Contraceptive Coverage: A 10-Year Retrospective

As Congress debated health insurance reform in 1994, groundbreaking research showed that private health insurance plans routinely failed to cover contraceptives. This finding would leave a considerable imprint on pending legislative proposals to achieve universal health insurance and launch an advocacy movement to achieve contraceptive equity that would far outlive that ill-fated debate. A decade later, new research shows that this movement has yielded handsome dividends. This special analysis traces the 10-year history of the drive for contraceptive coverage, from its origins in the debate over national health insurance reform through the present.

By Cynthia Dailard

Just over a decade ago, in October 1993, President Clinton delivered to Congress a sweeping, controversial proposal to achieve universal health insurance coverage for all Americans. A cornerstone of the legislation, known as the Health Security Act, was that every insurance plan in the nation would be required to include a "comprehensive benefit package" that was spelled out in the legislation and based on the relatively generous plans then currently offered to employees of the nation's largest firms. The package explicitly included coverage of "family planning services." The bill's definition of that term, however, was limited to "voluntary family planning services and contraceptive *devices*" [emphasis added]. Contraceptive *drugs* were assumed by administration officials to be included as part of the package's required prescription drug benefit.

Within six months, however, landmark research from The Alan Guttmacher Institute (AGI) would prove that assumption unwarranted. At a March 1994 Senate hearing entitled, "Women's Health Care in the President's Health Care Plan," AGI's president, Jeannie Rosoff, unveiled dramatic findings from the Institute's nationwide survey of private health insurers: Although health plans typically covered abortion and sterilization, they typically failed to include coverage of contraception—an inequity that was particularly glaring given that these plans routinely covered prescription drugs in general. Rosoff attributed the lack of coverage to the then-existing biases of the health insurance industry toward surgical care over nonsurgical care, and treatment over prevention, as well as the common marginalization of women's health needs. Adding fuel to the fire, Betty Dooley, executive director of Women's Research and Education Institute (WREI), also testified at the hearing that women of childbearing age spent 68% more in out-of-pocket health care costs than did men of the same age, and that reproductive health services accounted for a large portion of women's health spending. Together, the AGI and WREI research would have a profound effect on the health insurance reform debate. From that point on, the major health insurance bills introduced in Congress would specifically mandate coverage of contraception.

Unfortunately, congressional efforts to enact universal health insurance—a mammoth and extremely difficult undertaking by any measure—were marked by conflict and jurisdictional infighting from the start. Ultimately, health care reform, at least on the grand scale envisioned by President Clinton, would die under its own weight by Labor Day 1994. Shortly thereafter, and partially in response to what many critics deemed the Clinton health care debacle, the "Republican revolution" would place Republicans in control of both houses of Congress for the first time in decades, and in many governorships across the nation.

The Birth of EPICC

Although the demise of the Clinton plan and the Republican takeover of Congress in 1995 stopped the movement for universal health insurance dead in its tracks, it did not signal the end of federal health insurance reform entirely. Instead, it harkened an era of incremental reform, starting with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Substantively, HIPAA prevents health insurers from denying coverage to individuals based on preexisting conditions, among other things. Perhaps more importantly, however, HIPAA established a precedent for changing the relationship between the federal and state governments when it comes to regulating health insurance. Historically, health insurance regulation was left entirely to the states. States, however, only have the legislative authority to regulate employment-based health plans that are purchased by employers on behalf of their employees; they cannot regulate those plans created by employers that self-insure, which cover approximately half of Americans with employment-based coverage. Through HIPAA, Congress not only intruded on what was historically the jurisdiction of the states, but also established a model for regulating the entire market of employment-based plans, including self-insured plans.

By establishing such a model, moreover, HIPAA paved the way for federal legislation mandating the inclusion of specific benefits in health insurance plans. Such single-service mandates—derided by critics as "legislation by body-part"—include 1996 laws to end "drive-through deliveries" and to achieve mental health parity.

For the reproductive health community, these laws provided a legislative framework for addressing deficiencies in contraceptive coverage. Accordingly, in the spring of 1997, Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV), and Reps. James Greenwood (R-PA) and Nita Lowey (D-NY), introduced the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). The bipartisan legislation would require health insurance plans to provide the same level of coverage for prescription contraceptives and contraceptive services that they provide for other prescription drugs and outpatient health services.

The enormous political and popular appeal of this approach was readily evident on several levels. With a group of bipartisan legislators with differing views on abortion on board, EPICC demonstrated the potential to stake out "common ground" by emphasizing the role that contraceptives play in preventing unintended pregnancy and reducing the need for abortion; it provided a simple remedy to an easy-to-understand, well-documented problem; and it addressed a "middle class" issue that had great potential to tap into women's anger over gender inequities. Finally, it provided prochoice advocates, who were becoming increasingly beleaguered by a series of political losses on the abortion front, with the beginnings of a proactive vision for the future on a national scale.

