Hi Bruce!
Although I miss all my friends at the DPC, I am enjoying my work here at AGI. Will be working hard next year to enact contraceptive coverage in private insurance. Hope you will support the effort!
Have a wonderful holiday season + a happy new year.
—Cynthia

Health Care Contraceptive Coverage

30 THE ANNIVERSARY YEAR

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Dear Colleague:

I am pleased to enclose three recent articles from *The Guttmacher Report on Public Policy*, examining key issues raised by the effort to require coverage of contraceptive services and supplies in private-sector insurance plans.

Although contraception is basic health care for women, health insurers historically have not viewed it that way, with many plans providing far less extensive coverage for contraceptives than for other prescription drugs. This disparity in coverage helps explain why women of childbearing age have considerably higher out-of-pocket health care costs than do similarly aged men. At the same time, the lack of contraceptive coverage places many women in this country at unnecessary risk of unintended pregnancy and its consequences.

In that light, it is notable that 1998 was a year of unprecedented movement toward requiring contraceptive coverage in private-sector group health insurance plans. Legislation in this area was introduced in 20 states, with Maryland becoming the first state to enact a coverage requirement. At the same time, Congress set an important precedent for private-sector plans by enacting legislation requiring coverage in the health insurance plans available to federal employees.

Throughout the year, debates at the state and federal level crystallized around three key questions: the need for and cost of a government mandate; the appropriate scope of any exemption to a mandate that would be granted on the grounds of conscience; and the methods that should be included in a mandate, specifically in terms of what constitutes "contraception" and what constitutes "abortion." The enclosed articles can help inform these policy discussions and provide policymakers, advocates, and others with important information they need to craft creative solutions to the complex problems at the heart of these debates.

Sincerely,

Cory L. Richards
Vice President for Public Policy

The Need for and Cost of Mandating Private Insurance Coverage of Contraception

by Rachel Benson Gold

With the issue of contraceptive coverage rapidly gaining public attention and political momentum, a central question is whether a government mandate on private, employment-related insurance coverage would constitute good public policy. The question largely boils down to whether a mandate, in this instance, is necessary to achieve an important public interest and whether it is justified in light of its fiscal impact on employers and employees.

Industry representatives oppose mandates in general, charging that they are unnecessary and serve mostly to drive up the costs of insurance coverage. Women's health advocates, on the other hand, argue that, whether from benign neglect or outright discrimination, women traditionally have been disadvantaged in insurance coverage. They point to past examples where government mandates were necessary to secure coverage even of women's most basic health care needs and argue that similar action is required and appropriate now with regard to contraception.

Women and Insurance

As their most striking example of historic discrimination against women in insurance coverage, advocates cite maternity care—basic prenatal and delivery services—which, until the late 1970s, private insurance plans in the United States often did not cover. Indeed, it took enactment of a federal law—the Pregnancy Discrimination Act of 1978 (PDA), which mandates maternity coverage in most private-sector policies—to change the situation. And change the situation it did: Coverage for maternity care jumped from 57% of policies written in 1977 to 89% of policies just five years later.

While the PDA undeniably played a major role in ending de facto insurance discrimination against women, advocates argue that the job is not done. Even now, according to the Women's Research and Education Institute, women of childbearing age spend 68% more in out-of-pocket health care costs than do men of the same age. Contraception, advocates contend, is now in the same position maternity care was just 20 years ago—which is to say, it is basic health care for women that private insurance fails to adequately cover.

Gaps in Contraceptive Coverage

If a sexually active woman between ages 20 and 45 wants—as do most American women—two children, she will spend, on average, almost five years of her life trying to become pregnant, or being pregnant or postpartum, and more than *four times that long* trying to avoid pregnancy.

Overwhelmingly, American women use contraception to avoid unintended pregnancy. Among women aged 20–44 who have ever been sexually active, for instance, 85% have used oral contraceptives at some point in their lives. Among women with some form of private health insurance coverage who are at risk for unintended pregnancy, only 7% use no method of contraception.

Although American women clearly view contraception as basic to their lives, and their health care, health insurers in this country traditionally have not. While three-fourths of American women of childbearing age rely on private insurance, the extent to which they are covered for contraception can differ dramatically depending on their type of insurance.

