains an exemption for religious organizations; thus, such organizations (e.g. religious schools, associations, etc.) are free to discriminate where secular employers are not.⁴⁶ While I am not contesting the validity of this religious exemption from Title VII, if all religious employers were exempt from providing contraceptive coverage to their employees, another large group of women would lack the power to gain such

⁴³See *id.* at 1276.

⁴⁴See *id.*

⁴⁵See Susan A. Cohen, *Federal Law Urged as Culmination of Contraceptive Coverage Campaign*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Oct. 2001, at 5 (noting that "fewer than one-fifth of all U.S. employers are affected by Title VII, leaving out some 14 million people working for small businesses as well as another 16 million who obtain health insurance through the individual market").

⁴⁶42 U.S.C. §2000e-1.

coverage. While Erickson's importance as a landmark decision cannot be overemphasized, to ensure coverage for all women Congress and the states must pass legislation mandating coverage by insurance plans with no, or a very limited religious exemption that provides affordable alternatives through which religiously-employed women can obtain contraception.

State Legislation

In the absence of private insurers and employers voluntarily providing contraceptive coverage and Congress's failure to pass a comprehensive bill requiring such coverage, many states have enacted their own legislation to mandate insurance coverage of prescription contraception.⁴⁷ At the end of 2001, seventeen states had enacted laws or regulations requiring equitable insurance coverage of contraception.⁴⁸ Although this is less than half of the states, it is a drastic improvement from just three years ago, when only one state had such a law.⁴⁹ North Carolina for instance, recently enacted a contraception coverage law, requiring that

[E]very insurer providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device... every insurer providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services.⁵⁰

⁴⁷Insurance law has historically been the province of the states and states thus have statutory and administrative regulation of health insurance. States may regulate the substance of the insurance contract by requiring that certain benefits, such as contraception, be covered. See RAND E. ROSENBLATT, SYLVIA A. LAW, & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 143-144 (1997). Although in recent years, courts have interpreted the federal ERISA (Employee Retirement Income Security Act) statute of 1974 as preempting much state insurance law. See *id.* at 160-61.

⁴⁸See NARAL Report, *supra* note 7. See also *Who Decides? A State-By-State Review of Abortion and Reproductive Rights, 2002*, NARAL Foundation/NARAL, accessible at www.naral.org (visited Feb. 28, 2002). States that have passed equitable contraceptive coverage legislation include CA, CT, DE, GA, HI, IA, ME, MD, MO, NV, NH, NM, NC, RI, TX, VT, and WA.

⁴⁹See NARAL Report, *supra* note 7.

Although many states are taking the initiative to pass their own legislation, the National Abortion and Reproductive Rights Action League (NARAL) released a report in December, 2001 concluding that “a majority of states still are not doing enough to promote access to contraception.”⁵¹ “Who Decides? A State-by-State Review of Abortion and Reproductive Rights, 2002” graded states not only on whether they had enacted some form of insurance legislation to cover contraception but also on whether reproduction-related legislation enhanced or impeded women’s ability to make decisions about childbearing, protected or harmed women’s health, and reduced the need for abortion by reducing unintended pregnancies and expanding women’s health options.⁵² NARAL is a reproductive rights organization committed to

develop[ing] and sustain[ing] a constituency that uses the political process to guarantee every woman the right to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion.⁵³

In 2001, twenty-two states introduced bills to require health insurance plans to provide coverage for contraceptives and three states enacted such bills.

Although the fact that seventeen states now have regulations that address the lack of private insurance coverage for contraception demonstrates that the momentum for equitable insurance coverage has been building at many levels of government, twelve of the seventeen states that enacted contraceptive equity legislation over the last three years included “denial clauses” that allow employers and/or insurers to refuse to provide contraceptive coverage on religious or moral grounds.⁵⁴ Despite widespread public opposition to such denial or “conscience” clauses, many states would not have passed the contraception legislation without an exemption for employers and insurers that object to providing or paying for contraceptive coverage. Hawaii seems to have struck an acceptable balance in its contraceptive services statute. Religious entities (that

⁵¹ See NARAL Report, *supra* note 7.

⁵² See *Who Decides?*, *supra* note 48 at 1.

⁵⁴ See *Who Decides*, *supra* note 48 at 8.

primarily employ persons who share the employer's religion and that are not staffed by public employees) are exempt from the mandate requiring health plans to include contraceptive services but allows those employees who want contraception but are employed by religious entities to directly purchase such services at the "pro rata share of the price the group purchaser would have paid for such coverage had the group plan not invoked a religious exemption."⁵⁵ Thus, the statute satisfied lawmakers on both sides of the religious exemption issue, allowing it to be passed, but provided women affected by the exemption with an alternative way of accessing affordable contraception.

The fierce debate over whether a state's contraception legislation should contain a religious exemption has been holding up the passage of such laws in a number of states. For example, New York has been attempting to pass a women's health bill that would require health insurers to cover contraceptives, and a variety of other health care treatments for women, including screenings for osteoporosis, cervical cancer and breast cancer.⁵⁶ Republican and Democratic lawmakers though, have been divided over the specifics of the bill, particularly because Republicans have long insisted that a bill requiring contraceptive coverage contain a "conscience clause" exemption for the Roman Catholic Church, as the use of "artificial" birth control violates church teachings. The Democrats have opposed that type of exemption, but recently the State Senate believed it had come to a compromise regarding the divisive issue. The compromise conscience clause would be much narrower than those proposed in the past, providing that a religious institution "could deny birth control coverage through its employee health plan *only* if most of the people it employs and most of the people it serves share that religion"⁵⁷ (emphasis added).

Not surprisingly, the bitter disagreement on the religious exemption between New York Democrats and

⁵⁵HI ST §431:10A-116.7. Contraceptive Services; Religious Employers Exemption.

⁵⁶See Richard Perez-Pena, *Albany Bill Would Cover Birth Control*, N.Y. TIMES, Feb. 4, 2002 at B1.

⁵⁷See *id.*

Republicans is a highly sensitive issue. Cardinal Edward Egan of the Catholic Archdiocese of New York visited New York's state capital last March to voice his opposition to any legislation that forced contraceptive coverage without an exemption for religious institutions that oppose birth control.⁵⁸ Egan said he would rather see the bill die in the Senate (even though he supported the coverage for cancer and osteoporosis screenings) than have it pass without the religious exemption.⁵⁹

III. The FDA-approved Methods of Reversible Prescription Contraception

The following is a brief description of the six types of FDA-approved reversible prescription contraception. To fully understand why women need contraception coverage of all available methods, it is important to know that contraception safety, effectiveness and delivery methods vary somewhat among the FDA-approved forms of prescription birth control.

Oral Contraceptives (the "Pill")

The Pill, approved by the FDA in 1960, is the most popular form of reversible birth control in the United States.⁶⁰ It suppresses ovulation through a combination of the hormones estrogen and progestin and must be taken every day for maximum effectiveness in preventing pregnancy. Because the woman taking the pill

⁵⁸ See Somini Sengupta, *Egan Takes Church's Issues to Albany: Contraception Insurance Leads List of Interests*, N.Y. TIMES, Mar. 13, 2001 at B1.

⁵⁹ See *id.*

⁶⁰ See Tamar Nordenberg, *Protecting Against Unintended Pregnancy: A Guide to Contraceptive Choices* at 3, (visited Mar. 25, 2002), www.fda.gov.

must remember to take it every day, the typical failure rate of oral contraceptives is about five percent. In other words, in typical (not perfect) use, the pill is about ninety-five percent effective.⁶¹

In addition to preventing pregnancy, the pill has numerous health benefits including, making a woman's periods more regular and lighter, protecting against pelvic inflammatory disease and protecting against ovarian and endometrial cancers.⁶² Certain pills, such as Ortho-Tricyclen, are prescribed to women for the relief of an acne problem.⁶³ There are minor side effects associated with oral contraceptives, such as nausea, breast tenderness and weight gain, but most of these subside after a few months of use.⁶⁴ Although for forty years the pill has been extensively studied for the adverse health consequences it may cause, for women who do not smoke, the pill is a very safe method of birth control.⁶⁵ Perhaps the most serious health question has been whether using the pill causes breast cancer, but no studies have proven that there is a significant link between pill use and the incidence of breast cancer.⁶⁶

The pill is prescribed in monthly cycles and thus women must purchase a new pack of pills every thirty days. In addition, obtaining a pill prescription requires at least one visit to the gynecologist every six months to a year. The approximate yearly cost of using oral contraception is over \$400.00.

Injectible Contraceptives (Depo-Provera/Lunelle)

Depo-Provera, approved by the FDA in 1992, is the brand name for the hormone injection (progestin) given by health professionals into a woman's arm or buttocks every three months.⁶⁷ Depo-Provera also prevents

⁶¹See Trussell, *supra* note 2 at 4, Table 2.

⁶²See Nordenberg, *supra* note 60 at 3-4.

⁶³<http://www.orthotricyclen.com/about/prodinfo.html> (visited Apr. 8, 2002).

⁶⁴See Emory University Department of Gynecology & Obstetrics Family Planning Program, (visited Mar. 25, 2002) www.emory.edu/WHSC/MED/FAMPLAN/pills.html.

⁶⁵See Nordenberg, *supra* note 60 at 4 ("Birth control pills are...safer even than delivering a baby.")

⁶⁶See Emory University Family Planning Program, *supra* note 64 at 2.

⁶⁷See Nordenberg, *supra* note 60 at 5.

pregnancy by inhibiting ovulation and is highly effective – with a failure rate of only.3%.⁶⁸ Because, unlike the pill, the woman using Depo-Provera does not have to remember to ingest anything on a daily basis, the failure rate is extremely low. However, using Depo-Provera requires a visit to the physician or clinic every three months to get the injections. And, there can be minor side effects, such as irregular periods and weight gain and some women may be allergic to the medication entirely.⁶⁹ Long-term, Depo-Provera may cause weakened bone density because it lowers a woman’s estrogen level, but this can be prevented through calcium supplements and exercise.⁷⁰ Depo-Provera’s cost is comparable to that of oral contraceptives, about \$400.00 per year.