State Activity Takes Off

In addition to launching single-service mandates at the federal level, the demise of comprehensive health insurance reform at the national level once again returned leadership on health insurance reform to the states. And similar to the federal experience, states began both exploring ways to achieve comprehensive coverage (through some combination of mandated employer-based insurance and expansions of their Medicaid program, for example) and experimenting with more incremental approaches.

Predating the introduction of EPICC by three years, California legislators in 1994 introduced a state-level mandate linking contraceptive coverage to a prescription drug benefit. By the end of 1997, legislators in 10 other states had followed suit. It was not until the spring of 1998, however, that two events would jump-start the legislative strategy for achieving contraceptive coverage, making the issue a subject of debate in state legislatures across the nation. First, and perhaps most importantly from a public relations standpoint, the male-impotency drug Viagra was approved by the Food and Drug Administration; press reports that insurers were flocking to cover the drug prompted considerable indignation among women who believed that insurers were eager to accommodate men's prescription drug needs while ignoring important needs of their own. Second, AGI issued an analysis concluding that the cost to employers of providing contraceptive coverage would be minimal, thus refuting the then–commonly heard argument that requiring such coverage would impose significant financial burdens on employers (see box).

The Costs and Benefits of Providing Contraceptive Coverage

Two key studies were instrumental in helping advocates rebut claims that contraceptive coverage would increase costs for employers. First, a 1998 analysis by AGI and Buck Consultants found that adding coverage for the full range of prescription contraceptives to health plans that exclude such coverage would increase costs by an average of $21.40 per employee per year. Assuming that the employer covers 80% of the premium, the added cost to employers would be $1.43 per employee per month, representing a premium increase of 0.6%. Moreover, because this represents the cost of adding coverage to a plan that does not cover any contraceptive methods, the cost would be less for those plans that cover at least some of these methods ("The Need for and Cost of Mandating Private Insurance Coverage of Contraception," TGR, *August 1998, page 5).*

The second study built on AGI's cost estimate to determine whether employers would reap any savings from providing contraceptive coverage. According to the Washington Business Group on Health and the employee benefits consulting firm William M. Mercer, providing contraceptive coverage reduces employers' direct and indirect costs associated with unintended pregnancy. These direct costs include health care expenditures associated with live births, abortions, miscarriages and ectopic pregnancies; indirect expenses include wages and benefits associated with employee absences, as well as costs associated with reduced productivity and with replacing employees who do not return to work after a pregnancy. The bottom line of the analysis is that not covering contraceptives in employee health plans would cost employers 15–17% more than providing such coverage.

In 1998, Maryland became the first state in the nation to actually enact a contraceptive coverage mandate. Within six short years, a total of 20 states would have such laws in effect (see table). But despite this breathtaking pace, legislators in many states had to overcome considerable hurdles before enacting their laws. For example, Virginia was poised in 1997 to become the first state to enact a contraceptive coverage mandate, when the legislature transformed the mandate into a requirement that insurers offer contraceptive coverage as part of a benefits package to employers, with no attendant requirement that employers actually purchase such coverage. California legislators would see their bill vetoed by the governor three times before a new governor would sign it into law. Several state legislatures have had to address the question of what constitutes a contraceptive versus an abortifacient ("What Methods Should Be Included in a *Contraceptive* Coverage Insurance Mandate?," *TGR,* October 1998, page 1). And finally, almost all of the states have had to confront the issue of "conscience"—in other words, the question of whether and which entities could opt out of contraceptive coverage requirements on religious grounds (see box).

Targeting Individual Employers

As the movement to secure contraceptive coverage through state legislation gathered steam, advocates simultaneously began using tools already at their disposal to apply pressure directly on employers—namely, litigation under existing gender discrimination laws. In June 2001, they celebrated a landmark victory in litigation alleging that an employer who excluded contraceptive coverage from an otherwise comprehensive prescription drug plan violated Title VII of the Civil Rights Act of 1964 (which prohibits sex discrimination in the workplace by employers). In *Erickson v. Bartell Drug Co.,* a federal court in Seattle ruled that "the law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception. The special or increased healthcare needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other healthcare needs." The decision confirmed a December 2000 ruling by the Equal Employment Opportunity Commission in a similar claim.

STATES WITH LAWS REQUIRING COMPREHENSIVE INSURANCE COVERAGE OF PRESCRIPTION CONTRACEPTIVES*

1998	**2000**
Maryland	Delaware
1999	Iowa
California	Rhode Island
Connecticut	**2001**
Georgia	Missouri
Hawaii	New Mexico
Maine	Washington†
Nevada	**2002**
New Hampshire	Arizona
North Carolina	Massachusetts
Vermont	New York
	2003
	Illinois

****Virginia and Texas (the latter vitiating a 2001 mandate in 2003) only require insurers to offer employees a plan with contraceptive coverage. †By regulation.***

As a result of these decisions, employers with 15 or more employees are on notice that excluding contraceptives from employee health plans that cover other prescription drugs constitutes gender discrimination. Consequently, a number of large employers have added contraceptive coverage, sometimes as the result of litigation or the threat of litigation. These include Dow Jones & Company, Albertson's Grocery Stores and DaimlerChrysler, among others. Similarly, major universities have moved to include contraceptive coverage for their employees and students, and contraceptive coverage advocates have partnered with labor unions such as the American Federation of State, County and Municipal Employees to secure contraceptive coverage through the collective bargaining process.