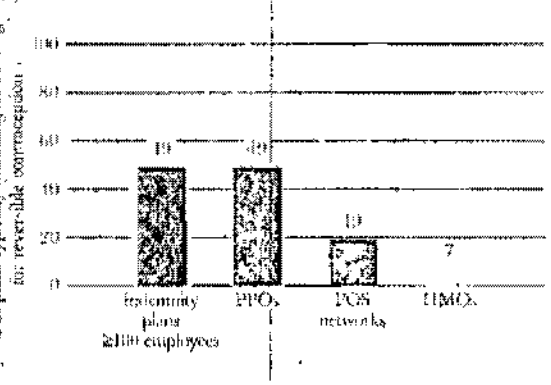
A Note from the Editor

After simmering slowly for a number of years, the effort to ensure comprehensive coverage of contraceptive services and supplies in private-sector, employment-related group health insurance plans has exploded. This year alone, nearly 20 states have addressed the issue—including Maryland, which enacted the first statewide coverage mandate this spring. For its part, Congress is on the verge of setting an important precedent for its own consideration of a federal mandate and, at the same time, an example for employers across the country: Last month, both houses passed bills requiring contraceptive coverage in the health insurance plans made available to federal employees (see For The Record, *page 12). With momentum building, the contraceptive coverage debate is crystallizing around three key questions: the need for and cost of a government mandate; the appropriate scope of any exemption to a mandate that would be granted on grounds of conscience; and the methods that should be included in a mandate, specifically in terms of what constitutes "contraception" and what constitutes "abortion."*

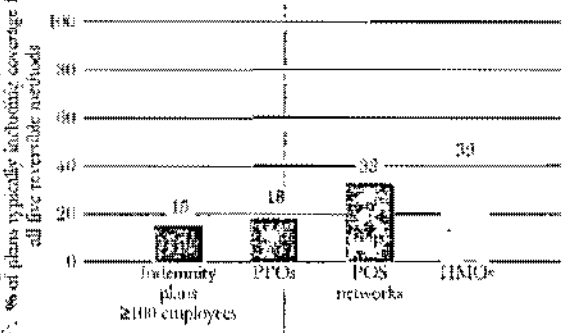
Beginning with this issue, The Guttmacher Report on Public Policy *will examine these questions in a special series of articles supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in these analyses are those of the authors and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation.*

Inadequate Coverage

Many plans cover no contraception at all



Few plans cover the five leading reversible methods*



*Oral contraceptives, IUD, Norplant®, Depo Provera®, diaphragm.

according to a 1994 study by The Alan Guttmacher Institute (AGI).

Traditional indemnity (fee-for-service) plans—which cover one in five privately insured Americans (18%), according to KPMG Peat Marwick—clearly provide the least comprehensive coverage for contraceptive services and supplies (see chart). Half of these policies typically cover none of the five leading reversible prescription contraceptive methods (IUD, diaphragm, hormonal implant [Norplant®], contraceptive injectable [Depo Provera®] and oral contraceptives), and only 15% cover all five methods. While 97% of indemnity plans cover prescription drugs in general, only 30% cover the costs of oral contraceptives, the most commonly used reversible contraceptive method in the United States.

Health maintenance organizations (HMOs), which cover one-third of the market (33%), provide the most comprehensive contraceptive coverage of any type of insurance plan: Some 39% cover all five leading methods, and only 7% cover no contraception at all.

Newer types of managed care plans—which serve half the U.S. market—provide less extensive coverage than do HMOs. Preferred provider organizations (PPOs)—which cover almost as many Americans as do HMOs (31% of the market)—are closer to traditional indemnity plans in their coverage patterns; coverage in point of service (POS) networks is somewhat more comprehensive.

In sharp contrast, almost nine in 10 plans, regardless of plan type, cover sterilization services. And, about two-thirds routinely cover abortion.

Why Coverage is Important

According to a recent poll commissioned by the Kaiser Family Foundation (KFF), three in four adult women say cost is an important factor when choosing between a method that is covered and one that is not. In the absence of comprehensive coverage, many women may "choose" a method covered by their plan rather than one that might be more appropriate to their medical or life circumstances. The impact could be significant. Some methods, like the IUD and the contraceptive implant, Norplant®, have up-front costs that can be prohibitive for women without significant discretionary income; at the same time, they are among the most effective of all methods.