Lunelle is a brand-new contraceptive drug, approved by the FDA in October, 2001 that combines the hormones progesterin and estrogen to inhibit ovulation.⁷¹ Lunelle is injected once per month by a health care provider during the first five days of a woman’s menstrual period. Clinical trials indicate that the failure rates of Lunelle are less than one percent and the most common side effect was weight gain, which caused six percent of the women in the clinical trials to discontinue its use.⁷²

Implantable Contraceptives (Norplant)

Norplant is the brand name of an implantable hormonal method that was approved by the FDA in 1990 (its newer version, Norplant 2, was approved in 1996).⁷³ Like Depo-Provera, it is a progesterin-only contraceptive but its matchstick-like rods are surgically implanted under the skin of the upper arm, providing protection for up to five years (but Norplant can be removed earlier if pregnancy is desired before the five years are expired).⁷⁴ Norplant is another highly effective contraceptive, preventing pregnancy over ninety-nine percent of the time. Its main advantage is that it requires no regular maintenance by the woman, although

⁶⁸ See Trussell, *supra* note 2 at 4, Table 2.

⁶⁹ See *Depo-Provera Injections*, Emory University Department of Gynecology & Obstetrics Family Planning Program, (visited Mar. 25, 2002) www.emory.edu/WHSC/MED/FAMPLAN.html.

⁷⁰ See *id.*

⁷¹ See *FDA Updates – January-February 2001*, FDA Consumer (visited Apr. 5, 2002) www.fda.gov/fdac/departs/2001.

⁷² See *id.*

⁷³ See *Achievements in Public Health, 1990-1999: Family Planning*, CDC Weekly Report, Dec. 3, 1999 at Table 1.

⁷⁴ See Nordenberg, *supra* note 60 at 5.

the implant must initially be inserted by a health professional. There are minor side effects such as weight gain and breast tenderness and there may be inflammation or infection at the sight of insertion. Now that Norplant has been on the market for over ten years, many women have gone through the entire five year cycle with a Norplant implant and some report difficulty in removal, including scarring at the insertion site.⁷⁵ Because of the insertion by the health professional, the start-up cost of Norplant is higher than the other hormonal methods – about \$900.00. Over the five year period, the total cost of Norplant though, including removal, is approximately \$1500.00, which is actually less than that of both oral contraceptives (\$2200) and Depo-Provera (\$2000) over a five year period.⁷⁶

Intrauterine Devices (IUDs)

IUDs are medical devices containing either copper or the hormone progesterone, inserted into the uterus by a health care professional. Makeshift IUDs have existed for over one hundred years, but IUDs did not gain widespread acceptance by the medical community until the late 1960s.⁷⁷ The reputation of the IUD suffered immensely in this country when in the early 1970s thousands of lawsuits were filed against manufacturer A.H. Robins alleging that its popular Dalkon Shield IUD caused infection, miscarriage, birth defects and even death to women using it.⁷⁸ The Dalkon Shield was removed from the market and current IUDs have been declared safe, especially for couples in monogamous, stable relationships where there is little risk of sexually transmitted infection.⁷⁹

IUDs are highly effective, (copper IUDs are currently the most effective reversible method of birth control available in the United States) with overall failure rates of less than two percent, and can be left in place for up to ten years.⁸⁰ The initial cost is high – about \$600 in the first year, but over five years the total IUD

⁷⁵ See Harrison, *supra* note 13 at 19.

⁷⁶ See Trussell, *supra* note 2 at 7, Table 4.

⁷⁷ See Tone, *supra* note 1 at 30-31 and 265-66.

⁷⁸ See *id.* at 279-280.

⁷⁹ See Nordenberg, *supra* note 60 at 5, quoting Lisa Rarick, M.D., former director of the FDA's division of reproductive and urologic drug products.

⁸⁰ See *Birth Control Guide*, US Food and Drug Administration at 3 (visited Mar. 25, 2002) www.fda.gov.

cost is between \$1000 and \$2000 (depending on whether the woman uses the copper or progesterone type; the copper IUD is less expensive).⁸¹ Currently, IUDs are far more popular with women in Europe than in the United States, probably because of the negative publicity that surrounded IUDs in the 1970s.⁸²

Diaphragms/Cervical Caps

The diaphragm is a removable, non-hormonal (barrier) method that while initially must be fitted and sized by a health professional, is then inserted and removed by the woman before and after sexual intercourse. Diaphragms must be used with spermicide but overall effectiveness is only about eighty percent, giving the diaphragm a relatively high failure rate of twenty percent.⁸³ Diaphragm users must be quite vigilant, inserting the device before intercourse and leaving it in place for at least six hours but no more than twenty-four hours after intercourse.⁸⁴ The cervical cap is very similar to a diaphragm in structure and method but can be left in place for forty-eight hours, protecting for multiple acts of intercourse within this time, but is somewhat less effective (thirty-three percent failure rate). The costs for diaphragms and cervical caps is between \$500 and \$800 per year and weight fluctuations or giving birth will require the refitting and possibly purchase of a new diaphragm.

Emergency Contraceptives (“Morning After Pill”)

In 1997 the FDA approved the emergency use of oral contraceptive pills to prevent a woman from becoming pregnant *after* she has had sexual intercourse where contraceptives failed or no contraceptives were used.⁸⁵ Preven (the brand name of one of the popular emergency regimens) is about seventy-five percent effective in preventing pregnancy by delaying or inhibiting ovulation or by keeping a fertilized egg from implanting in the uterine wall. The regimen (first developed in 1974 but only approved after the FDA requested

⁸¹See Trussell, *supra* note 2 at 7, Table 4.

⁸²See Harrison *supra* note 13 at 21 (“Despite major improvements that have made intrauterine devices appropriate for a large number of women, the method has not yet overcome its difficult history and regained its former acceptability, at least in the United States”).

⁸³See Trussell, *supra* note 2 at 4, Table 2.

⁸⁴See Nordenberg, *supra* note 60 at 2.

⁸⁵See *id.* at 4.

pharmaceutical companies submit applications for emergency contraceptive use of their already-approved oral contraceptives⁸⁶) consists of two contraceptive pills taken within seventy-two hours of unprotected intercourse and two pills taken twelve hours later.⁸⁷ Side effects may include nausea, vomiting, and breast tenderness. While emergency contraception is only recommended for use in emergency situations and not as a woman's regular form of birth control, it has filled an important gap in women's contraceptive options. Clearly, there are a number of safe, effective, reversible birth control methods available by prescription in the United States. Like any medical drug or device, each method involves some risk or causes some side effects. Women should be able to evaluate each method with their physician and decide which of those risks they are willing to absorb, and which side effects are tolerable, given the woman's desired level of effectiveness. For women in a stable relationship with one partner, an IUD may be an excellent choice because her risk of sexually transmitted infection is low. For those women who do not want to think about birth control every day, the pill may be inappropriate but Norplant may be an ideal method. Some women may be willing to forgo some effectiveness in exchange for not using a hormonal method and thus not altering their body chemistry. Thus, a diaphragm may be the right contraceptive approach. When a woman forgets to take her contraceptive pill, insert her diaphragm, or is forced to have intercourse against her will, the morning-after pill can be used as an effective check on the risk of becoming pregnant.

The point here is that we are very fortunate to have a wide range of safe, effective birth control choices available in the United States, but a woman must be able to make a choice that's appropriate for her particular lifestyle, body and age. Birth control is not one-size-fits-all. A woman should not have to base her choice of birth control on whether her insurance plan covers a particular method. Just as someone who is allergic to penicillin has the option of taking erythromycin and still having it covered by their prescription drug plan,

⁸⁶See *FDA Calls for Applications for Emergency Use of Oral Contraceptives*, FDA Talk Paper, Feb. 24, 1997.

⁸⁷See *FDA Approves Application for Preven Emergency Contraceptive Kit*, FDA Talk Paper, Sept. 2, 1998.

a woman with a history of familial breast cancer should have the option of choosing Depo-Provera instead of oral contraceptives if she feels uncomfortable with the minimal breast cancer risk the pill may present. A married woman who has completed her family but does not want to undergo surgical sterilization should be able to use an IUD without worrying that she cannot afford the start-up cost. Nor should women without health insurance coverage be forced to choose less expensive over-the-counter methods of birth control, such as condoms, sponges and spermicides. These non-prescription methods are less effective than prescription contraceptives and have more potential for human error.

Another problem created by sporadic coverage of reversible contraceptive methods is the choice of many women to undergo essentially irreversible, surgical sterilization because their insurance policy covers sterilization services but not other prescription methods of contraception.⁸⁸ While some women are choosing sterilization (tubal ligation, or for men, vasectomy) because they are absolutely sure they do not want more children, some decide prematurely on sterilization because the prospect of paying hundreds of dollars per year for ten years or more in reversible contraceptive costs pushes women towards sterilization when it may not necessarily be the ideal method for them.⁸⁹

All of these reversible prescription methods are FDA-approved but not all of them fit every woman's birth control and health needs.⁹⁰ Covering just one or two methods of contraception should not be sufficient for employers and insurers; rather, federal and state legislation should mandate that *all* FDA-approved contraceptive methods be covered by comprehensive prescription drug plans, so that women base their contraception choices on what is right for their bodies and not their wallets.

⁸⁸ See Brown, *supra* note 33 at 139 (over eighty-five percent of private insurers cover surgical sterilization procedures).

⁸⁹ See Harrison, *supra* note 13 at 21 (“sterilization is the most used contraceptive in . . . the United States. While the method is most satisfactory for individuals who consider their families complete, many women are resorting to sterilization at unexpectedly early ages.”).

⁹⁰ See *Hearings on S. 104*, *supra* note 3 (testimony of Anita Nelson, MD) (“Over the last 16 years, I’ve helped thousands of women choose the birth control method that is right for them, and I can tell you that men and women really do need an extensive menu of options for contraception to meet their particular needs”).

IV. Historical Background of Family Planning

Is the exclusion of prescription contraceptives from private health insurance plans an “unquestioned holdover” from a less enlightened time, (as Judge Lasnik suggested in *Erickson*) or are there other reasons why historically, private health insurers exclude contraceptives from otherwise comprehensive prescription drug coverage? This section will examine the different types of health insurance available in this country, the extent to which each of these insurance mechanisms covers prescription contraceptives and possible explanations for why contraceptives are commonly excluded from insurance coverage.

