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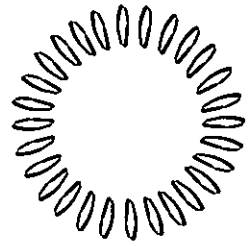
Women's Issues-Contraception [2]

Improving Access to Contraception  A Plan for Action

Nicole/Jen -
FYI
Elena

Dear Friend:

File: Women's Issues - Contraception

Are you tired of constantly defending your reproductive rights — never getting the opportunity to promote a forward-thinking agenda to improve women's health? Well times have changed! And we need your help.

The Center for Reproductive Law and Policy, the nation's only public interest legal organization committed solely to protecting women's reproductive rights and health, believes that universal access to safe, effective, and appropriate contraception is a cornerstone of a reproductive rights agenda for the next century. Like many other women's health care services, however, not all contraceptive options are available to all women.

In the United States, nearly half of large-group health plans do not routinely cover any contraceptive method. Of the 97 percent that cover prescription drugs and devices, only 33 percent cover oral contraceptives. Government workers and members of the military are also not given comprehensive coverage for contraception. Many women who are uninsured or underinsured must turn to family planning clinics that face ever-shrinking funding. For low-income women who rely on Medicaid, one of the most comprehensive federal health programs, the guarantee of access to family planning services is being undermined by lack of adequate information and the transition to managed care. At a time when women around the world, especially in Southern nations, have few contraceptive options and little access to other reproductive health care services, relentless pressure from anti-choice forces has dramatically curtailed funding for international population assistance.

Access to safe, effective, and appropriate contraception remains an urgent — but generally unrecognized — public health need.

CRLP believes that now is the time to address this problem. And we have developed a simple, six-step plan to improve access to contraception. These recommendations range from ensuring that contraceptives are included in private insurance to the extension of coverage for contraception in federal and state health programs to increasing public funding for family planning efforts.

We recognize that attacks on reproductive rights and health, particularly on the right to choose abortion, will persist. And we will continue to counter them aggressively. But we cannot wait for those assaults to end before turning to the critical task of providing women with the ability to choose from the full range of reproductive health services. Improving access to contraception will be a significant step toward that goal. We hope we can count on you to be a part of this effort.

Very Truly Yours,

Janet Benshoof
President

Janet Crepps
Staff Attorney
State Program

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Contraception
An Urgent Public Health Need

When it upheld a woman's right to choose abortion in *Planned Parenthood v. Casey*, the U.S. Supreme Court recognized that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[1] Unwanted or mistimed childbearing can curtail a woman's educational and work opportunities, constrict her social role, and exclude her from full participation in the "marketplace and the world of ideas."[2] Unintended pregnancies, which result in part from lack of access to contraceptive care, also exact tragic tolls on the health and well-being of women and their families and place a burden on society as a whole. For these reasons, access to appropriate and affordable contraception plays an indispensable role in promoting women's health and advancing women's equality.

Like many women's health care services, however, not all contraceptive drugs, devices, and medical services are available to all women. Each year, an estimated 31 million women are at risk for unintended pregnancy.[3] Those who rely on private insurance may find that their health benefit plans do not include prescription contraceptive drugs, devices, or related medical services, or that the coverage they do receive is limited. Government employees at the federal, state, and local levels, and their dependents, face similar restrictions on coverage for birth control. Members of the uniformed services and their families are also denied the full range of contraceptive care. Women who are uninsured or underinsured, and those who otherwise have difficulty paying for medical care, often rely on family planning clinic providers that cannot meet the growing demand for their services — a direct result of shrinking public funding.

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Unintended pregnancy exacts tragic tolls on the well-being of women and their families

Lack of access to comprehensive contraceptive services and supplies is reflected in our nation's unacceptably high rates of unintended pregnancy, relatively low usage of family planning services, and ineffective use of contraception.

Compared with other industrialized countries, the United States experiences significantly greater numbers of unintended pregnancy.[4] Currently, about 60 percent of the 6.3 million pregnancies that occur annually in this country are unintended.[5] In 1988, 25 million women of childbearing age were not actively seeking to have children. Of those, just over 15 percent (four million women) were not using any contraception. This group accounted for 1.7 million unintended pregnancies, more than half of the 3.2 million unintended pregnancies reported that year.[6] Nearly 1.5 million unintended pregnancies occurred among the roughly 85 percent (21 million women) who indicated that they were using reversible contraceptive methods.[7] Each year, a little more than half of all unintended pregnancies result in abortion.[8]

The United States has alarming infant mortality and low-birthweight rates, both of which are associated with unintended conception.[9] In 1992, the infant mortality rate was 8.5 deaths per every 1,000 births; the rate of low-birthweight babies was 7.1 for every 100 births.[10] Women who carry unintended pregnancies to term are less likely than other women to receive adequate prenatal care, resulting in greater risks to their health and poorer birth outcomes.[11]

According to the National Commission to Prevent Infant Mortality, "[i]f all pregnancies were planned, infant mortality could be reduced by an estimated 10 percent."[12] An effort to increase access to contraceptive services may also lead to a reduction in low-birthweight babies. One study concluded that each additional state dollar spent on family planning was associated with a .049 percentage reduction in low-birthweight infants.[13] Another study estimates that elimination of unplanned pregnancies would reduce the number of babies with low birthweights by 12 percent.[14]

FDA-Approved Contraceptives and Related Medical Services

A good health benefit plan will cover the full range of government-approved prescription contraceptive drugs, devices, and related medical services. Prescription birth control methods currently approved by the Food and Drug Administration are:

Oral contraceptives (daily and emergency)

Injectible contraception (Depo Provera)

Contraceptive implants (Norplant)

Diaphragms

Intrauterine devices (IUDs)

Cervical caps

The FDA has also approved over-the-counter non-prescription methods, such as condoms and spermicides, which are not eligible for insurance coverage.

