What Methods Should Be Included in a *Contraceptive* Coverage Insurance Mandate?

By Lisa Kaeser

With the momentum for requiring insurance plans to cover contraceptives and contraceptive services seeming to increase almost daily, two fundamental, interrelated goals of such an effort should be remembered. The first is to redress a common insurance inequity (and logical inconsistency)—the fact that many of today's plans cover abortion and contraceptive sterilization but do not cover reversible contraception, reflecting a longstanding insurance practice of covering surgical and other remedial services but giving scant attention to prevention. The second is to ensure that a woman can use her insurance to choose a particular contraceptive based on whether it is the most appropriate one for her—not whether the method happens to be covered by her plan.

To accomplish these goals, the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) currently pending in Congress would require most private-sector insurance plans to cover "prescription contraceptive drugs or devices approved by the Food and Drug Administration (FDA), or generic equivalents." Also required would be coverage of "outpatient contraceptive services"—"consultations, examinations, procedures, and medical services…related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy."

During an early skirmish on the issue on the House floor this summer, however, hard-line abortion opponents made an attempt to narrow the scope of a contraceptive coverage mandate on the grounds that certain methods are not, in their view, contraceptives but rather "abortifacients." The debate illustrated just how highly politicized issues concerning reproductive health have become—and how little understanding there is of what constitutes a pregnancy and, therefore, its prevention (through contraceptive use) or its termination (through abortion). Indeed, efforts to narrow the scope of "real" contraception by legislative dictum not only ignore medical science (*and* longstanding government policy) but, if successful, would also severely compromise the ability of a woman to choose from the range of available methods the one most suitable for her.

The 'Conception' of a Pregnancy

The establishment of a pregnancy is a process that takes several days, from fertilization of a woman's egg through implantation of that fertilized egg in the lining of the woman's uterus. (While "conception"—a nonmedical term—often is used synonymously with fertilization, the term more properly may be used to describe this entire process.)

A wide array of medical experts, including the American College of Obstetricians and Gynecologists (ACOG), agree that becoming pregnant depends on many factors. To be sure, not every act of intercourse results in a pregnancy. *Ovulation* (the monthly release of a woman's egg) first must occur, and at least one sperm must reach and unite with that egg during the very short period before it is sloughed off through menstruation. *Fertilization*, which can take up to 24 hours and usually occurs in the fallopian tubes, describes the process by which a single sperm gradually penetrates the layers of an egg ("oocyte") to form a new cell ("zygote"). The new cell begins to divide and differentiate and is carried down the fallopian tube toward the uterus. *Implantation* of the "preembryo" in the woman's endometrium, or uterine lining, begins around day five; it can be completed as soon as day eight

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but usually closer to day 14 (some estimates range as high as day 18). *Pregnancy* is considered to have begun when implantation is complete. Not until the third week after fertilization has the implanted entity developed sufficiently to be deemed an "embryo."

[This early period is highly unstable. Research shows that between one-third and one-half of all fertilized eggs never fully implant. This extremely high rate of loss may be part of a natural, necessary biological process to weed out the unhealthiest preembryos. After implantation, about 15% of pregnancies end in spontaneous abortion (miscarriage).]

For two decades, the federal government has accepted this definition of pregnancy—and, by extension, its prevention. Since 1978, the Department of Health and Human Services has formally included the following in the Code of Federal Regulations: "*Pregnancy* encompasses the period of time from confirmation of implantation (through

any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until the expulsion or extraction of the fetus."

This is the definition of pregnancy FDA officials use when considering applications for approval of new contraceptive drugs or devices. The most recent example occurred in early September, when the FDA announced its approval of a new kit that, for the first time, separately packages four standard oral contraceptives for use within 72 hours of unprotected intercourse (see *For The Record*, page 13). Emergency contraceptive pills (ECPs) act similarly to other hormonal methods; as is the case with those methods, they do not terminate an established pregnancy (see box).