Medicaid

Medicaid is a public health insurance program created in 1964 to cover the health care needs of the impoverished. It is jointly funded by federal and state governments.⁹¹ As of March, 2002, Medicaid covered approximately thirty-six million individuals.⁹² State Medicaid programs must cover *all* FDA-approved prescription drugs for their medically accepted purposes.⁹³ The only FDA approved drugs excluded from this mandate are those used for anorexia, weight loss, cosmetic purposes, smoking cessation, the promotion of fertility, barbiturates and prescription vitamins.⁹⁴ Prescription contraceptives fall into none of these excluded categories. Just as federal law requires Medicaid providers to purchase Viagra, they must also purchase contraceptives.

Medicaid is the principal public funding source for contraception, accounting for over fifty-eight percent of all federal family planning expenditures.⁹⁵ For *extremely* low-income women, Medicaid is a viable option for obtaining contraceptive services. However, eligibility for Medicaid is very limited – in most states a woman

⁹¹ See www.hcfa.gov/medicaid, (visited on March 20, 2002).

⁹² See *id.*

⁹³ See Kaminski, *supra* note 41.

⁹⁴ See *id.* at 83 and note 64.

⁹⁵ See Brown, *supra* note 33 at 141.

must usually be single and have at least one child (thereby making her eligible for Aid to Families with Dependent Children [AFDC]) benefits, which are often tied to Medicaid eligibility), and an income that is about fifty percent of the poverty level (about \$6,000 for a family of three).⁹⁶ Thus, while those women who receive Medicaid benefits may rely on coverage for contraceptive-related physician visits and prescriptions, Medicaid covers only the poorest women, leaving many working-class and middle-class women who have employer-based or privately purchased health insurance without prescription contraception coverage.⁹⁷

Health Maintenance Organizations (HMOs)

Today's typical HMO is an organization that contracts with physicians to provide health care services to people who purchase insurance through the HMO. The HMO pays the physician a capitation (a fixed payment per patient) in exchange for the physician's agreement to care for the HMO's insured. The HMO structure was developed as a way to control health care costs and has been especially appealing to young, healthy people who have few health care needs.⁹⁸ The general premise behind these health insurance organizations is that healthy patients will not use up the entire capitation payment provided to the physician by the HMO, while sick patients will use more than their share of the capitation. In an ideal situation, there will be more healthy patients than sick ones; therefore the physician will continue to earn a profit.⁹⁹

Commercial Health Insurance

Commercial health insurers such as AETNA and Cigna simply reimburse the insured for costs incurred in

⁹⁶See *id.* at 141. See also CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TROYEN A. BRENNAN, *HEALTH CARE LAW & POLICY*, 115 (2d. ed. 1998) ("states are not generally free to extend federally supported Medicaid eligibility to single individuals, childless couples, families with two resident parents, or others who were not within the reach of traditional welfare programs").

⁹⁷This paper will not address in detail the scope of the problem of women, especially adolescents and those of college-age, who do not qualify for Medicaid, do not have employer-based health insurance, but do not earn enough money to purchase private health insurance. This segment of the female population faces a nearly impossible task of obtaining quality, affordable contraceptive services. See e.g. *Can More Progress Be Made? Teenage Sexual and Reproductive Behavior in Developed Countries*, The Alan Guttmacher Institute, Executive Summary, 2001 at 5:

In the United States...substantial portions of adolescents lack health insurance and therefore have poor access to health care...countries other than the United States [France, Sweden, Great Britain, and Canada] have national systems for the financing and delivery of health care for everyone. Although the systems vary, they provide assurance that teenagers can access a clinician.

⁹⁸See *Hearings on S. 104*, *supra* note 3 (testimony of Kate Sullivan, Director of Health Care Policy for U.S. Chamber of Commerce).

⁹⁹See Havighurst, *supra* note 96 at 62-65.

obtaining medical care. There are generally fewer restrictions for insureds (e.g. they have a wider choice of physicians) in commercial plans than in HMOs, but customers pay higher premiums than those in HMO plans.¹⁰⁰

Scope of Coverage

According to a comprehensive study conducted by the Institute of Medicine in 1995, only forty percent of HMOs covered all five of the FDA-approved reversible contraceptive methods included in the study – IUDs, diaphragms, hormonal implants and injectables (Norplant and Depo-Provera) and oral contraceptives (the “Pill”).¹⁰¹ Seven percent of HMOs provided no contraceptive coverage at all and the coverage for selected methods varies widely (from 59 percent for Norplant insertion to 86 percent for IUDs).¹⁰² In addition, many HMOs require co-payments for these drugs and devices.¹⁰³ Commercial health insurers are far worse offenders when it comes to failing to cover contraceptives. While over eighty-five percent of commercial health insurance policies cover surgical sterilization services and sixty-six percent cover abortion, “*none* of the five reversible methods... is routinely covered by more than forty percent of typical plans” (emphasis added). Furthermore, “half of the large-group plans cover *no* methods at all, and only *fifteen percent* cover all five” (emphasis added).¹⁰⁴ Oral contraceptives are the most commonly used reversible method but are routinely covered by only one-third of large group plans even though virtually all large group plans cover prescription drugs generally.¹⁰⁵ Thus, two-thirds of large group plans that offer prescription drug coverage do not cover oral contraceptives. The Institute study also found that despite the fact that *ninety percent* of group plans cover medical devices generally, “less than twenty percent of these plans cover IUDs or diaphragms and [only]

¹⁰⁰ See *id.* at 205-206.

¹⁰¹ See Brown, *supra* note 33 at 139-140.

¹⁰² See *id.* at 140.

¹⁰³ See *id.*

¹⁰⁴ See *id.* at 139.

¹⁰⁵ See *id.* at 140.

twenty-five percent cover hormonal implants.”¹⁰⁶ Not only do these coverage statistics reflect a wholesale problem in contraceptive coverage generally, but they also demonstrate that insurers are more likely to cover less effective and less cost-effective methods of contraception. The most cost-effective reversible contraceptive methods are the copper IUD, Norplant and Depo-Provera.¹⁰⁷ The IUD and Norplant have high initial costs but become more cost effective over a longer usage period.¹⁰⁸ In contrast, oral contraceptives, at a cost of about \$30 per month, have very low start-up costs, but are less effective contraceptives because of the potential for human error.¹⁰⁹ Thus, not only are insurance companies making poor economic decisions in their failure to cover many prescription contraceptives, but they are also making poor medical choices when they choose to cover only selected methods and then choose less effective methods to cover.

Thus, the vast majority of non-governmental health insurance plans do not cover all FDA-approved prescription contraceptive methods. And, while a majority of HMOs cover at least one method, a majority of commercial group plans cover no prescription contraceptive drugs or devices.¹¹⁰ First, why the discrepancy between HMOs and commercial insurers? According to the Institute of Medicine study, in their efforts to cut the costs of health care, HMOs historically have emphasized preventive care.¹¹¹ In contrast, the fact that commercial fee-for-service insurance is least likely to cover contraceptives is “consistent with [the industry’s] historic traditions. . . providing coverage of surgical services but not covering preventive care.”¹¹² One reason why traditional fee-for-service insurers may have historically been resistant to covering preventive care is

¹⁰⁶ *See id.*

¹⁰⁷ *See* Trussell, *supra* note 2 at 5 – 6.

¹⁰⁸ *See id.* at 6.

¹⁰⁹ *See Achievements, supra* note 73 at Table 2 (IUDs are used by less than 1% of couples yet are 99.2% effective in preventing pregnancy; Norplant is used by 1.3% of couples yet is 99.95% effective in preventing pregnancy; Depo-Provera is used by only 2.7% of couples, yet is 99.7% effective in preventing pregnancy. Contrasted with oral contraceptives, which are used by 24.9% of couples yet because of human error the typical success rate is 95%).

¹¹⁰ *See id.*

¹¹¹ *See* Brown, *supra* note 33 at 140.

¹¹² *See id.* at 139.

that there is always the chance that the subscriber will switch employers, providers, or plans and thus the outlays on preventive care by that insurer will have been “wasted” on a subscriber who will no longer save the original provider subsequent health care costs as a result of the preventive care.¹¹³ Contraception qualifies as preventive care, because it works to prevent pregnancy, which while certainly not a disease, is a medical condition that requires substantial health care.

In fact, pregnancy and giving birth are far more expensive than contraception. The policy of most insurance companies to cover medical conditions and costs resulting from pregnancy – prenatal care, delivery and baby care – but not cover prescription contraception is utterly cost ineffective.¹¹⁴ According to the American College of Obstetricians and Gynecologists, a “fifteen percent increase in the number of oral contraceptive users in a health plan would provide enough savings in pregnancy costs alone to provide oral contraceptive coverage for all users in the plan.”¹¹⁵ Childbirth costs average between \$3,000 - \$5,000 per woman¹¹⁶ and that figure drastically increases when a child is born with a low birth-weight.¹¹⁷ In contrast, the average cost for a one year supply of birth control pills is \$400.¹¹⁸ Another study conducted by The Alan Guttmacher Institute concluded that the average total cost of adding coverage for the full range of reversible contraceptives to health plans that do not currently cover them will increase total health insurance costs for employees by \$21.40 per employee per year, \$17.12 of which would be borne by the employer. This means that employer cost would be \$1.43 per employee per month – less than one percent of employers’ costs of providing

¹¹³See Harrison, *supra* note 13 at 15 (“The benefits and savings from preventing unintended pregnancies are reaped by whoever is already footing the bill for not preventing them. . . however for profit-oriented health service. . . returns to investment in prevention may end up benefiting the next plan or plans in which a given individual enrolls.”)

¹¹⁴See Jacqueline E. Darroch, *Cost to Employer Health Plans of Covering Contraceptives*, The Alan Guttmacher Institute, 1998 (“A 1993 survey of private insurance plans found that 97-98% of indemnity plans covering 100 or more employees and of HMOs routinely cover childbirth; 66% and 70%, respectively, routinely cover abortion, and 9 in 10 will pay for it under some circumstances.”).

¹¹⁵Kathleen A. Bergin, *Contraceptive Coverage Under Student Health Insurance Plans: Title IX as a Remedy for Sex Discrimination*, 54 U. MIAMI L. REV. 157, 160 (2000).

¹¹⁶Hayden, *supra* note 40.