Similarly, cost concerns may affect how well women are able to use their chosen method. Some women may delay refilling a prescription for oral contraceptives, for example, or put off obtaining a Depo Provera® injection because of cash-flow problems. And even a brief gap in method use can have a major impact. Notably, half of the unintended pregnancies in the United States are to women who are "using" contraception—but not always consistently or with maximum effectiveness.

Most dramatically, in the absence of insurance coverage some few women may forego contraceptive use entirely—and a sexually active woman not using contraception is many times more likely to become pregnant unintentionally than a woman who is. In any single year, 85 of 100 sexually active women not using a contraceptive method will become pregnant, in contrast to less than one-tenth that many of every 100 oral contraceptive users.

How Much Would It Cost?

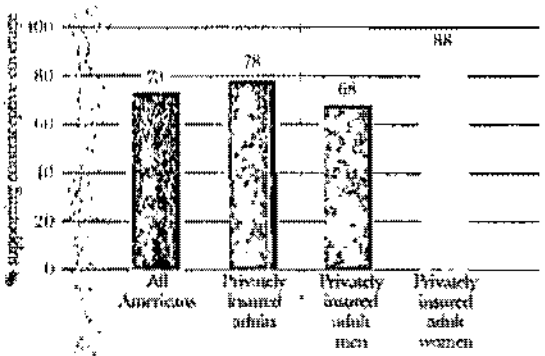
Central to any discussion of an insurance mandate is the question of its cost—specifically, whether the mandate will drive up the cost of insurance so much that coverage will become prohibitively expensive to some employers and their employees will suffer as a result.

New AGI estimates—based on the actual experience of plans that cover the cost of oral contraceptives (information obtained from pharmacy benefit managers administering plans covering over half the U.S. population) and on national data on use of other methods by privately insured women—show that the cost of covering the full range of FDA-approved reversible contraceptive methods is minimal. (The estimate does not include the costs of any associated medical services.)

Providing coverage for the full range of reversible contraceptive methods would result in a total cost of $21.40 per employee per year. Assuming standard cost-sharing between employers and employees, employers would pay $17.12, which translates into a monthly cost of $1.43 per employee. This would increase employers' overall insurance costs by only 0.6%. Employees would contribute $4.28 per year, or $0.36 per month.

Widespread Support

Americans overwhelmingly support contraceptive coverage, even if it would increase their insurance costs by $5 a month



Source: The Kaiser Family Foundation

As minimal as these costs are, they would only be borne in their entirety by a plan that does not now cover any of these reversible methods. The cost would be less for those plans that cover at least some of these methods, and there would be *no* added costs for the many plans that currently cover the full range of FDA-approved reversible contraceptive methods.

Support for Contraceptive Coverage

According to the recent KFF poll, America's public overwhelmingly supports mandating contraceptive insurance coverage (see chart). Eight in 10 privately insured adults (78%), support contraceptive coverage, even if it were to mean that their insurance costs would increase by as much as $5 a month—almost 14 times the actual cost to individuals of a contraceptive coverage mandate. Support for contraceptive coverage rises to 88% among privately insured women.

In addition, seven in 10 privately insured Americans (71%)—and eight in 10 insured women (79%)—believe that a mandate should require coverage of all FDA-approved contraceptive methods.

Industry Perspectives

As noted, the U.S. insurance industry opposes governmental mandates across-the-board on philosophical grounds. At the same time, it fights harder against some than others. The industry is now considering its options amid clear signs that the contraceptive coverage issue is resonating among the public and politicians alike—and that the costs of a mandate are minimal.

In that light, many observers found it significant that, even as Congress was moving last month to mandate contraceptive coverage for federal employees, the Health Insurance Association of America (HIAA) declined an invitation to present its position at a Senate hearing on the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). Authored by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV), EPICC would require coverage nationwide in private, employment-related plans. Instead, HIAA President Willis Gradison (himself a former Member of Congress) was quoted by *Washington Post* reporter and syndicated columnist David Broder as saying, "We oppose mandates, but we're not going to spend a dime fighting this."