Lack of access to appropriate contraceptive care harms women's health

Access to the full range of contraceptive care is essential to women's health because it ensures that they are able to choose methods that are the most appropriate for their health and lifestyles. Indeed, as the Institute of Medicine of the National Academy of Sciences noted in a recent report:

> [T]here is the virtually undisputed reality that no existing contraceptive method can meet the requirements, intentions, and preferences of all individuals in all circumstances over entire reproductive lifetimes. Nor can any method be totally without side effects, risks, or trade-offs in terms of safety, efficacy, convenience, usability, and appropriateness. . . .[15]

Women with medical conditions that require the avoidance of pregnancy or that preclude the use of one or more contraceptive methods have a particularly urgent need for increased availability of comprehensive contraceptive care. Yet the significant financial burdens associated with contraceptive services and some forms of birth control may steer women away from the most appropriate and effective family planning options. In 1993, for example, the total cost of Norplant insertion was approximately $700, the total cost of an IUD insertion was approximately $400, and a year's supply of oral contraceptives and the associated physical exam cost approximately $300.[16]

Thanks in large part to efforts to educate the public on the prevention of HIV, it is well known that some forms of contraception can prevent sexually transmitted infections (STIs). But it may be less commonly recognized that the availability of contraceptive services also provides a route toward education, screening, and treatment related to STIs. Detection of STIs is essential to stemming the epidemic of such infections, which affect nearly 12 million women and men in this country annually.[17] Early treatment can reduce the chance that a woman will experience pelvic inflammatory disease or an ectopic pregnancy.[18]

Women and their families suffer economically and socially from lack of access to affordable contraception

On average, women of childbearing age (15 to 44) pay more for their health care than their male counterparts. According to one study, these women spend 68 percent more in out-of-pocket medical costs.[19] In addition, women make up 69 percent of those in this age category who are forced to spend 10 percent or more of their income on out-of-pocket health expenses, a figure that includes almost five million women who are privately insured.[20]

Women and their families also face economic and social disadvantages when a lack of access to contraception results in unintended pregnancy. The unplanned addition of a child to a family may stretch already limited resources, particularly for single mothers, who are more likely to have lower incomes than two-parent families. The same is true for adolescents, who experience unintended pregnancy and resulting births at a greater rate than other groups of women. Studies indicate that there is a strong association between a young age at first birth and both poverty and the receipt of public assistance.[21] In addition, studies indicate that teenagers who become mothers are more likely to drop out of high school, leaving them less able to compete in the job market.[22]

Failure to ensure access to comprehensive contraceptive care is expensive

According to one estimate, a sexually active woman who does not use contraception over the course of five years will experience 4.25 unintended pregnancies, costing upwards of $14,500 for a private insurer and nearly $6,500 for public health systems.[23] These expenses are significantly greater than the costs associated with any form of contraception.[24] At the same time, early detection and treatment of STIs can reduce serious and potentially costly health problems associated with these diseases, such as pelvic inflammatory disease, infertility, premature delivery, and infection in the newborn.[25]

Public expenditures for contraceptive services have also proven cost-effective. One study recently concluded that every tax dollar spent on contraceptive care saves an average of three dollars in Medicaid funds alone that would have been spent providing care to pregnant women and newborns.[26] In 1987, had there been no public-sector expenditures for contraceptive services, expenses associated with unintended births and pregnancy terminations would have cost federal and state governments an additional $1.2 billion in Medicaid funds.[27]

Private insurance plans unfairly exclude contraceptive coverage

A recent study on private insurance found that 49 percent of large-group plans do not routinely cover any contraceptive method.[28] In fact, oral contraceptives, the reversible birth control method used by the greatest number of women in the United States, are routinely covered by only 33 percent of large-group plans. Yet 97 percent of those plans generally provide prescription coverage for other drugs. Similarly, 92 percent of typical large-group plans routinely cover medical devices, but only 15 percent include coverage for diaphragms, 18 percent cover IUDs and 24 percent cover Norplant.[29] Coverage for all of the five most-used reversible contraceptive methods — oral contraceptives, fittings for diaphragms, injection of Depo Provera, and insertion of an IUD or Norplant — is provided by as few as 15 percent of typical large-group health plans.[30]

In addition to denying women the ability to choose the contraceptive option that is the best for their health and life circumstances, the failure to cover the complete range of contraceptive care is discrimination.[31] By excluding medically appropriate drugs and devices needed exclusively by women, insurance plans are unfairly basing their coverage on the medical needs of men. This denial of contraceptive care by insurance plans also perpetuates the historic assumption that women are solely responsible for meeting their reproductive health care needs,[32] including the prevention of pregnancy.

Government insurance programs deny the full range of contraceptive care

At the federal level, government employees are eligible to receive health insurance under the Federal Employees Health Benefits Act ("FEHBA").[33] Federal employees can choose from among any of the plans offered to them. However, because the federal government contracts with private insurance companies to provide health coverage under FEHBA, some government workers and their dependents face the same shortcomings in coverage for contraceptive care as individuals who are insured by their private employers or purchase coverage on their own.

Members of the uniformed services and their dependents who are not covered under FEHBA are eligible to receive health insurance through the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"),[34] which provides only limited coverage for contraceptives. Regulations governing CHAMPUS specifically cover some, but not all, family planning services. For example, Norplant insertion and removal, cervical caps, and Depo Provera are not included,[35] even though they are FDA-approved contraceptives.