A particularly momentous victory came when an influential member of the House of Representatives decided to take on the federal government in its role as an employer. In July 1998, Rep. Lowey successfully offered an amendment to a pending annual appropriations bill requiring contraceptive coverage in insurance plans participating in the Federal Employees Health Benefits Program (FEHBP). In addition to making contraceptive coverage a reality for the 1.2 million women of reproductive age participating in the program, the new law had significant implications for the private insurance market. As the largest employer-sponsored health plan in the world, FEHBP often serves as a bellwether for private employers shaping their employee health plans.

President Bush would attempt to eliminate the FEHBP requirement in his first budget proposal to Congress in the spring of 2001. The fact that, only months before, the federal agency that administers the program had reported that implementation of the contraceptive coverage benefit "occurred smoothly and without incident"—and that it had not raised premiums, "since there was no cost increase due to contraceptive coverage"—revealed the Bush move for what it was: a bald-faced effort to appease the conservative base that elected him to office. However, there was no turning back the clock. Congress resoundingly rejected the

Contraceptive Coverage and the Issue of 'Conscience'

A key challenge facing advocates of contraceptive coverage mandates is to ensure that any exemptions provided to employers who object to covering contraceptives on religious grounds are narrowly tailored to minimize the number of people denied such coverage. This effort received an important boost recently as the result of two court decisions in California and New York.

Of the 20 mandates now in effect, 13 have some type of exemption for employers who object to providing contraceptive coverage on religious grounds. The specific provisions of these exemptions vary widely across the states. For example, Maryland's law contains a broad exemption that simply permits religious employers to refuse to include contraceptive coverage, without defining the term "religious employers."

The laws in California and New York are at the other end of the spectrum. Both permit an employer to refuse to cover contraceptives, even though it covers other prescription drugs, only if it has as its mission the inculcation of religious values, it primarily employs and serves people who share its religious tenets, and it falls under a U.S. tax code provision that applies to churches, church auxiliaries and religious orders.

Almost as soon as the California law went into effect, Catholic Charities of Sacramento filed suit. Interestingly, the organization readily acknowledged that it did not meet any of the tests required under the law; nonetheless, it alleged that the statute violated the establishment and free exercise clauses of the U.S. and California constitutions. In a strongly worded decision in March, the state supreme court disagreed.

One of the cornerstones of Catholic Charities' case was the allegation that the law interferes with matters of internal church governance. The court found this charge baseless: "This case does not implicate internal church governance; it implicates the relationship between a nonprofit pubic benefit corporation and its employees, most of whom do not belong to the Catholic Church. Only those who join a church impliedly consent to its religious governance on matters of faith and discipline." Moreover, the court found the law to be narrowly tailored to serve the state's compelling interest in eliminating gender discrimination. According to the court, a religiously affiliated organization not meeting the law's requirements "becomes subject to the same obligations that apply to all other employers."

In a similar ruling last year, a lower court in New York upheld a virtually identical exemption for religious employers; that ruling, in a suit brought by Catholic Charities of Albany and other organizations, is expected to be appealed to the Court of Appeals, the state's highest court. Meanwhile, Catholic Charities of Sacramento has until the end of May to file an appeal with the U.S. Supreme Court.

President's proposal to eliminate contraceptive coverage, and since then has renewed the requirement on an annual basis without debate.

What Is Left to Be Done?

In the year 2000, the Department of Health and Human Services made increasing private-sector insurance coverage of contraceptives an official public health goal for the nation in *Healthy People 2010*. New AGI research shows considerable progress toward that goal: levels of coverage have risen sharply in the past 10 years, and disparities in coverage among contraceptive methods have been greatly reduced (see related story, page 4). This progress promises to make true method choice a reality for many privately insured women in this country.

Yet there is still much work left to be done. The fact remains that only half of all women of reproductive age live in states that require contraceptive coverage. The other half live in states where there is no such mandate. Further, state mandates reach only those covered through employers who purchase from insurers; they do not reach the half of all covered employees who work for employers who self-insure. Passage of EPICC is necessary to guarantee coverage for women in states without mandates and for individuals in self-insured plans. Similarly, enhanced enforcement of gender discrimination laws, coupled with other efforts to persuade employers to provide coverage, also will play vital roles. In short, in the absence of comprehensive health insurance reform at the federal level, a continued multiplicity of targeted efforts and strategies will likely be necessary to ensure that women have the contraceptive coverage they need to best avoid unintended pregnancy.

Interestingly, the very issue that gave birth to the multipronged drive for contraceptive coverage a decade ago is now back on the American political agenda. As the nation gears up for the 2004 presidential election, the need for comprehensive health insurance reform is once again emerging as a major subject of national debate. At a time when so much has been accomplished to advance contraceptive coverage, and yet so much is left to be done, this 10-year odyssey has come full circle.