Contraceptive Coverage: Toward Ensuring Access While Respecting Conscience

By Rachel Benson Gold

Recent high-profile confrontations over requiring coverage of contraceptive services in insurance plans have raised long-standing, thorny "conscience" issues, albeit in a new context. But whether the debate is over coverage for federal employees or coverage for all private-sector employees, the central questions remain the same: What individuals or entities should be entitled to claim a conscientious objection to contraceptive coverage on what grounds, and how can the deleterious impact of those objections on individuals needing and entitled to services be minimized?

Government as Employer

This fall, the federal government took the crucial step of guaranteeing contraceptive coverage for its own employees in the largest employer-sponsored insurance program in the world, the Federal Employees Health Benefits Program (FEHBP). Clearly, grappling with the question of conscience was key to allowing the proposal to become a reality for the nine million enrollees in the program (see *For the Record*, page 12.)

As ultimately played out in the FEHBP debate, the conscience issue had two distinct aspects—the first regarding *health plans* that sign contracts as corporate entities with the Office of Personnel Management (OPM), the federal agency administering the insurance program, and the second regarding individual health care providers operating within those plans.

The first issue was by far the more contentious. Opponents of contraceptive coverage argued for the widest possible conscience exemption—one that would allow *any* plan to decline to provide the coverage because of a "moral" objection to doing so. In order to guarantee access to the greatest number of enrollees, contraceptive coverage supporters pressed for the narrowest possible exemption—one that would permit only clearly *religious* plans to opt out of coverage. In the end, supporters prevailed; the final language allows an exemption only for plans that object to contraception "on the basis of religious beliefs."

As for individual health care providers operating within plans, the provision as enacted codifies the widely accepted standard that individual practitioners may decline to provide specific medical services if doing so would be contrary to their religious beliefs or "moral convictions."

Private Sector Challenges

As difficult as these questions were in the debate over the FEHBP, they become even more complex when the issue is not the federal government imposing a mandate on itself as an employer but, rather, federal or state policymakers imposing a mandate on private-sector coverage in general. Here, the balance between the perceived need to exempt some individuals and institutions from covering or providing contraceptive services on conscience grounds and the right of individual employees to obtain the coverage or care to which they are entitled is a tricky one. Given the specific players involved, it may be more or less difficult to achieve. Fortunately, there are sufficient models—in both public policy and private-sector action—to indicate that the problems are not unsolvable.

Models in both public policy and private-sector action indicate that the problems are not unsolvable.

When Providers Opt Out

The question of an individual health care provider declining to provide a specific service does not pose an overwhelming obstacle to a patient's care in traditional fee-for-service plans in which the choice of provider is essentially unrestricted. However, when the context is a managed care plan, in which enrollees are limited to a specified network of providers, allowing individual providers to opt out raises more difficult issues.

The extent to which this is problematic may be eased somewhat by the long-standing and well-recognized obligation of managed care plans to make covered services accessible to enrollees. As articulated most recently by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in its Patient Bill of Rights, this includes the obligation of the plan to ensure that adequate providers are available for all covered services: "All health plan networks should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without delay...If a health plan has an insufficient number or type of providers to provide a covered benefit with the appropriate degree of specialization, the plan should ensure that the consumer obtains the benefit outside the network at no greater cost than if the benefit were obtained from participating providers."

Indeed, this standard was reiterated by OPM in implementing the mandate for federal employees' coverage. OPM directed federal agencies to inform their employees that if an individual provider within a plan declines to provide contraception, they should contact the plan, which "will arrange for you to have access to a provider who will...."

When Employers Opt Out

The question of employers who may object to contraceptive coverage for their employees adds yet another dimension to an already complex situation. This question was moot in the FEHBP debate, where the employer—the federal government—clearly does not have a religious objection to contraception. In the general private sector, however, it is more difficult.

Here, as in the case with FEHBP plans, the goal should be crafting an exemption as narrowly as possible. This is because in the private sector, it is largely employers who choose

When a religious employer objects to contraceptive coverage, it does so for all its employees–many of whom may not share the employer's beliefs.

their employees' insurance plans. For example, when a large religious university—in its role as employer—claims a conscientious objection to contraception, it is making that choice for all of its employees, many of whom may have no affiliation whatsoever with the employer's religious beliefs.