Similarly, many state and municipal employee health benefit plans may fail to cover the full range of contraception. In many states, plan administrators select the offered benefits and do not always provide comprehensive contraceptive care. For some state and municipal employees, benefits are determined by statutes or regulations or through collective bargaining agreements, all of which may limit or exclude contraception.

Public funding for family planning services is insufficient to meet the needs of low-income women and the uninsured

It is estimated that almost one out of every four of the 21 million women in the United States who use some form of reversible birth control rely on public funds for their contraceptive care.[36]

Direct federal support for subsidized contraceptive services and supplies is available through two major sources: Title X of the Public Health Services Act[37] and the Medicaid program.[38] State governments also provide substantial financial support to family planning programs.[39] According to one study, an estimated 1.3 million women a year are able to avoid unintended pregnancies thanks to publicly funded family planning

services.[40] If not prevented, 533,800 of these would result in unintended births and 632,300 would be terminated by abortion.[41]

Despite the proven health benefits and cost-effectiveness of these programs, they have been repeatedly targeted for cuts – and even elimination – by legislators and the executive branch at the federal and state levels. When inflation is taken into account, overall spending by federal and state governments to provide contraceptive care fell by 27 percent between 1980 and 1994.[42]

Appropriations for Title X, the only federal program whose sole goal is to fund family planning services, suffered a particularly significant reduction during this period — a decline of 65 percent in constant dollars.[43] Due to this decrease, Title X-supported clinics cannot provide services to the degree that they have in the past. In order to cover their costs, these facilities may cut back on the number of patients they serve, eliminate some services, or require fees.[44]

A call to action

Access to affordable and appropriate contraceptive options is a cornerstone of women's health, equality, and reproductive rights. Yet many women continue to be left without the ability to choose from the full range of contraceptive drugs, devices, and medical services. Private health care plans exclude contraceptive coverage, government insurance programs deny comprehensive contraceptive care, and public funding for family planning services is insufficient to meet the needs of low-income women and the uninsured.

As a result, the health and well-being of women and families in this country continue to suffer due to preventable unintended pregnancies, poor birth outcomes, decreased educational and work opportunities, and inconsistent or inappropriate medical care. We can and must act now to address the failure of our health care system to provide for women's most basic medical needs.

Six Steps You Can Take to Improve Access to Contraception

1. Let your members of Congress know that you support federal legislation that would require private insurance plans to cover the full range of FDA-approved contraceptives and related medical services.

The 105th Congress is expected to consider legislation that would ensure that contraception is covered by private insurance plans in the same manner as other non-contraceptive health care services. A copy of the legislation and a sample letter of support are available from CRLP.

2. Work with the governor, legislators, and agency administrators in your state to ensure that private insurance plans cover the full range of FDA-approved contraceptives and related medical services.

Passage of new state laws or regulations will benefit women and their families in your state. It also demonstrates to Congress that there is widespread support for comprehensive contraceptive coverage in private health insurance plans. CRLP has developed model state legislation and can assist you in modifying the proposals to meet the particular circumstances of your state.

3. Work to ensure that insurance coverage being offered to those enrolled in a federal health benefit program (such as FEHBA or CHAMPUS) and state and municipal employee benefits plans include the full range of FDA-approved contraceptives and related medical services.

Changes in insurance coverage for government employees and members of the military will benefit large numbers of women and their families. It can also serve to spur private insurers to change the standard benefit package offered to private employees and self-insured individuals. Extension of coverage for contraceptive care may be accomplished through any of several means, based on the structure of the benefits plan.

For federal employees, plan administrators must be urged to contract with private insurers that provide comprehensive coverage. For members of the military covered by CHAMPUS, the regulations governing the program will need to be changed. Effective advocacy for state and municipal employees will require a determination of whether their coverage is dictated by the scope of private insurance, statutes or regulations, or collective bargaining agreements. Sample letters available from CRLP specifically address some of these health plans; they can be adapted as appropriate to particular circumstances.

4. Become your own advocate. Find out whether your own health insurance plan provides coverage for the full range of contraceptive care and adequately protects your confidentiality.

CRLP's survey, "Twenty Questions to Ask About Your Contraceptive Care," can help you be "insurance smart." If you discover that your own policy fails to measure up, take action to make a change. If you are covered by private insurance through your employer, urge the plan's administrators to revise your policy. If you purchase your own insurance, contact your health benefit provider directly. If you are a government employee or member of the military, take the relevant steps outlined in item 3. Members of unions should also make sure that union officials add contraceptive coverage to their list of topics for negotiation. Sample letters to employers and insurance companies are also available from CRLP.

5. Urge large employers, health insurers, and health plans in your area to include in their policies the full range of FDA-approved contraceptives and related medical services.

Start by asking all the organizations within your statewide coalition of pro-choice organizations or other groups working for social change to revise their own health benefit packages. Then identify large employers in your state or city — such as universities, Fortune 500 companies, and health care institutions — that may be willing to modify their own employee health plans.

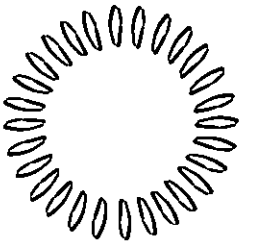
Meet with key management to seek the change. The larger the company, the more likely it is that it self-insures or has enough clout to demand a modification of its health plan. Similarly, urge management at health insurance companies or managed care plans to amend their policies and use the change as a marketing tool to attract new business. Every time another company provides full coverage for contraceptive care, reward them with publicity. Keep CRLP informed of your organizing efforts so that we can share your success with others.