Congress Weighs In

In what may prove to be a "dry run" for congressional consideration of EPICC, the House in July debated—and adopted—an amendment to a FY1999 appropriations bill offered by Rep. Nita Lowey (D-NY) to require federal employees' health plans to cover prescription contraceptives if they cover other prescription drugs (*TGR*, Vol. 1, No. 4, August 1998). Immediately afterward, however, a surprise amendment was offered by Rep. Chris Smith (R-NJ) to exclude "coverage for abortifacients." Although initially confusing, since the bill already prohibited federal funds from being spent on abortions, Smith soon made it clear that his intent was to exclude from the mandate intrauterine devices (IUDs) and ECPs on the grounds that they sometimes act to prevent implantation of a fertilized egg. He and Rep. Tom Coburn (R-OK) flatly declared these methods to be abortifacients, even while decreeing—in a glaring self-contradiction—that other birth control pills were not.

Rep. Nancy Johnson (R-CT) took on Smith directly; in a passionate statement, she demonstrated both her knowledge of biology and her understanding of the stakes for American women. "Is there no limit to my colleague's willingness to impose his concept of when life begins on others?" she asked. "Conception is a process. Fertilization of the egg is part of that process. But if that fertilized egg does not get implanted, it does not grow…. For those who do not believe that life begins upon fertilization, but believe, in fact, that that fertilized egg has to be implanted, the gentleman is imposing his judgment as to when life begins on that person and, in so doing, denying them what might be the safest means of contraception available to them." The amendment was defeated, 222-198.

Smith's attempt to redefine certain contraceptive methods as abortifacients is not the first time abortion rights opponents have tried unsuccessfully to enshrine in federal law, directly or indirectly, the notion that "human life" and legal "personhood" are synonymous—and that both begin at fertilization. Inevitably, the impact of doing so on the legality of contraception or contraceptive research has entered the discussion.

In 1982, the Senate considered but rejected highly controversial legislation "finding" that human life begins with the fertilization of a woman's egg and that the fetus is a "person" entitled to full legal protection—an attempt to overturn, by simple statute, the Supreme Court's 1973 *Roe v. Wade* decision legalizing abortion nationwide. (In that decision, the Court ruled that the fetus is not

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How Do Contraceptive Methods Prevent Pregnancy?

FDA-approved contraceptive drugs and devices act to prevent pregnancy in three major ways: they can suppress ovulation; prevent fertilization by blocking the sperm and egg from uniting; or prevent implantation of a fertilized egg in the uterine lining.

Systemic methods can act in any of these three ways. While some methods are considered to have a primary *mode of action, how a specific method works may vary from woman to woman and, depending on the timing of intercourse in relation to ovulation, even in an individual woman from month to month. Hormonal methods either contain both estrogen and progestin, as is the case with the many different formulations of so-called combined* oral contraceptives *(the pill), or progestin alone, as is the case with* injectables *(Depo-Provera®),* implants *(Norplant®) and so-called minipills. Both combined pills and minipills, in specific doses, also may be used to prevent pregnancy if taken within 72 hours following unprotected intercourse (*emergency contraception*)—although, to date, only combined pills have specifically been approved by the FDA for this purpose. Progestin* intrauterine devices *(IUDs) act similarly to other progestin-only methods. Copper IUDs release copper ions, causing changes in the fluids surrounding the egg and sperm so that fertilization cannot occur; they also cause changes in the uterine lining so that implantation cannot occur.*

Barrier methods act by preventing the sperm and egg from uniting, or by killing the sperm altogether; they have no impact on ovulation or implantation. Condoms *(male and female),* diaphragms *and* cervical caps *block the passage of semen into a woman's cervix. The latter two must be used with spermicides for maximum efficacy;* spermicides *can also be used alone. Contraceptive* sterilization *may be considered the ultimate barrier method in that it involves surgical cutting or blocking of a woman's fallopian tubes or a man's vas deferens, thus permanently preventing an egg and sperm from uniting.*