The scope of an exemption for employers was very much at issue in the 12 states in which contraceptive coverage was seriously considered this year, including Maryland, where a measure was actually enacted, and California, where a measure passed by both houses of the legislature was vetoed by the governor. All told, most of the states considering legislation chose to limit the exemption to religious employers, either "qualified church-controlled organizations" as defined by the U.S. tax code or, more generally, employers for whom covering contraception would conflict with "bona fide" religious tenets.

Thus far, California is the only state whose legislature has taken specific action designed to prevent individual employees from being disadvantaged as a result of a conscientious objection being invoked by their employer. As passed, the California contraceptive coverage mandate made employees whose employers objected to contraceptive coverage eligible for state-funded coverage, as part of a larger state-funded family planning program.

The California measure required that the employees in such situations be notified that their employer is a religious organization that has elected not to provide contraceptive coverage in its plan, and that they may be eligible to obtain services through the special state-funded program. The legislation went so far as to require that these employees be given the toll-free phone number for the state's family planning program.

While the California bill ultimately fell victim to the governor's veto pen (see *For The Record*, page 12), it stands as an important model for attempts to strike a balance between maintaining the ability of employers to adhere to religious doctrine in opposition to contraception and protecting the right of employees and their dependents not to be hurt as a result of their employers choosing to do so.

When Plans Opt Out

Finally, in the general private sector, the question of allowing plans to claim an exemption raises the question of how a religious plan that objects to providing contraception can survive in a marketplace in which most employers are required to provide contraceptive coverage. In fact, numerous religious plans across the country have already been able to quietly craft their own solution in roughly analogous situations, allowing them to either participate in Medicaid programs that require coverage of contraception or compete in the private marketplace when contraceptive coverage is demanded by those seeking coverage. These solutions effectively keep the religious plan at sufficient arm's length from the actual provision of services to which they may object on religious grounds.

For example, a religious plan in the Southwest recently contracted with an outside agency to administer the family planning benefits for its Medicaid enrollees. (Under Medicaid, family planning is a mandated service to which enrollees are legally entitled.) The plan gives a portion of its Medicaid capitation payment to the outside agency, which in turn reimburses providers for the family planning services provided to enrollees. Individual providers within the plan sign independent contracts with this outside agency for family planning services only, and are reimbursed directly by it on a fee-for-service basis. Enrollees obtain care from their own plan providers, making the transition seamless from the enrollees' perspective.

In a letter to providers, the plan explained the balance it was seeking to strike, saying it "does not endorse these services nor are you required to provide them. However, these services must be available to our members."

Similarly, a Catholic-sponsored health plan in the Midwest has crafted an arrangement in a private-sector contract. Here, the plan sought to bid on a contract from a large corporation that required cov-

(Continued on page 14)

Contraceptive Coverage...
Continued from page 2

erage of a range of reproductive health care services in its policy. To allow it to secure the contract, the plan arranged for the premiums to go first to an intermediary, which divides the funds between the plan and a separate insurer that has agreed to cover the contraception, abortion and sterilization services that the religious plan will not. To obtain these services, enrollees go to the providers listed in the plan's provider directory, and the charges for these services are billed to the separate insurer.

Both of these models allow religious plans to participate in a market where coverage of contraceptive services is required while distancing themselves somewhat from the provision of those services.

Contraceptive coverage language considered this year in Connecticut included such a "black box" option. The measure—which passed the Senate but stalled in the House—would have allowed a religious plan "to provide coverage of contraceptive methods through another such entity offering a limited benefit plan; the cost, terms and availability of such coverage may not differ from that of other prescription coverage offered to the insured."

Both in the context of Medicaid and the private market, religious plans have found ways to provide access to contraceptives while remaining "at arm's length" from them.

In short, the contraceptive coverage issue highlights a number of fault lines at the intersection of religious beliefs and the provision of health care services. As Congress and state legislatures continue to consider private-sector contraceptive coverage mandates, however, they should be aware that for each of the difficult issues that have been raised, creative thinking has pointed the way to at least the beginnings of some tenable options.

This is the third in a special series of articles examining key policy questions raised by the effort to require coverage of contraceptive services and supplies in private-sector insurance plans. These analyses are supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in them are those of the author and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation.

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 non-medical 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

A woman should be able to use her insurance to choose a contraceptive method based on whether it is the most appropriate one for her—not whether the method happens to be covered by her plan.