6. Let your members of Congress know that you support increased funding for Title X, which provides millions of women throughout the United States with free or reduced cost family planning services, and for international family planning programs.

Sample letters are available from CRLP.

Endnotes

1. *Planned Parenthood v Casey*, 505 U.S. 833, 856 (1992).
2. *Stanton v Stanton*, 421 U.S. 7, 14-15 (1975).
3. Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 28 (Sarah S. Brown and Leon Eisenberg, eds., National Academy Press 1995) (hereinafter referred to as *The Best Intentions*).
4. Elise F. Jones et al., *Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries*, 20:2 Fam. Plan. Persp. 53, 54-55 (March/April 1988).
5. Committee on Contraceptive Research and Development, Institute of Medicine, National Academy of Sciences, *Contraceptive Research and Development: Looking to the Future* S-3 (Polly F. Harrison and Alan Rosenfield, eds., National Academy Press 1996) (hereinafter referred to as *Contraceptive Research and Development*).
6. *The Best Intentions*, at 92 (citing W.D. Mosher, *Contraceptive Practice in the U.S., 1982-1988*, 22:5 Fam. Plan. Persp. 198 (Sept./Oct. 1990).
7. *Id.* at 99.
8. Jacqueline D. Forrest, *Epidemiology of Unintended Pregnancy and Contraceptive Use*, 170 Am. J. Obstet. Gynec. 1485-88 (1994).
9. *The Best Intentions*, at 70-72.
10. Children's Defense Fund, *The State of America's Children Yearbook* 28 (1995).
11. *The Best Intentions*, at 66-72.
12. The National Commission to Prevent Infant Mortality, *Troubling Trends: The Health of America's Next Generation* 38 (Feb. 1990) (hereinafter referred to as *Troubling Trends*).
13. Kenneth J. Meier & Deborah R. McFarlane, *State Family Planning and Abortion Expenditures: Their Effect on Public Health*, 84:9 Am. J. of Pub. Health 1468, 1470 (Sept. 1994).
14. *Troubling Trends*, at 38.
15. *Contraceptive Research and Development*, at 1-2 (citation omitted).
16. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85:4 Am. J. of Pub. Health 494, 495-96 (April 1995) (hereinafter referred to as *The Economic Value of Contraception*).
17. David J. Landry & Jacqueline D. Forrest, *Public Health Departments Providing Sexually Transmitted Disease Services*, 28:6 Fam. Plan. Persp. 261 (Nov./Dec. 1996).
18. *See, e.g*, Susan D. Hillis et al., *The Impact of a Comprehensive Chlamydia Prevention Program in Wisconsin*, 27:3 Fam. Plan. Persp. 108 (May/June 1995).
19. Women's Research and Education Institute, *Women's Health Insurance Costs and Experiences* 2 (1994).
20. *Id.*
21. For example, approximately half of the adolescents who give birth before the age of eighteen receive welfare within five years of giving birth. *The Best Intentions*, at 56-58.
22. *Id.* at 55.
23. *The Economic Value of Contraception*, at 497.
24. *Id.* at 499.
25. The Alan Guttmacher Institute, *Issues in Brief: Sexually Transmitted Diseases in the U.S.: Risks, Consequences and Costs* 4 (April 1994); *The Best Intentions*, at 120.
26. Jacqueline D. Forrest & Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, 28:5 Fam. Plan. Persp. 188, 193 (Sept./Oct. 1996) (hereinafter referred to as *Impact of Publicly Funded Contraceptive Services*).
27. *Id.*
28. The Alan Guttmacher Institute, *Uneven and Unequal, Insurance Coverage and Reproductive Health Services* 12 (1995). This study indicates that "conventional indemnity plans" are the largest source of insurance coverage, affecting 58 percent of "insured employees" compared to the 20 percent covered by "preferred provider organizations," 19 percent by "health maintenance organizations," and 3 percent enrolled in "point-of-service networks." *Id.* at 5.
29. *Id.* at 17.
30. *Id.* at 12.
31. Excluding insurance coverage for medically appropriate prescriptions and devices needed exclusively by women while covering all medically appropriate prescriptions and devices needed by men is an impermissible gender-based classification. Although the U.S. Supreme Court has permitted pregnancy/gender-based classifications that purportedly equalize the sexes, *see e.g., Geduldig v Aiello*, 417 U.S. 484 (1974), and *Michael M. v Superior Court of Sonoma County*, 450 U.S. 464 (1981), it has never sanctioned the imposition of burdens on women alone because of their unique procreative abilities. *See, e.g, International Union, UAW v Johnson Controls*, 499 U.S. 187 (1991).
32. *See, e.g, Newport News Shipbuilding and Dry Dock Co v E.E.O.C.*, 462 U.S. 669 (1983) (health insurance plan that provided less extensive pregnancy benefits for spouses of male employees than for female employees unlawfully discriminated on the basis of sex and thus was an unlawful employment practice under Title VII); *E.E.O.C. v. South Dakota Wheat Growers Ass'n.*, 683 F. Supp. 1302 (D.S.D. 1988) (exclusion of pregnancy-related costs from conversion health benefit plan constituted unlawful sex discrimination under Title VII).
33. 5 U.S.C. §§ 8901, *et seq.* The Office of Personnel Management ("OPM") reviews applications and enters into annual federal procurement contracts with commercial insurance carriers and other organizations that wish to sponsor health plans for federal employees. OPM has final authority over all benefits, exclusions, and limitations in FEHBA plans and is authorized to contract for such benefits, limitations, and exclusion as it "considers necessary or desirable." *Id.* § 8902(d).
34. 10 U.S.C. §§ 1071, *et seq.*
35. *See* 32 C.F.R. §1994(e)(3).
36. *Impact of Publicly Funded Contraceptive Services*, at 189.
37. 42 U.S.C. §§ 300, *et seq.*
38. 42 U.S.C. §§ 1396, *et seq.*
39. Terry Solom, et al., *Public Funding for Contraceptive, Sterilization And Abortion Services, 1994*, 28:4 Fam. Plan. Persp. 166, 167 (July/Aug. 1996) (hereinafter referred to as *Public Funding*).
40. *Impact of Publicly Funded Contraceptive Services*, at 192-93.
41. *Id.* at 193.
42. *Public Funding*, at 170.
43. *Id.*
44. The Alan Guttmacher Institute, *Issues in Brief: Title X and the U.S. Family Planning Effort* 6 (Feb. 1997).