¹¹⁷See Law, *supra* note 28 (“For every low-weight birth that is averted, the health care system saves between \$14,000 and \$30,000 in hospitalization costs. . . reducing unintended pregnancy is the single most effective means of reducing the number of distressed, low birth weight babies”).

¹¹⁸See *It Saves \$ and Makes Sense*, (visited Mar. 13, 2002) www.covermypills.org.

employees with medical coverage.¹¹⁹

In 1995, researchers at Princeton's Woodrow Wilson School conducted a comprehensive study to determine the clinical and economic impact of fifteen different contraceptive methods.¹²⁰ The study concluded that *all* fifteen contraceptives examined were more effective in preventing pregnancy and less costly than using no contraceptive method.¹²¹ The researchers conclusively determined that "contraceptives save health care resources by preventing unintended pregnancies."¹²² If women of childbearing age use no contraceptive method over five years, the result will be 4.25 unintended pregnancies at a cost to private third-party payers of \$14,663¹²³ (this figure is based on 1993 health care costs and thus would be higher in 2002 dollars). Legally, insurance companies and employers cannot exclude pregnancy-related costs from an otherwise comprehensive insurance plan,¹²⁴ thus, the economic costs of unintended pregnancies must be borne by insurance companies and employers should the woman choose to go through with the pregnancy and birth.¹²⁵

Why do insurance plans that offer comprehensive coverage of almost all FDA-approved prescription drugs so often exclude contraceptives? I argue that the reasons for this common exclusion are based in the historically negative attitudes toward sexuality and anything related to sexual expression in the United States; the political influence of the Catholic Church and its staunch opposition to any use of contraception; and the

¹¹⁹ See Darroch, *supra* note 114 at 1 (The Guttmacher Institute commissioned Buck Consultants, an employee benefit, actuarial and compensation consulting firm to estimate the costs).

¹²⁰ See James Trussell, et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 4 (1995) (Trussell and his colleagues studied tubal ligation, vasectomy (the sterilization methods), oral contraceptives, contraceptive implant (Norplant), injectable contraceptive (Depo-Provera), progesterone T IUD, copper T IUD, diaphragm, male condom, female condom, sponge spermicides, cervical cap, withdrawal, and periodic abstinence).

¹²¹ See *id.* (cost savings ranged from \$8,933 [for barrier methods] to \$14,122 [for the copper IUD] over a five year period).

¹²² See *id.*

¹²³ See *id.* at 4.

¹²⁴ See Pregnancy Discrimination Act, 42 U.S.C. §2000e(k). (clarifying Title VII to indicate that discrimination because of "pregnancy, childbirth or related medical conditions" is discrimination on the basis of sex). See also Erickson, 141 F. Supp. 2d 1266, stating that the PDA was enacted in response to *General Electric Co. v Gilbert*, which held that an otherwise comprehensive short-term disability policy that excluded pregnancy from coverage did not discriminate on the basis of sex. The PDA was meant to correct what Congress thought to be an erroneous interpretation of congressional intent in enacting Title VII and thus statutorily recognized through the PDA that there are sex-based differences between men and women employees that require employers to provide women-only benefits or otherwise incur additional expenses on behalf of women in order to treat the sexes the same.

¹²⁵ See Trussell, *supra* note 120 at 6 ("Contraception clearly saves money. . . savings generally are realized by third-party payers. They currently pay most of the bills for ectopic pregnancies, spontaneous abortions, births and newborn hospitalizations. Most private plans also cover induced abortions.").

lack of acknowledgment by the insurance community that contraception is a “medically necessary” service for all women for the majority of their lives.

Attitudes

In countries such as France and Sweden, sexuality is seen as “normal and positive;” sexuality education does not focus on the promotion of abstinence but on providing reliable information about contraceptives, prevention of HIV and other STDs and the formation of respect and responsibility within relationships.¹²⁶ Sweden is the country with the lowest teenage birthrate; it can hardly be argued that it is simply coincidental that for the past fifty years, young people there receive mandatory sexuality education in addition to government-sponsored contraceptive services, which are usually integrated into regular medical care.¹²⁷

In contrast, the United States has a long history of having negative social and political attitudes towards sex, especially sex between unmarried persons. In 1872, during the famously prudish Victorian era, Congress passed what was commonly called “The Comstock Act,” named after Anthony Comstock, the morals crusader who instigated the bill. The Comstock Act outlawed the interstate dissemination of any “article of an immoral nature, or any drug or medicine or any article whatever for the prevention of conception.”¹²⁸ Contraceptives were deemed obscene and thus remained illegal in the U.S. for a good portion of the twentieth century.

In 1912 the modern birth-control movement began with Margaret Sanger, a public health nurse, who chal-

¹²⁶ See More Progress, *supra* note 97 at 4-5.

¹²⁷ See *id.* at 5.

¹²⁸ See Tone, *supra* note 1 at 4.

lenged the anti-contraceptive laws by opening the first family planning clinic in Brooklyn, New York to circulate information about and provide access to contraception.¹²⁹ However, it was not until 1965 (almost thirty years after the American Medical Association endorsed birth control and five years after the FDA approved the first birth control pill¹³⁰) that in *Griswold v. Connecticut* the Supreme Court declared it unconstitutional to prohibit contraceptive use.¹³¹ Even the 1965 *Griswold* decision though did not send a clear message that sex and contraception was behavior that American society found totally acceptable. The decision focused on married couples and their right to use contraception, thus continuing to perpetuate the morality claim that sex was only acceptable within the institution of marriage.¹³² It was not until 1977 in *Carey v. Population Services*¹³³ that the Court extended its decision to teenagers seeking contraception, striking down laws that prohibited teenagers from obtaining contraceptive services.

Currently, political and religious groups pressure school districts not to allow discussion of contraception or abortion in sexual education classes. Of the school districts that mandate sexuality education (unlike many European countries, the United States' local control of education means that there is no *national* mandate of sexuality education in public schools, leaving school districts to decide whether to include *any* type of sexual education in the curriculum), thirty-five percent require that “abstinence be presented as the only appropriate option outside of marriage for teenagers and that contraception either be presented as *ineffective* in preventing pregnancy and HIV and other STDs or not covered at all” (emphasis added).¹³⁴ In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act, better known as the Welfare Reform Act. The Act makes numerous findings about the public costs of unintended pregnancies, but repeatedly places the blame on “out-of-wedlock” births, emphasizing the importance of having sex only

¹²⁹ See *Achievements*, *supra* note 73 at 1.

¹³⁰ See *id.* at 6.

¹³¹ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹³² See *id.* (“This law, however, operates directly on an intimate relation of husband and wife”).

¹³³ See *Carey v. Population Services International*, 431 U.S. 678 (1977).

¹³⁴ See *More Progress*, *supra* note 97 at 5.

within the bounds of marriage.¹³⁵ Although some might argue that this standard for sexual relations is an admirable aspiration, it simply does not reflect reality. Sexual desire is a natural, human emotion that most people of reproductive age act on, whether they are married or not.¹³⁶ Furthermore, even if all sex took place within a monogamous, married relationship, the need for contraceptive education, information, and access would not be diminished. Few American married couples want more than two children.¹³⁷

The election of George W. Bush, an anti-choice, Republican president who opposes the funding of family planning services, demonstrates that Puritanical attitudes towards sexuality in this country are not a thing of the past. Since his election, George W. Bush has instituted a number of anti-family planning policies. On his first day in office, Bush reinstated the “global gag rule” that President Clinton had previously repealed (it was originally a Reagan policy), cutting off U.S. international aid money from going to any family planning organization that provided women with legal abortions, advocated changes in abortion-related policies and or counseled women on the option of legal abortions.¹³⁸ Later that year, the Bush administration refused to approve a New York proposal that would provide subsidized contraceptive services to hundreds of thousands of low-income New Yorkers through a combination of state and federal Medicaid money.¹³⁹ Then, Bush attempted to eliminate contraceptive coverage for federal employees, but that proposal was overturned by the House Appropriations Committee.¹⁴⁰ Finally, in his fiscal year 2003 budget proposal to Congress, President Bush will ask for \$135 million for abstinence-only sexuality education programs. This constitutes a thirty-three percent increase over this year’s funding level, and fulfills the President’s campaign promise to spend as much money on abstinence education as on family planning services for teenagers.¹⁴¹

¹³⁵ See generally 42 U.S.C.A. §601.

¹³⁶ See *Hearings on S. 104*, *supra* note 3 (testimony of Anita Nelson, MD) (“Sexual expression is obviously an important part of the human experience, or there would not be such interest in Viagra”).

¹³⁷ See Amended Complaint, Jennifer Erickson, et al. v. The Bartell Drug Company, No. C00-1213L at 5, Sept. 6, 2000.

¹³⁸ See *Unhealthy for Women*, THE CAPITAL TIMES, Feb. 15, 2002 and Daniel E. Pellegrin, *A Deadly Global Gag Rule*, N.Y. TIMES, Jan. 27, 2001, at A15.

¹³⁹ See Raymond Hernandez, *Bush Opposes Plan by Albany to Subsidize Birth Control*, N.Y. TIMES, Jul. 28, 2001 at B1.

¹⁴⁰ See *id.* at B2.

¹⁴¹ See The Alan Guttmacher Institute Media Center, (visited Apr. 10, 2002) www.guttmacher.org.

Numerous studies have demonstrated that public policies that promote “abstinence-only” are ineffective in reducing unintended pregnancies.¹⁴² In fact, there has not been a single study proving that abstinence-only policies are an effective, long-term method of fertility control.¹⁴³ Most people of reproductive age are sexually active and thus any sexual education in schools or public information programs must focus on contraception.¹⁴⁴ In the United States, we tend to focus on *whether* young people are having sex, rather than educating them from an early age on the benefits of contraception and STD prevention – giving them the tools to exercise personal responsibility when they choose to become sexually active. Although growing up in an economically or socially disadvantaged family is a strong predictor of whether teenagers will become pregnant, at *all* socioeconomic levels, American teenagers are less likely to use contraceptives than their peers in countries like France, Sweden, Great Britain and Canada.¹⁴⁵ As I will discuss further below, the instance of unintended pregnancy is certainly not confined to teenagers, but people learn lifelong behaviors when they are quite young; if we do not responsibly educate our adolescent population about contraception and give them access to contraceptive services, they will grow to be uninformed adults without knowledge or affordable access to contraception, perpetuating the instance of unintended pregnancy.