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 extrusion 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 EPCCA, 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

(Continued on page 12)

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.*

What Methods...
Continued from page 2

a person within the meaning of the 14th Amendment to the Constitution; as for when life begins, it said that, given the lack of consensus "in the respective disciplines of medicine, philosophy and theology," the judiciary was "not in a position to speculate as to the answer.") Among the key issues raised frequently during the measure's slow progress through Senate committees was the deleterious impact of Congress taking such action on the use and availability of most contraceptive drugs and devices, which effectively would be redefined as abortifacients.

A similar debate echoed earlier this year during Senate deliberations over a proposed federal ban on human cloning technology (*TGR*, Vol.1, No.2, April 1998). What initially had been considered largely noncontroversial, fast-track legislation quickly became bogged down when it became clear that the bill, as written, would ban any and all research involving postfertilization, but preimplantation, preembryos. Again, concerns about whether Congress would be placing roadblocks before a wide range of cutting-edge medical research—including contraceptive and infertility research—figured heavily in the eventual decision to indefinitely postpone debate on the measure.

While hardly revolutionary, then, the Smith amendment—and its rejection by the House—is highly significant in that this is the first time antiabortion congressional activists have mounted a direct assault on garden-variety contraception. While Smith and his antiabortion allies would prefer to limit their public opposition to IUDs and ECPs, it is clear that, by their own logic, all moderrier contraceptive methods could be implicated as well. Accordingly, as the contraceptive coverage discussion continues, provisions such as the Smith amendment must be weighed exceedingly carefully for the impact they could have on the millions of American women currently trying to prevent unintended pregnancy and those who may wish to do so in the future.

This is the second in a special series of articles examining key policy questions raised by the effort to require coverage of contraceptive services and supplies in private-sector insurance plans. These analyses are supported in part by a grant from the Prospect Hill Foundation. The conclusions and opinions expressed in them are those of the author and The Alan Guttmacher Institute and do not necessarily represent the views of the foundation.

Health Care - Contraceptive Coverage

THE WHITE HOUSE

WASHINGTON

May 18, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Chris Jennings
Mary Beth Cahill
Jennie Luray

SUBJECT: Impending Introduction of Contraceptive Coverage Legislation

We expect a bipartisan group of Congressional members to introduce the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) this week. The legislation would require health plans to cover prescription contraceptive coverage if they cover other prescription drugs; it is generally consistent with the measure you signed into law last year mandating such coverage in all plans participating in the Federal Employees Health Benefits Plan (FEHBP). This memorandum provides background information on this issue and seeks guidance as to whether you want to endorse the bill when it is introduced.

BACKGROUND

Current Coverage Status. While well over 80 percent of private insurance plans cover prescription drugs in general, only about one-third cover the costs of oral contraceptives (the most commonly used birth control method). HMOs provide slightly better oral contraceptive coverage but only 39 percent cover all five leading methods. According to the Kaiser Family Foundation, three out of every four women say that cost is an important factor when choosing between a birth control method that is covered and one that is not. Moreover, women of childbearing age spend 68 percent more in out-of-pocket health care costs than men do, although there is no specific breakout as to what percentage is for contraception.

EPICC Legislation. EPICC was first introduced in the last Congress by Senators Reid and Snowe and Representatives Lowey and Greenwood. This legislation would require insurance plans to cover all FDA approved forms of contraception if and to the extent that they cover other prescription drugs. The bill also would require plans to provide outpatient contraceptive services (such as exams and fittings) in the same manner as they cover other outpatient medical services. Similar legislation has been introduced in 19 states in the last two years, and Maryland and Georgia recently became the first states to enact such laws.

When it became clear that this legislation could not be passed last year, EPICC's sponsors focused their attention on working on encouraging the Congress to extend these protections to FEHBP

plans. After a lengthy fight over "conscience clause" language, Congresswoman Lowey -- with the help of the Administration -- secured passage of the FEHBP provision in the Omnibus Appropriations measure you signed last fall. Leading women's groups and the pro-choice community hailed this as a major victory. The same group of supportive Members, along with supportive women's and pro-choice groups are now turning their attention to winning contraceptive coverage for those in all private plans.