The Facts About Contraceptive Coverage in Private and Government Insurance

Private insurance plans unfairly exclude contraceptive coverage

Forty-nine percent of large-group insurance plans do not routinely cover any contraceptive method.[1]

Although 97 percent of large-group plans provide prescription drug coverage, only 33 percent cover oral contraceptives.[2] Two-thirds of the plans covering prescription drugs fail to cover oral contraceptives.

Ninety-two percent of typical large-group insurance plans routinely cover medical devices in general, but only 15 percent include coverage for diaphragms, 18 percent cover IUDs, and 24 percent cover Norplant.[3]

Federal employees are not guaranteed comprehensive coverage

At the federal level, non-military employees are eligible to receive health insurance under the Federal Employees Health Benefits Act ("FEHBA"),[4] the single largest insurance program in the country.

Because the federal government contracts with private insurance companies, some of the health plans offered to federal workers and their dependents do not include coverage for all FDA-approved prescription contraceptive drugs and devices or medical services related to contraception.

State and municipal employees may not have coverage for the full range of contraception

In many states, plan administrators select the benefits offered to government workers and do not always provide comprehensive contraceptive care. For some state and municipal employees, benefits are determined by statutes or regulations or though collective bargaining agreements, all of which may limit or exclude contraception.

Members of the military are denied certain contraceptives

Members of the uniformed services and their dependents, including those stationed at overseas military bases, are eligible to receive health insurance through the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS").[5]

Regulations governing CHAMPUS do not cover all FDA-approved prescription contraceptive drugs and devices or medical services related to contraception. For example, Norplant insertion and removal, cervical caps,

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and Depo Provera are not covered,[6] even though these are FDA-approved contraceptives.

Women pay more, get less

On average, women of childbearing age pay more for their health care than their male counterparts. Women between the ages of 15 and 44 pay 68 percent more in out-of-pocket medical costs, with reproductive health services accounting for much of that difference.[7]

Women make up 69 percent of those in this age category who are forced to spend 10 percent or more of their income on out-of-pocket expenses, a figure that includes almost five million women who are privately insured.[8]

In 1993, the total cost of Norplant insertion was about $700, the total cost of an IUD insertion was approximately $400, and a year's supply of oral contraceptives and the associated physical exam cost approximately $300.[9]

Endnotes

1. The Alan Guttmacher Institute, *Uneven & Unequal, Insurance Coverage and Reproductive Health Services* 12 (1995). This study indicates that "conventional indemnity plans" are the largest source of insurance coverage, affecting 58 percent of "insured employees" compared to the 20 percent covered by "preferred provider organizations," 19 percent by "health maintenance organizations," and 3 percent enrolled in "point-of-service networks." Id. at 5.
2. *Id.* at 17.
3. *Id.*
4. 5 U.S.C. §§ 8901, *et seq.*
5. 10 U.S.C. §§ 1071, *et seq.*
6. See 32 C.F.R. § 199.4 (e)(3).
7. Women's Research and Education Institute, *Women's Health Insurance Costs and Experiences* 2 (1994).
8. *Id.* at 2.
9. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85:4 Am. J. of Pub. Health 494, 495-96 (April 1995).

The Facts About Public Funding of Family Planning

Increasing access to contraception is good medicine and good public policy

Public funding to increase access to contraception, including sterilization and FDA-approved prescription contraceptive drugs and devices,[1] helps:

- prevent many unintended pregnancies;
- provide an avenue for prevention, detection, and treatment of sexually transmitted infections,[2] and
- reduce rates of infant mortality and low-birth weight infants.[3]

Each year, approximately 60 percent of the 6.3 million pregnancies that occur in the United States (roughly 3.5 million pregnancies) are unintended.[4] A little more than half of all unintended pregnancies results in abortion.[5]

Nearly 12 million women and men in this country are affected by sexually transmitted infections (STIs) annually.[6] Detection and early treatment of STIs are essential to stemming the epidemic of such infections and reducing related medical complications.