Religion

The influence of religious organizations, in particular the Roman Catholic Church, on political and social policy has contributed to the negative attitudes Americans have toward sexual expression and the use of contraception. Historically, the Catholic Church has opposed artificial contraception, sterilization and

¹⁴² See DEBORAH R. MCFARLANE & KENNETH J. MEIER, THE POLITICS OF FERTILITY CONTROL 160 (2001).

¹⁴³ See *id.*

¹⁴⁴ See *id.* at 161.

¹⁴⁵ See More Progress, *supra* note 97 at 1.

abortion¹⁴⁶ and has been a powerful political force in the United States. In the 1950s, 60s and 70s, presidents such as Eisenhower, Johnson and Nixon feared a political backlash from the Catholic Church and Catholic voters if the federal government funded family planning services.¹⁴⁷

The initial impetus for federal family planning policy came from policy activists who believed that the world was headed for global disaster as a result of overpopulation that would threaten political, economic and social stability in the United States.¹⁴⁸ In the post-WWII era, private organizations and philanthropic foundations played an essential role in initiating family planning programs designed to control population growth because the federal government and pharmaceutical companies avoided supporting contraceptive research and development.¹⁴⁹ They avoided contraceptive research largely as a result of pressure from the Catholic Church and because in the post WWII era, twenty-five percent of voting Americans were Catholic.¹⁵⁰

In the 1960s, with Johnson's Great Society measures, the justification for the need for extensive federal family planning shifted from population control to a way in which to alleviate poverty and reduce rising welfare costs.¹⁵¹ As a result, family planning programs were greatly expanded but not only faced continued opposition from the Catholic Church but accusations from the African-American community that family

¹⁴⁶See DONALD CRITCHLOW, INTENDED CONSEQUENCES: BIRTH CONTROL, ABORTION AND THE FEDERAL GOVERNMENT IN MODERN AMERICA 17 (1999). See also *Ethical and Religious Directives for Catholic Health Care Services*, National Conference of Catholic Bishops at 5 ("employees of a Catholic health care institution must respect and uphold the religious mission of the institution"), 10 ("The Church cannot approve contraceptive interventions that either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible") and 11 ("Catholic health institutions may not promote or condone contraceptive practices").

¹⁴⁷See Critchlow, *supra* note 146 at 228.

¹⁴⁸See Critchlow, *supra* note 146 at 225.

¹⁴⁹See *id.* at 33.

¹⁵⁰See *id.* at 228.

¹⁵¹See *id.* at 226. See also June Preston, *Ted Turner Urges Limit of One Baby Per Family*, BUFFALO NEWS, Sept. 12, 1998 at A4. Interestingly, this concern about population seems to have been revived somewhat in the 1990s. In 1998, media mogul Ted Turner called for a worldwide policy of one-baby-per-family, claiming that the only way to improve the quality of life is to reduce the planet's population to 2 billion over the next 100 years. Turner has pledged \$1 billion to the United Nations for international programs including population control.

planning targeted poor blacks as a way to reduce their family sizes in particular.¹⁵² It was not until the early 1970s that the importance of family planning for the liberation and equality of women was fully realized, as support for a Constitutional right to abortion grew, culminating in the Supreme Court's infamous 1973 decision, *Roe v. Wade*.¹⁵³

For sure, the Catholic Church is not the only religious organization that has opposed family planning, sexual education and contraceptive use. In fact, despite the Church's official stance on contraception, Catholic couples use contraception at about the same rate as non-Catholics.¹⁵⁴ And, although Catholic voters were twenty-five percent of the voting population, in 1969 eighty-nine percent of Americans supported government-sponsored dissemination of birth control information. The growth of the conservative Christian Right (non-Catholic) in the late twentieth century and its influence on the Republican Party has also had a profoundly negative effect on the government's family planning policies in the 1980s and 1990s, and the attitudes towards sexuality many people still hold.¹⁵⁵

“Medically Necessary”

“There is nothing optional about contraception. It is a *medical necessity* for women during thirty years of their lifespan. To ignore the health benefits of contraception is to say that the alternative of twelve to fifteen pregnancies during a woman's lifetime is medically acceptable”¹⁵⁶ (emphasis added).

¹⁵² See Critchlow, *supra* note 146 at 6. See also Tone, *supra* note 1 at 233.

¹⁵³ 401 U.S. 173 (1973).

¹⁵⁴ See Critchlow, *supra* note 146 at 236 (“By 1990 most Americans used artificial contraception. There was little difference among Protestants, Catholics and Jews in overall contraceptive practice, with about three of five women in each religious group using artificial contraception”) and Darroch, *supra* note 114.

¹⁵⁵ See McFarlane, *supra* note 142 at 46 (“The election of Ronald Reagan in 1980 brought significant changes to the national family planning effort. Public funding was imperiled [because]... Reagan owed a political debt to the conservative coalition which opposed public support of family planning.”) and 150 (“Throughout the 1980s and early 1990s, anti-abortion activists argued that Title X and Planned Parenthood of America fostered abortion and teenage promiscuity. Although many members of Congress were skeptical, they also feared the power of the anti-abortion movement and the Christian Coalition”).

Generally, insurance policies exclude coverage for medical services, equipment or supplies which are not considered “medically necessary.”¹⁵⁷ Medical necessity is almost “universally employed as the test for coverage in plan/subscriber contracts.”¹⁵⁸ What is meant by this legal term of art is often ambiguous and in such cases where the language is ambiguous, in considering whether a treatment or equipment can be excluded under the medical necessity doctrine, courts will look to the terms of the policy, the nature of the treatment and the circumstances under which it was rendered.¹⁵⁹ Reproductive-related services that have been held *not* to be medically necessary include reversals of prior sterilization procedures and in vitro fertilization procedures.¹⁶⁰ Thus far though, there do not appear to be any cases brought claiming that contraception is a medically necessary service and thus cannot be excluded from a comprehensive insurance policy. *Erickson v. Bartell* was a Title VII claim, not one challenging the language of the insurance policy.

The typical American woman wants only two children and thus spends about seventy-five percent of her reproductive life trying to prevent unintended pregnancy.¹⁶¹ Therefore, it would be difficult to make a plausible argument that contraception is not a medical necessity for all women and couples. It is time for the health insurance community and federal and state legislatures to recognize that contraception is part of a woman’s *basic* health care and its use is both normal and essential.¹⁶² A basic health need is certainly medically necessary.

V. Why It Is Necessary to Cover Contraceptive Services, Drugs and Devices

¹⁵⁷ See Annotation, *Health Insurance*, 75 A.L.R. 4th 763 (1989).

¹⁵⁸ See Havighurst, *supra* note 96 at 1228.

¹⁵⁹ See *Health Insurance*, *supra* note 157.

¹⁶⁰ See *id.*

¹⁶¹ See Amended Complaint, *supra* note 137 at 5.

¹⁶² See McFarlane, *supra* note 142 at 160 (“public policies that promote abstinence are largely ineffective [because] the demand for sex is relatively inelastic”). See also *Hearings on S. 104*, *supra* note 3 (testimony of Anita Nelson, MD) (“Without contraception, the average woman could become pregnant more than twelve times, a prospect that is unacceptable to most women and would place a woman’s and her children’s health at unnecessary risk. Women cannot simply opt out of the need to control their fertility for three or more decades”).

Unintended Pregnancy

Unintended pregnancy is a global problem, and the United States, despite its status as the richest and most “developed” nation in the world, has one of the highest rates of unintended pregnancy among all industrialized nations.¹⁶³ Over fifty percent of all pregnancies in the United States are unintended. Unintended pregnancies are not only a problem that affects teenagers or poor women;¹⁶⁴ over forty percent of pregnancies to married women are unintended.¹⁶⁵ Americans are not more sexually active than people in other nations, but they are less effective users of contraception.¹⁶⁶ Teenage pregnancy rates are higher in the United States than any other developed nation aside from Hungary.¹⁶⁷ But, contrary to the suggestions of the conservative establishment, American teenagers do not have more sex than teenagers in other nations. As Andrea Tone notes, “in Sweden. . . sex among young adults is more prevalent, yet rates of pregnancy, birth and abortion are significantly lower. The reason is simple. Young adults in Sweden use contraceptives more frequently than their American counterparts.”¹⁶⁸ Unintended pregnancy causes a number of serious economic, social and health consequences for women, families and the taxpaying public that could be avoided if the rates of unintended pregnancies were reduced.¹⁶⁹

Women with unintended pregnancies have lower rates of prenatal care,¹⁷⁰ are more likely to expose their fetus to damaging substances such as tobacco, alcohol and drugs and as a result, their babies are often

¹⁶³ See Harrison, *supra* note 13 (percentages of unintended pregnancies across the globe range from twenty-four to sixty-four percent).

¹⁶⁴ See *Achievements*, *supra* note 73 at 1.

¹⁶⁵ See Brown, *supra* note 33 at 250.

¹⁶⁶ See McFarlane *supra* note 142 at 162.

¹⁶⁷ See Tone, *supra* note 1 at 289.

¹⁶⁸ See *id.*

¹⁶⁹ Note that the term “unintended pregnancy” encompasses conceptions that are unwanted and those that are mistimed. In some contexts there are reasons to draw a distinction between unwanted and mistimed pregnancies but this paper will discuss unintended pregnancies generally, because both types are a result of either a lack of contraception or misuse or failure of the contraceptive method being employed.

¹⁷⁰ See McFarlane, *supra* note 142 at 143.

born with low birth weight.¹⁷¹ Unwanted conceptions are at an even greater risk of dying in the first year of life, of being abused and not being cared for sufficiently for healthy development.¹⁷² Babies born with a low birth weight are at increased risk for neuro-developmental handicaps, respiratory tract infections, learning disorders, behavioral problems, visual and hearing problems, autism, cerebral palsy and epilepsy.¹⁷³ Low birth weight and these resulting disorders are largely preventable if women are educated beforehand about the dangers of unwanted and mistimed pregnancies and given affordable access to contraception. The aforementioned disorders that frequently occur in low birth weight babies place an enormous drain on the resources of the public health care system, and later in life, public education and social services programs by for example, increasing special education expenditures.¹⁷⁴

For sure, unintended pregnancies do not only adversely affect women or the public, they also impose burdens on the resulting babies, and other family members, including the father and other children. A mother with an unintended pregnancy is at a greater risk of depression and physical abuse and the relationship with her partner is at greater risk of failing.¹⁷⁵ As a result of an unintended pregnancy, an entire family may suffer economic burden and both parents may fail to achieve their educational and career goals. Less attention may be paid to the other children in the family when parents are faced with an unintended pregnancy. All of these consequences may harm the development of a strong family unit and even destroy a once-cohesive family.