Policy Arguments for EPICC. The women's and pro-choice communities believes that EPICC provides an all-too-rare opportunity to promote a positive agenda. Better contraceptive coverage means fewer unintended pregnancies, which means fewer abortions. For this reason, EPICC is now a top legislative priority for many of the leading women's and pro-choice organizations.

Endorsing this legislation would be consistent with your past position on FEHBP and would once again position us on a women's health issue that has strong policy rationale. It strengthens our hand on the pro-choice agenda and would be extremely well received by the women's advocacy community. Just as important, your endorsement would make a substantive contribution towards increasing the likelihood that this legislation would pass the Congress this year.

Mandates and Potential Impact on Cost/Coverage. We generally have avoided endorsing bills that impose insurance coverage requirements -- particularly when they are initially introduced. We have taken this position for two reasons: (1) to avoid the criticism that such "rifle shot" requirements increase premiums and thereby increase the number of uninsured and (2) to avoid starting down the slippery slope of supporting a slew of other insurance requirements.

As you know, you already support the Patients' Bill of Rights legislation, which although mostly requiring procedural rather than coverage requirements, is projected by CBO to increase premiums by about 4 percent). In addition, you have been asked to support legislation to impose further coverage requirements for mental health and substance abuse treatment and to assess a 1 percent premium fee on private plans to help finance the cost of training physicians in teaching hospitals and academic health centers. Although EPICC is projected to add only 1 percent to average private sector premiums, the accumulation of these policy initiatives could make us vulnerable the criticism that we are decreasing the affordability of insurance.

Conscience Clause Issue. One notable shortcoming of the current EPICC bill is that it does not include a "conscience clause" for plans that have religious objections to providing contraceptive coverage. Although the bill's sponsors and the pro-choice community recognize that this issue will have to be addressed before any bill reaches your desk, they oppose including any "conscience clause" language at the time of introduction. They are taking this position for two main reasons. First, they believe that the "conscience" problem is not as great in the context of contraception as in the context of abortion. Second, they believe that adding such language could leave too many women without access to contraceptives in light of Catholic-affiliated providers participating in the managed care market. The sponsoring members and groups would rather deal with this issue as and when it arises than introduce a bill that they believe already represents a significant compromise.

We believe that the advocates' position on this matter is mistaken, and that it is important to signal up-front an explicit commitment to accommodate plans with religious scruples. To omit it makes advocates vulnerable with respect to an issue that they will lose in the end. In addition, omitting conscience language makes the bill supporters vulnerable to a "double-standard" charge; they are willing to support such language when it applies to the Congress and federal health plans, but not when it applies to health plans in the private sector. The sponsoring members and groups, however, have rejected our advice on this issue.

OPTIONS

The following are the most viable options for your consideration:

(1) **Issue a statement of support for the new legislation, but do so in a manner that subtly signals your willingness to work on conscience clause language.** Under this scenario, you would release a statement at the time of introduction that notes your support for similar legislation last year and calls on the Congress to take further action, applying to private health plans, on this high priority issue. Such a statement would imply support for a conscience clause (since last year's bill had one), but would not offend the pro-choice community at the time of introduction.

(2) **Not endorse this legislation, but work behind the scenes to get legislation passed with an appropriate conscience clause.** Under this approach, you would take no formal position at the time of introduction, but advise the pro-choice community that we will provide technical and strategic support to pass this bill on Capitol Hill. Such an approach would allow you to avoid criticism relating to the cost of imposing insurance mandates and also would allow us to develop a workable conscience-clause compromise.

White House and Agency Positions on These Options. DPC, the Women's Office, the Office of Public Liaison, and OMB support option one. Although believing that the pro-choice community is making a significant error by not including a conscience clause provision in the bill at the time of introduction, these offices believe we should respond positively to the women's community on this key legislative priority and provide momentum to a bill guaranteeing equity for women at a low cost. In addition, these offices believe that the Administration should provide early support for this positive, proactive message on choice. HHS believes that this decision depends on whether you are likely to endorse other coverage mandates (like mental health parity) in the near future (like mental health parity); if you are, they would support option 2 because the cumulative impact of these endorsements will undermine our credibility on the cost/coverage issue.

Option 1: _____ Option 2: _____ Let's Discuss: _____