The United States has alarmingly high infant mortality and low-birthweight rates,[7] both of which are associated with unintended pregnancy.[8]

The rate of "infant mortality could be reduced by an estimated 10 percent" if "all pregnancies were planned."[9] Elimination of unplanned pregnancy could also reduce the number of low-birthweight infants by 12 percent.[10]

Public funding for contraceptive care is cost-effective

A 1996 study concluded that every tax dollar spent for contraceptive services saves an average of $3.00 in Medicaid funds alone that would have been spent providing care to pregnant women and newborns.[11]

In 1987, had there been no public-sector expenditures for contraceptive services, expenses associated with unintended births and abortions would have cost the federal and state governments an additional $1.2 billion in Medicaid funds.[12]

Public funding for family planning services is insufficient to meet the needs of low-income women and the uninsured

Almost one in four of the 21 million women in the United States who use some form of reversible contraception rely on public funds for their contraceptive care.[13]

Each year, publicly funded family planning helps 1.3 million women avoid unintended pregnancy.[14] If not prevented, 533,800 of these pregnancies would result in unintended births and 632,300 would be terminated by abortion.[15]

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Endnotes

1. The following are FDA-approved prescription contraceptive drugs and devices: all regimes of oral contraceptives, injectable contraceptives, contraceptive implants, IUDs, diaphragms, and cervical caps.
2. David J. Landry & Jacqueline D. Forrest, *Public Health Departments Providing Sexually Transmitted Disease Services,* 28:6 Fam. Plan. Perp. 261 (Nov./Dec. 1996) (hereinafter referred to as *Public Health Departments*).
3. Kenneth J. Meier & Deborah R. McFarlane, *State Family Planning and Abortion Expenditures: Their Effect on Public Health,* 84:9 Am. J. of Pub. Health 1468, 1470 (Sept. 1994); National Commission to Prevent Infant Mortality, *Troubling Trends: The Health of America's Next Generation* 38 (1990)(hereinafter referred to as *Troubling Trends*).
4. Committee on Contraceptive Research and Development, Institute of Medicine, National Academy of Sciences, *Contraceptive Research and Development: Looking to the Future* S-3 (Polly F. Harrison & Allan Rosenfield, eds., National Academy Press 1996).
5. Jacqueline D. Forrest, *Epidemiology of Unintended Pregnancy and Contraceptive Use,* 170 Am. J. Obstet. Gynec. 1485-1488 (1994).
6. *Public Health Departments,* at 261.
7. Children's Defense Fund, *The State of America's Children Yearbook* 28 (1995).
8. Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 70-72 (Sarah S. Brown & Leon Eisenberg eds., National Academy Press 1995).
9. *Troubling Trends,* at 38.
10. *Id.*
11. Jacqueline D. Forrest & Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures,* 28:5 Fam. Plan. Persp. 188, 193 (Sept./Oct. 1996) (hereinafter referred to as *Impact of Publicly Funded Contraceptive Services).*
12. *Id.*
13. *Id.* at 189. Direct federal support for subsidized contraceptive services and supplies is available through two major sources, Title X of the Public Health Services Act and Medicaid. *See* 42 U.S.C. §§ 300 *et seq.*, 42 U.S.C. §§ 1396 *et seq.*
14. *Impact of Publicly Funded Contraceptive Services,* at 193.
15. *Id.* at 193.

The Facts About U.S. Funding for International Family Planning

Funding for international family planning benefits families

U.S. funding for international family planning programs enables women and men to exercise a basic human right: the right to choose the number and spacing of their children.

For over 30 years, the U.S. has been essential to international family planning efforts, providing services to families in 60 countries.[1]

When women lack reproductive health services, children and their mothers die:

- Seven million infants die annually because their mothers were not physiologically ready for childbirth or lacked obstetric care.[2] One in five infant deaths could be averted by birthspacing alone.[3]
- Approximately 585,000 women die each year from causes related to pregnancy and childbirth, rendering at least one million children motherless each year. An additional 18 million women suffer from serious maternity-related disabilities.[4]

Funding for international family planning is good health policy

The U.S. population assistance program supports:

- maternal and child health;
- breastfeeding initiatives;
- the provision of basic health information and services for youth;
- the prevention of sexually transmitted infections, including HIV/AIDS;
- the reduction of female genital mutilation;
- improvement of women's status; and
- environmental health.[5]

Modern contraceptive use in low-income countries has risen from under 10 percent in the 1960s to 35 percent today, helping to reduce high-risk pregnancies and abortions and saving the lives of hundreds of thousands of women.[6]

In countries as diverse as the Central Asian Republic, Colombia, Mexico, and Russia, studies have documented that increased contraceptive use reduces abortions.[7] According to the World Health Organization, 50 million women have abortions each year, half of them illegal. Seventy-five thousand women die annually from self-induced or unsafe abortions.[8]

Funding for international family planning is sound foreign policy

International family planning programs promote the health and well-being of families, which is related to a number of essential foreign policy goals, including:

- worldwide recognition of basic human rights, including the right to achieve the highest standard of health; and

The Center for Reproductive Law and Policy 120 Wall Street New York, New York 10005 212/514-5534 *fax* 212/514-5538

- the ability of countries to improve their citizens' standard of living.[9]

Seventy-two percent of Americans believe the U.S. should help make family planning services available to those in low-income countries who want them.[10]

There is a great unmet need for international family planning services

One hundred million couples worldwide still have unmet family planning needs.[11]

One in six women in low-income countries lack access to effective contraceptive methods and services.[12]

By law, U.S. funds support family planning services, not abortion

The Foreign Assistance Act ("FAA") bars the use of U.S. funds to provide abortions or to motivate any person to have an abortion.[13] The FAA permits the U.S. to provide assistance only for "voluntary family planning" and also prohibits the use of U.S. funds for the performance of involuntary sterilizations.[14]

Prior to his retirement in 1996, Senator Mark Hatfield, a staunch abortion opponent, thoroughly reviewed materials claiming that international family planning funds were being spent on abortion. Senator Hatfield found nothing to support this assertion and additionally noted that the U.S. Agency for International Development ("AID") has a rigorous process, enforced by outside monitors, to carry out the existing abortion ban.[15]