¹⁷¹ See Brown, *supra* note 33 at 250-51.

¹⁷² See *id.* at 251. See also Rosenblatt, *supra* note 47 at 1257 (“a low birth weight baby is forty times more likely to die during the neonatal period and twenty times more likely to die during the first year as normal weight infant”).

¹⁷³ See Rosenblatt, *supra* note 47 at 1257.

¹⁷⁴ See *e.g.* MARK G. YUDOF, DAVID L. KIRP, BETSY LEVIN, & RACHEL F. MORAN, EDUCATIONAL POLICY AND THE LAW, (4th Ed. 2002).

¹⁷⁵ See Brown, *supra* note 33 at 251.

In addition to the emotional and economic costs an unintended pregnancy imposes on a woman and her family, women with unintended pregnancies have approximately 1.5 million abortions each year in the United States.¹⁷⁶ Fifty-four percent of unintended pregnancies end in abortion, giving the United States the second highest abortion rate among the fifteen Western countries with similar reproductive behavior.¹⁷⁷ Although women in other Western democracies often have easier access to abortion than those in the United States, the U.S. ratio of one abortion to every three live births is “two to four times higher than that in other Western democracies.”¹⁷⁸

While safe abortions performed by medically licensed health professionals pose practically no health risks, there are important reasons to reduce as much as possible the need for and use of abortion. First, *actual* access to abortions in the United States is not universal. While the Supreme Court has preserved the *Constitutional* right of a woman’s right to choose whether or not to terminate a pregnancy (although the bare majority decision in *Planned Parenthood v. Casey*, 5-4 in favor of upholding *Roe*, means that this right is constantly at risk of being eliminated should the composition of the Court change),¹⁷⁹ *practical* access to abortion is limited for many women, particularly in rural areas of the country where women may have to travel hundreds of miles to reach an abortion provider.¹⁸⁰ Furthermore, many states have restrictions on abortions ranging from mandatory waiting periods, to mandatory parental consent, to lack of funding of abortions for low income women.¹⁸¹ Because of the limited access to abortion many women face, after realizing they are unintentionally pregnant, they may choose to have unsafe abortions performed by unlicensed persons and these pose severe health consequences.¹⁸²

¹⁷⁶ See *id.*

¹⁷⁷ See *Achievements*, *supra* note 73 at 3.

¹⁷⁸ See *Brown*, *supra* note 33 at 251.

¹⁷⁹ See *Roe v. Wade*, 401 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

¹⁸⁰ See *Who Decides*, *supra* note 48 at 3-5.

¹⁸¹ See *McFarlane*, *supra* note 142 at 79.

¹⁸² See *id.* at 164 - 165 (“When abortion was illegal in the United States, many women took the risk of having an unsafe procedure, often performed by poorly trained, if not incompetent, operators. Abortions often failed and mortality was high. . . restrictions on access to abortion consistently generate efforts to circumvent the restrictions”).

Even if a woman can access a safe abortion and afford to have the procedure done or has insurance coverage for it, the emotional consequences of choosing abortion are an important reason to reduce its usage as a form of “contraception.” Having an abortion is a painful decision for any woman to make and the long term consequences of such an emotionally wrenching decision can be extremely hard to overcome. Many women will feel guilty about their choice. Radical anti-choice groups make it more difficult for women to elect this procedure and have it done in private when they picket outside of abortion clinics shouting at the women who enter and passing out graphic flyers of aborted fetuses. Although it is important to ensure that abortion remains a legal, safe and practical option for women who want to elect it, most women would prefer never to be in the situation where they had to make that painful choice. Increased coverage of contraceptives reduces unintended pregnancies and thus reduces abortion. Perversely, sixty-six percent of private insurers offer abortion coverage, while only fifteen percent cover contraceptives.¹⁸³

Given the conservative political movement’s virulent opposition to abortion rights one would think that support for increased coverage of contraception would be universal. If we accept that men and women will continue to be sexually active, and that lack of coverage for contraception leads to decreased contraceptive use and thus an increase in unintended pregnancy and abortion, it is axiomatic that one solution to this problem lies in increasing access and coverage to contraception.¹⁸⁴

Equality and Power in the Workforce

In enacting the Pregnancy Discrimination Act, Congress sought to equalize employment opportunities avail-

¹⁸³ See Brown, *supra* note 33 at 139.

¹⁸⁴ See McFarlane, *supra* note 142 at 164 (“funding for contraceptives is negatively and significantly related to the incidence of abortions”).

able to women and men and prevent discrimination against female employees based on the view that they would eventually become pregnant and leave their jobs. “The assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs.”¹⁸⁵

The ability of a woman to control the timing and number of pregnancies is essential to her ability to participate equally in the workplace with men. Recently, the Centers for Disease Control declared family planning one of the top ten achievements in public health in the 20th century noting that “smaller families and longer birth intervals... have improved the social and economic role of women.”¹⁸⁶ Women who unintentionally become pregnant are often forced to quit their jobs, or take extended leave to give birth and care for a newborn baby. Becoming pregnant at the beginning or a crucial time in one’s career can have devastating consequences for a woman’s future in the workplace. Women who become pregnant are often perceived as not as “serious” about their careers as men.¹⁸⁷ For working-class and blue-collar women, an unexpected pregnancy might mean being fired from a job that did not provide much security to begin with or not being able to perform physically-demanding aspects of a labor-intensive job.¹⁸⁸

If women cannot control if or when they become pregnant, they will never attain equality with men in the workforce. Although one should not minimize the participation of fathers in the birth of their children, the reality is that fathers do not *have* to take the paternity leave that more progressive companies have begun to offer in recent years. While ideally we want to encourage the full involvement of men in the pregnancies of their partners, men do not face the same danger of derailing their careers when they have a baby with their

¹⁸⁵ See H.R. REP. 948, 95th Cong., 2d Sess. 3 (1978).

¹⁸⁶ See *Achievements*, *supra* note 73 at 1.

¹⁸⁷ See e.g. Keith Cunningham, *Father Time: Flexible Work Arrangements and the Law Firm’s Failure of the Family*, 53 STAN. L. R. 967, 977, 996 (2001). (“ ‘For female attorneys, the struggle is between being a good mother and a dedicated attorney. People are afraid that they’ll be stigmatized because they’ll be perceived as not being a player,’ says June Eichbaum, a New York legal recruiter. Eichbaum practiced law full-time for eleven years in Manhattan; when she switched to a flex-time schedule as a corporate associate, Eichbaum says she was taken off the A Team and given paralegal work.”)

¹⁸⁸ See generally Vicki Schultz, *Life’s Work*, 100 COLUM. L. REV. 1881 (2000).

partner. Physically, men bear none of the burdens that attach to pregnancy and giving birth, while because of the physical strain, most pregnant women will have to stop working towards the end of their pregnancy and cannot immediately return after giving birth. Furthermore, the unfortunate truth is that many women do not have the luxury of sharing a pregnancy with an involved, caring mate who will assist them with the baby after they have given birth. Women end up bearing a disproportionate share of not only the physical stress of pregnancy, but the mental, financial and career implications of becoming pregnant, giving birth and raising children. If we are committed to breaking down any barriers that women face in attaining equality with men in the labor force, we must be committed to providing quality, affordable contraceptive services for any woman who wants them.

Pharmaceutical Development

For a variety of economic, regulatory and social reasons, in recent years, the research and development of contraceptives has stalled in the pharmaceutical industry.¹⁸⁹ Despite the variety of FDA-approved contraceptive technologies available in the United States, there are a number of areas where contraceptive options could be improved, including prescription methods for use by males, and methods that act as barriers both to conception and to transmission of sexually transmitted disease (currently, the only prescription contraceptive that accomplishes this at all is the diaphragm and as seen above its effectiveness is far from perfect).¹⁹⁰ Despite the enormous social, economic, and scientific benefits we realize from the use of contraception, for pharmaceutical companies to invest in the exorbitantly expensive and time-consuming process of research-

¹⁸⁹See Harrison, *supra* note 13 at 1 (“the field of contraceptive research and development has somehow lost the energy that characterized it at the time of what is called the ‘first contraceptive revolution’.”).

¹⁹⁰See *id.* at 9.

ing, developing, seeking approval, producing and marketing new drugs and devices, there must be a strong, profitable, politically safe and predictable market for new products.¹⁹¹

Comprehensive insurance coverage of contraception is one way to insure that there is a predictable market for new contraceptive products. If prescription contraceptive coverage is expanded, the number of women using inexpensive non-prescription methods of contraception will switch to more effective prescription methods, and others will be willing to experiment with new technologies they might otherwise not have if they had to pay out of their own pocket for the prescription. Insurance coverage will create a consumer population able to afford prescription contraceptives, and thus create a larger user base for contraceptives, giving pharmaceutical companies an incentive to aggressively innovate and market new products.¹⁹² In addition, a woman using prescription contraceptives must visit her gynecologist more often than women who are not using contraception. More frequent visits to physicians means physicians will have a greater chance to inform women about new contraceptive options. Thus, pharmaceutical firms can market new technologies through physicians by providing information packets and free samples, and women will become more aware of their options in the process.

Why should we give pharmaceutical companies such an incentive? Do we really need new contraceptive technologies and services? The Institute of Medicine has concluded that yes, we do need more contraceptive options because the contraceptive needs of many women and couples are not being met.¹⁹³ Women want effective, safe contraceptives that have minimal side effects. They also want methods that are discreet and easy to use and methods that protect against both conception and sexually transmitted infections. While in

¹⁹¹ See *id.* at 15. The costs of researching and developing a new drug are extremely high. The process from inception to FDA approval takes an average of twelve to fifteen years and costs about \$500 million. See e.g. www.phrma.org, (visited March 10, 2002).