Restrictive family planning funding policies are inefficient and counterproductive

In 1996, Congress cut funds for population assistance by 35 percent and imposed complex spending restrictions that effectively reduced funding by 87 percent, from $583 million to just $72 million in that year.[16]

A consortium of expert organizations examined the impact of the 35 percent funding cut alone and concluded that 7 million couples in low-income countries would lose access to modern contraceptive methods, resulting in 4 million unintended pregnancies. This, in turn, would lead to 1.9 million unplanned births; 1.6 million more abortions; 8,000 more pregnancy-related maternal deaths, including those resulting from unsafe abortion; and 134,000 more infant deaths.[17]

"Mexico City Policy":

- In effect from 1984 through 1992, the Mexico City Policy prohibited overseas organizations from receiving U.S. family planning aid if, *with their own funds and in accordance with the laws of their own countries, they provided any* abortion-related information or services.
- While in effect, this international "gag rule" disrupted the delivery of family planning services by denying funding to some of the most experienced and qualified family planning and maternal-child health care providers.[18]

"Metering":

- Imposed by Congress beginning in fiscal year 1996, metering arbitrarily restricts the release of already appropriated funding to maximum monthly installments of approximately 8 percent.
- Metering has been shown to undermine effective program management, jeopardize the availability and use of family planning services, and impose unnecessary costs on U.S. taxpayers and AID implementing partners.[19]

The United Nations Population Fund (UNFPA) ban:

- This proposed restriction would withhold funds from UNFPA, the key multilateral agency that promotes family planning services and maternal and child health worldwide through projects in 150 countries.[20]
- UNFPA has more population professionals and a larger field presence than any other donor agency, including AID.[21] Continued

financial support from the U.S. is crucial if UNFPA is to continue to provide much-needed reproductive health services in underserved regions of the world.

- UNFPA is being targeted because it has provided limited support to family planning programs in the People's Republic of China. There is no evidence of complicity by UNFPA in China's coercive population practices. The international agency's global programs should not be held hostage to the conduct of the Chinese government.

Endnotes

1. U.S. Agency For International Development, *The Impact of Delaying USAID Population Funding from March to July 1997* 5 (Jan. 1997) (hereinafter referred to as *The Impact of Delaying*).
2. The Rockefeller Foundation, *High Stakes: The United States, Global Population and Our Common Future* 8 (1997) (citing World Bank, *Population and Development: Implications for the World Bank* (1994)) (hereinafter referred to as *High Stakes*).
3. The Alan Guttmacher Institute, *Issues in Brief, A Response to Concerns about Population Assistance* 4 (1997) (hereinafter referred to as *A Response to Concerns*).
4. *High Stakes*, at 8 (citing UNICEF, *The Progress of Nations 1996* (1996)); The Alan Guttmacher Institute, *Issues in Brief, Endangered: U.S. Aid for Family Planning Overseas* 2 (1996) (hereinafter referred to as *Endangered*).
5. *A Response to Concerns*, at 1; *The Impact of Delaying*, at 4.
6. *The Impact of Delaying*, at 6 ("developing" countries reviewed excludes China); High Stakes, at 5 (citing 50 percent contraceptive prevalence in "developing" countries, including China).
7. *The Impact of Delaying*, at 6.
8. *High Stakes*, at 8.
9. *Id.* at 4.
10. *A Response to Concerns*, at 6.
11. *The Impact of Delaying*, at 6.
12. *A Response to Concerns*, at 2.
13. 22 U.S.C. § 2151b (b) & (f) (1994). This provision of the Foreign Assistance Act prohibits the use of funds "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions." *Id.* at § 2151b(f)(1). The provision also prohibits the use of funds "for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations." *Id.* at 2151b(f)(1). In addition, a U.S. Agency for International Development Policy Determination was codified as a regulation barring funding for, *inter alia*, "information, training, or communication programs that seek to promote abortion as a method of family planning." 48 C.F.R. 752.7016(b) (1996).
14. 22 U.S.C. § 2151b(b) & (f).
15. Letter from Mark O. Hatfield, U.S. Senator, to The Hon. Christopher H. Smith, U.S. Representative (Sept. 24, 1996) (on file with The Center for Reproductive Law and Policy).
16. *High Stakes*, at 24-25.
17. *Endangered*, at 2.
18. Population Crisis Committee, *Impact of the Mexico City Policy on Family Planning Programs and Reproductive Health Care in Developing Countries, Major Findings* 4-5 (1988).
19. *The Impact of Delaying*, at 8-9.
20. Cynthia P. Green, *Profiles of UN Organizations Working in Population* 20 (Population Action International, 1996).
21. *Id.* at 20-21.

Elena -

As always, there are some good suggestions here (e.g. on research) and some that we wouldn't go anywhere near (e.g. requirements in private insurance). So, there's nothing wrong with talking, but I worry a bit about any implication that we would act on this.

Jen

Women's issues — contraception

THE WHITE HOUSE
WASHINGTON

5/5/97

Elena —

Here is the set of policy proposals I mentioned to you from the Center for Reproductive Law and Policy. They cover contraceptive coverage in private and federal insurance + government plants; also access to services and research and development.

Leslie Harris requests that the First Lady's office convene a group to discuss — what do you think?

Emanuel

66266

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February 20, 1997

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20005

Dear Mr. President:

On behalf of the Center for Reproductive Law and Policy (CRLP), the nation's only public interest legal organization committed solely to protecting women's reproductive rights and health, I write to offer our recommendations for a forward thinking reproductive rights agenda for the next four years. We firmly believe that the cornerstone of that agenda is universal access to safe, effective and affordable contraception for American women as well as women around the world.