¹⁹² See Harrison, *supra* note 13 at 15 (“no firm will undertake commercialization of a new medical technology without at least a strong belief in the existence of a substantial market of consumers able and willing to pay for it”).

¹⁹³ See *id.* at 2 (“the committee should refocus itself toward approaches in areas where the needs of women are still unmet by existing methods”).

the short-term the best thing we can do for women is provide insurance coverage for existing contraceptive technologies, in the long-term it is essential that new services be developed, to increase the effectiveness of contraception and provide all women with a convenient method. Supplying pharmaceutical companies with clear market demand will help to achieve the latter goal.

End Historic Gender Discrimination

Currently, women pay sixty-eight percent more in out-of-pocket health care expenditures than men. Reproductive-related costs constitute the majority of that difference.¹⁹⁴ Nationwide, women like Jennifer Erickson do not have their basic health needs met by private insurance for which they or their spouses work or pay high premiums. As a result, the average woman will spend between seven and ten thousand dollars for birth control throughout her reproductive life.¹⁹⁵ Historically, insurers and employers have categorically excluded most contraception from their prescription drug plans. In contrast, the one method of “prescription” contraception that can be used by males – vasectomy – is and has been covered by the vast majority of insurance plans.¹⁹⁶ Although I have noted that traditional indemnity plans cover surgical services more often than preventive services, most insurers now provide coverage for a number of preventive services and drugs, including routine physician exams/well-visits, immunizations, blood-pressure lowering drugs, etc.¹⁹⁷ Yet, even as insurance plans and employers move toward covering these types of essential preventive services, a large number do not include contraception, which is also preventive, in that coverage.

In a less enlightened time, not very long ago, our Supreme Court upheld an otherwise comprehensive dis-

¹⁹⁴ See Amended Complaint, *supra* note 137 at 8.

¹⁹⁵ See Hatcher, *supra* note 23.

¹⁹⁶ See Brown, *supra* note 33 at 139.

¹⁹⁷ See *e.g.* Erickson, 141 F. Supp at 1268, n.1.

ability policy that excluded pregnancy-related disabilities from coverage. The Court did not believe that pregnancy discrimination in the workplace equaled Title VII gender discrimination.¹⁹⁸ Thankfully, Congress was convinced that the dissenting opinion had correctly interpreted Title VII and thus enacted the PDA to overrule the majority's interpretation.¹⁹⁹ In enacting the PDA Congress acknowledged that sex-based differences between men and women (of which the capacity to become pregnant is the primary one) are real, and require employers to provide women-only benefits. By excluding contraception from otherwise-comprehensive health plans, employers and insurance companies have been engaged in pervasive sex discrimination in their failure to provide these women-only benefits. Although only employers, and not insurers, can be sued under Title VII, the majority of employers have a self-insurance mechanism, which means there are a thousands of potential employer-defendants if women, civil rights organizations and reproductive rights organizations mobilize to bring Title VII suits.²⁰⁰ Now that the EEOC, Congress, the federal judiciary and state legislatures have admitted that contraception exclusion is a legal and moral wrong, hopefully most employers and insurance plans will voluntarily alter their coverage to include contraceptive services, thereby saving scarce judicial resources and getting this crucial coverage to women. Unfortunately, we cannot rely on these entities to do so voluntarily, thus we need a legislative mandate to insure that all women have sufficient access as soon as possible.

¹⁹⁸ See *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976).

¹⁹⁹ See *Pregnancy Discrimination Act*, 42 U.S.C. §2000e(k).

²⁰⁰ See *Havighurst*, *supra* note 96 at 67.

VI. Counterarguments

Mandatory Insurance Coverage of Contraceptives is Prohibitively Costly

“Any mandate, no matter how well-intentioned, raises the costs for everyone and increases the number of people without insurance.”²⁰¹ The recession has caused large and small businesses to trim or eliminate health benefits.²⁰² The cost of private health insurance is rapidly rising. Premiums rose eight percent in 2000, eleven percent in 2001 and are expected to jump fifteen percent this year.²⁰³ All of these are examples of the form the “cost argument” takes when opponents of contraceptive coverage voice their reasons for opposing state and federal insurance mandates.

The U.S. Chamber of Commerce, which opposes all legislatively imposed insurance mandates because it claims they directly raise the cost of health plans, sent a representative to testify against the EPICC legislation. Kate Sullivan, the Chamber’s Director of Health Care Policy, argued that Congress’s attempt to supplement the coverage of those already covered by health insurance was well-intentioned but misguided. Instead of mandating contraceptive coverage, Ms. Sullivan testified that Congress should be “tackling the . . . issue of one out of six people in this country [being] uninsured.”²⁰⁴ The Chamber believes that by mandating insurers and employers to include certain benefits in plans, employers, and small businesses in particular, will pass on increased costs to employees in the form of higher premiums or elect not to provide insurance coverage at all.²⁰⁵

²⁰¹ See Tamar Lewin, *Agency Finds Many Health Plans Should Cover Contraceptive Costs*, N.Y. TIMES, Dec. 15, 2000 at A1 (quoting Richard Coorsh, spokesman for the Health Insurance Association of America).

²⁰² See David S. Broder, *Fix Health Care Now*, THE WASHINGTON POST, Jan. 6, 2002.

²⁰³ See *id.*

²⁰⁴ See *Hearings on S. 104*, *supra* note 3 (testimony of Kate Sullivan, Director, Health Care Policy, U.S. Chamber of Commerce).

²⁰⁵ See *id.*

Ms. Sullivan is partially right; Congress should be addressing the fact that millions of people in the United States have no health insurance at all. But the number of uninsured is such a vast problem that instituting universal coverage would require revolutionary changes to our nation's health care system. President Clinton's 1993 health care initiative failed miserably in its attempt to provide universal health insurance to all Americans. Including contraceptive coverage in already comprehensive prescription plans is a much less expensive proposition that does not require a total revamping of the health insurance scheme. It simply requires that insurers remove the exclusion that currently exists for contraception in most plans. It simply requires an additional per employee expense of \$1.43 per month.²⁰⁶ Ninety-seven percent of all traditional insurance plans already cover prescription drugs generally,²⁰⁷ adding six more types of FDA-approved drugs and devices to a preexisting plan is unlikely to cause scores of employers to eliminate health insurance benefits altogether. And, if insurance costs rise slightly for employees as a result of offering contraceptive (and it is not proven they will), the additional price is what we must bear if women are to be treated equally in the disposition of employment benefits.

The Federal Employees Health Benefits Program (FEHBP) added contraceptive coverage in 1998 for nine million employees and their dependents. FEHBP's vast health insurance program is a good example of the financial implications of adding contraception to an already-comprehensive insurance plan. In 2001, the federal Office of Personnel Management reported that the coverage law, effective in 1999, caused *no increase* in the federal government's premium costs.²⁰⁸ As the largest employer in the United States, the federal government's success in offering comprehensive contraceptive coverage without a corresponding rise in premiums is an excellent model to which employers and insurers can look, if they choose not to believe the numerous studies that have established the cost-effectiveness of contraceptive use.

Finally, regardless of whether Congress decides to pass EPICC, a federal agency and federal court have

²⁰⁶ See Darroch, *supra* note 114 at 1.

²⁰⁷ See www.covermypills.org/facts/factsheet.asp, (visited Mar. 13, 2002).

²⁰⁸ See *Hearings on S. 104*, *supra* note 3 (testimony of Marcia D. Greenberger, Co-President National Women's Law Center).

already determined that contraceptive exclusion violates Title VII. Given the weight of these precedents and the strength of the reasoning, other federal courts are likely to rule the same way if presented with similar Title VII suits. If excluding contraception from an otherwise comprehensive benefit plan is illegally discriminatory, the cost argument is largely moot. The increased cost an employer may bear as a result of providing equal benefits is not a defense to a Title VII discrimination claim.²⁰⁹ Thus, even if Congress does not pass EPICC in the near future, employers have a choice of voluntarily adding contraceptive benefits at a cost of \$1.43 per employee or waiting to see if, armed with the EEOC and Erickson precedents, women bring class action lawsuits against their employers in federal court alleging Title VII violations. Considering the negative publicity that would result from such suits, the costs incurred in defending them and the long-term economic benefits employers are likely to realize once complete contraceptive coverage is instituted, employers should voluntarily add contraceptive coverage to their health plans now.

A Legal Mandate Should Not be Necessary

Ideally, private employers and insurers would recognize that to be fiscally, legally and socially responsible they should add contraceptive coverage and voluntarily do so, making a legal mandate unnecessary. Unfortunately, employers and insurers have proven that they will not act to provide coverage unless ordered to by Congress or the courts. The PDA was enacted over twenty years ago, but Bartell Drugs waited until Jennifer Erickson brought a Title VII claim before adding contraception coverage to its benefits. Statistical information on the high costs of unintended pregnancy (many of which are borne by both employers and insurance companies) is readily available to anyone capable of conducting an Internet or library search, yet employers and insurers have ignored such research, which establishes the long-term savings realized from contraceptive coverage.

²⁰⁹Los Angeles Dept. of Water & Power v. Manhart, 435 U.S. 702, 717 (1978) (“neither Congress nor the courts have recognized such a [cost justification] defense under Title VII”).

Instead, employers and insurers have opted for the short-term savings generated by not covering upfront contraceptive services.

Employers and insurers have been able to get away with this unfair and discriminatory practice because it overwhelmingly and directly affects only women. What else could explain the rush to cover Viagra prescriptions soon after its FDA approval? Where was the Chamber of Commerce when its members decided to offer Viagra coverage? Did it advise employers and insurers of the high cost that covering Viagra would entail? With the help of former senator and presidential candidate Bob Dole's endorsement, Viagra was immediately accepted into our culture as a drug to be celebrated. Employers and insurers responded by offering coverage for it in their prescription drug plans.

Despite the clear financial incentives for employers and insurers to offer contraceptive coverage, a legislative mandate is necessary because it is clear that we cannot trust employers or insurers to voluntarily provide this coverage.

Covering Contraceptives Would be Treating Women "Special"

There is an argument that by forcing insurance companies to cover contraceptive services, drugs and devices, women and contraceptives would be getting *special* rather than equal treatment under insurance policies. However, the state legislation, EEOC decision, EPICC legislation and Erickson decision do not require insurance companies to treat contraceptives as "special," only as *equal* to the level of coverage already provided for all other FDA-approved prescription drugs and related outpatient services. Furthermore, the mandate would only apply to those insurance policies which *already* offer comprehensive prescription drug plans. If a policy offers prescription drug benefits, included in that benefit must be all FDA-approved contraceptives.

Under the proposed legislation, no insurer would be forced to cover prescription contraceptives if it was not already covering other prescription drugs. It simply could not choose to exclude the FDA-approved contraceptives from its otherwise comprehensive plan.

VII. Conclusions

It Makes Economic Sense

“If broader coverage leads to improved access and substantially more effective contraceptive use... payers may save resources by avoiding the costs of unintended pregnancies.”²¹⁰

“Contraception saves health care dollars... regardless of the setting.”²¹¹

It is generally accepted that contraceptive use saves both private and public funds by reducing the incidence of unintended pregnancy. The question that may remain for insurers and employers though is whether coverage of contraceptives will actually increase *use*, thereby generating immediate savings from the reduced number of pregnancies. Preliminary studies demonstrate that increased coverage leads to increased usage. Among low-income women who use clinics for family planning services, those who are not low-income enough to be eligible for Medicaid (which covers all methods of contraception) are only 1/12th as likely to get Norplant than are other women at the same clinics who are on Medicaid (and thus had coverage).²¹² Among 129 patients enrolled in a Texas study in which they obtained a free IUD, forty-seven percent said they could not have afforded and would not have been willing to pay for the IUD if it had not been provided free of charge through the study.²¹³

Thus, all available signs point to the fact that when contraception is covered by insurance, more women

²¹¹ See Trussell, *supra* note 2 at 6.

²¹² See Darroch, *supra* note 114 at 5.

²¹³ See *id.*

utilize it. Although I have already extensively mentioned the public health and social benefits realized from preventing unintended pregnancies, I realize that such information is not as important to employers and insurers as their bottom line. Insurers want to know whether covering contraception will save the immediate costs they incur in covering pregnancy-related expenses. Employers want to know whether the additional one percent investment in monthly health care premiums will be offset by the increased productivity of women who are not forced to take time off or quit their jobs because of pregnancy, miscarriage and abortion. Although admittedly more research is needed in this area, increased coverage will probably lead to increased use. All parties involved will thus economically benefit from contraception coverage – employers, insurers, women and the general public.

It's Been Proven that Prevention Works

Where young people receive social support, full information and positive messages about sexuality and sexual relationships, and have easy *access* to sexual and reproductive health services, they achieve healthier outcomes and lower rates of pregnancy, birth, abortion and STDs (emphasis added).²¹⁴

From a policy standpoint, there is no logical reason to continue to restrict access to contraceptive services, drugs and information. From every perspective, it makes sense to start increasing access to these services by making sure that those women who have insurance have a complete set of basic health benefits available to them. Covering contraception does not only mean that insurance companies will cover the cost of the package of pills a woman obtains at the pharmacy each month, it also means that the woman who chooses prescription contraception will see a physician every three or six months for a check-up and prescription renewal. Thus, women will obtain reliable, regular information about their reproductive health, be tested

for cancers and sexually transmitted infections and hear about new contraceptive technologies from their physicians. Even though all women should visit a gynecologist annually, women who use non-prescription contraception do not have the same incentives to visit their physicians as those with prescriptions and may go years at a time without getting a check-up, often waiting until they realize they are pregnant or believe they might have contracted an infection. Covering prescription contraception will increase the number of women using prescription contraceptive drugs and thus increase the regularity of gynecological visits, which can positively impact women's overall health.

EPICC is the Best Form of Legislation

Despite the EEOC ruling, Erickson decision, and state legislation, the passage of EPICC is necessary to ensure that all women enrolled in health insurance plans have contraceptive coverage. The EEOC is an administrative agency whose decisions are binding only on the parties before them. Erickson's Title VII reasoning only applies to employers with fifteen or more employees. Fewer than one-fifth of all U.S. employers are covered by Title VII, leaving out fourteen million people working for small businesses as well as another sixteen million who obtain health insurance through the individual market.²¹⁵ The Erickson rationale and legal foothold only applies to employers, not directly to insurers, so people who are self-employed, part-time or temporary and purchase non-employer related health insurance, need a federal mandate that is not contingent on employment discrimination law. Even if every state passed legislation mandating coverage within that state, state insurance law fails to cover any self-insured health plans, because they are preempted by the federal ERISA statute.²¹⁶ And, approximately seventy percent of the 160 million Americans covered

²¹⁵ See Cohen, *supra* note 45 at 5.

²¹⁶ See Havighurst, *supra* note 96 at 67 ("ERISA's preemptive provisions... permit self-insured plans alone to escape both the burdens of state insurance regulation and the impact of other state laws applicable to health insurers").

by employer-sponsored health plans are in self-insured plans that enjoy the benefits of ERISA.²¹⁷ Thus, only a Congressional mandate would cover all of those women who are left out of the other legislative and judicial remedies. Only the passage of EPICC would serve to insure that all women who pay for insurance are afforded equal and adequate coverage of their most pressing health care needs.

Aside from being the most comprehensive way of accomplishing universal contraceptive coverage, the benefits of EPICC can appeal to both political parties. EPICC is bipartisan legislation introduced by Senators Harry Reid, a Democrat of Nevada and Olympia Snowe, a Republican of Maine. Democrats are more typically supportive of family planning and women's rights but insurance coverage for contraception is something Republicans can use to appeal to their constituents as well. For the conservative anti-choice wing of the Republican party, creating a means for women to access affordable and effective birth control will reduce the number of abortions performed in this country. By increasing coverage, we will expand use, reduce the rate of unintended pregnancy and thus reduce the demand for abortion.

Conservation of scarce judicial resources is another benefit that will be realized if EPICC is passed. The federal mandate would eliminate the lawsuits that women, with the help of groups like Planned Parenthood, will continue to file against their employers as long as contraceptive coverage is not a reality for all women with insurance. The Erickson decision sent a strong message to women's groups that the federal judiciary may no longer be willing to tolerate the employment discrimination that occurs when employers fail to offer insurance plans with contraceptive coverage. To avoid the onslaught of federal lawsuits that will occur as a result of the favorable Erickson ruling, Congress should pass EPICC, thus saving our judicial system the time and money that will be spent litigating hundreds of Title VII claims in federal courts.

²¹⁷ See *id.*

Finally, there is a strong precedent for a federal insurance mandate in the reproductive health arena. In 1997, after findings that “drive-through deliveries” were related to health problems in both newborns and new mothers, Congress passed a law prohibiting the early discharge of women who have given birth. As a result, group health plans may not “restrict benefits for any hospital length of stay in connection with childbirth. . . following a normal vaginal delivery, to less than 48 hours, or restrict benefits for any hospital stay in connection with childbirth. . . following a cesarean section, to less than 96 hours.”²¹⁸ A conservative Congress passed this legislation to protect the health rights of mothers. Today’s Congress should pass EPICC to protect the health rights of all women, who one day may want to become mothers, but only when the time is right for them and their partners.

Numerous reproduction-related studies by healthcare researchers and organizations have concluded that increasing access to and affordability of contraception is a valuable goal. The Institute of Medicine Committee that studied the effects of unintended pregnancy made five recommendations for reducing the number of unintended pregnancies, one of which was improving access to contraception by reducing financial barriers.²¹⁹ There is a “need for contraceptive services to be covered more adequately by health insurance, as is increasingly the case for such other preventive interventions such as immunizations.”²²⁰ An economic study headed by James Trussell of Princeton’s Woodrow Wilson school concluded that “providing insurance coverage for contraception could be a cost-effective strategy. . . current coverage policies constitute a significant disincentive for effective contraceptive use.”²²¹ The Institute of Medicine’s study on contraceptive research and development recommended that “third-party payers, who bear the costs and may reap the benefits

²¹⁸Standards Relating to Benefits for Mothers and Newborns, 26 U.S.C.A. §9811.

²¹⁹See Brown, *supra* note 33 at 254.

²²⁰See *id.* at 260.

²²¹See Trussell, *supra* note 2 at 14-15.

of the health status of their covered populations, include contraception as a covered service.”²²² Deborah McFarlane and Kenneth Meier’s analysis of U.S. family planning policy supports regulatory initiatives for contraceptive access because “substantial numbers of women who are not low-income have unintended pregnancies. . . timely access to contraception can be problematic for these women, even those who have private insurance.”²²³

Clearly, physicians, scientists, and economists agree; insurance coverage for contraception has tangible, long-term, medical, social and financial benefits that outweigh the initial costs employers would bear in slightly increased insurance premiums. If Congress wants to send a message to American women that it cares about their health, their rights and their equality, it must start by passing EPICC.

Looking toward the Future

Requiring health insurance coverage for contraception is an essential step in addressing the numerous problems caused by unintended pregnancy. But not until we begin to eliminate the negative attitudes towards sexuality and contraception can we dramatically reduce the incidence and effects of unintended pregnancies. Along with extending health insurance coverage, we must expand our sexual education programs in schools, insure that low-income women without health insurance have access to effective contraceptive and reproductive health services and stop placing barriers in the way of a woman’s constitutional right to choose abortion.

Since the “war on terrorism” began in Afghanistan, the plight of the Afghan women has been extensively

²²² See Harrison, *supra* note 13 at 16.

²²³ See McFarlane, *supra* note 142 at 163.

publicized in the United States.²²⁴ The burkas they were forced to wear, the fact that women could not attend school, the number of young girls selling their bodies to feed their families, all of these are conditions with which Americans are horrified. Yet we continue to discriminate against our own women; we continue to allow them to place their bodies and their families at risk by not providing universal contraceptive services and this leads to the world's most industrialized, prosperous and developed nation having a shameful unintended pregnancy and abortion rate that exceeds that of any other industrialized nation. To change these conditions, we must offer affordable, effective contraceptive services to every woman but we must also educate boys and girls from a young age that sexuality is normal, and that contraception is a basic health need that will be provided to whomever desires it.

²²⁴See e.g. Amy Waldman, *A Nation Challenged: Resistance: Behind the Burka: Women Subtly Fought Taliban*, NY. TIMES, Nov. 19, 2001 at A1.