Unfortunately, like many other aspects of women's health care, contraception is neither accessible nor affordable for many American women. For example, although ninety-seven percent of large group health plans generally cover prescription drugs and devices, only thirty-seven percent cover oral contraceptives. At the same time, a significant percentage of low-income women who are uninsured or underinsured, as well as many women who receive their health care through plans controlled by religious institutions, have limited access to safe and effective contraception. For women covered by Medicaid, one of the most comprehensive federal health programs, the guarantee of access to family planning services has been undermined by lack of adequate information about contraceptive options, and the transition to managed care. Finally, even when health care plans provide contraceptive coverage, American women have far fewer contraceptive choices than women in the rest of the industrialized world. Relentless pressure from antichoice forces and the realities of current product liability law have dramatically curtailed research and development of new contraceptive products. Yet access to safe and effective contraception remains an urgent -- but generally unrecognized -- public health need for women worldwide.

Meaningful access to contraceptives and reproductive health services is even further from reality for women living in low-income countries. In the more than sixty countries that have received U.S. AID family planning funds, many men

and women have virtually no access to contraceptives apart from those provided pursuant to U.S.-supported programs. Even with these programs, over 100 million couples still have unmet needs for family planning services. The inability of women in these developing countries to obtain modern contraceptive methods leads to shockingly high rates of unintended pregnancy, abortion, and death during pregnancy and childbirth.[1] Access to contraception and reproductive health services is thus essential to improving the health and survival of women and children around the world.

The Administration has already demonstrated its strong support for family planning -- lifting the gag rule, supporting early release of international population assistance, and backing increases in Title X. But we believe it is now time to address the problem of inadequate access to contraceptives in a more comprehensive and focused manner. Below we set out a number of recommendations that range from mandated contraceptive coverage in private insurance to the extension of Medicaid coverage for contraception for new mothers. We ask that you work with us to refine these proposals and then put the imprimatur and the power of the Presidency behind them.

The advancement of a comprehensive agenda in support of universal access to safe and effective contraception is consistent with this Administration's longstanding efforts to provide universal health care, as well as with the Democratic platform's goals "to make abortion less necessary and more rare, not more difficult and dangerous," and to support "contraceptive research, family planning and efforts to reduce unintended pregnancy." Not only is that agenda consistent with the consensus reached by over 150 countries at the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing last year, it has the overwhelming support of the American people.

We remain extremely grateful for your veto of H.R. 1833, the "Partial Birth Abortion Ban Act" of 1996, and we urge you to remain steadfast in your opposition to this onerous legislation. We further urge you to continue to oppose legislative restrictions on abortion funding in federal programs, and to continue vigorous enforcement of the Freedom of Access to Clinic Entrances Act to ensure that women can obtain reproductive health services free of coercion and violence. We recognize that the assaults on reproductive rights and health will persist, and we will continue to fight aggressively against them. But we cannot wait for those assaults to come to an end before returning to the critical task of fulfilling *Roe*'s

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[1]See ALAN GUTTMACHER INSTITUTE, ENDANGERED: U.S. AID FOR FAMILY PLANNING OVERSEAS 2 (1996).

promise of women's equal participation "in the economic and social life of the Nation."[2] We believe that our proposals for ensuring universal access to contraceptive care are a significant step toward that goal.

We look forward to discussing these proposals with you and members of your Administration.

Sincerely,

Janet Benshoof

[2]Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992).

TABLE OF CONTENTS

ENSURING UNIVERSAL ACCESS TO COMPREHENSIVE CONTRACEPTIVE SERVICES

We urge the Administration to take all possible measures to ensure that every woman of childbearing age has meaningful access to all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices.[1] Each year about sixty percent of the 5.5 million pregnancies that occur in the United States -- 3.3 million pregnancies -- are unintended. Worldwide, millions of women each year experience an unwanted pregnancy.[2] Many of these unintended pregnancies exact tragic tolls on pregnant women and their families and burden society as a whole. Increasing the availability and use of contraception is a crucial step toward preventing unwanted pregnancies; protecting against sexually transmitted infections; lowering the rates of infant mortality and low birthweight births;[3] reducing high school drop out rates and the incidence of child abuse and neglect; and minimizing long-term dependence on welfare.[4] Ensuring that all women have meaningful access to all

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[1]The following are currently FDA-approved prescription contraceptive drugs and devices: all regimes of oral contraceptives, injectable contraceptives, contraceptive implants, IUDs, diaphragms and cervical caps.

[2]U.N. DEP'T FOR ECON. & SOCIAL INFO. & POLICY ANALYSIS, THE WORLD'S WOMEN 1995: TRENDS AND STATISTICS, at 79, U.N. Doc. ST/ESA/STAT/SER.K/12, U.N. Sales No. E.95.XVII.2 (1995).

[3]Kenneth J. Meier & Deborah R. McFarlane, *State Family Planning and Abortion Expenditures: Their Effect on Public Health*, Vol. 84, No. 9 AM. J. OF PUB. HEALTH 1468, 1471 (1994).

[4]Approximately half of the adolescents who give birth before the age of eighteen receive welfare within five years of giving birth. COMMITTEE ON UNINTENDED PREGNANCY, INSTITUTE OF

(continued...)

medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices is also the most efficacious means of fulfilling this Administration's promise to make abortion "safe, legal, and rare." It is undeniable, however, that all contraceptives sometimes fail. Thus, this Administration must forthrightly acknowledge that every pregnant woman must be given full information about her options and access to either prenatal, abortion, or adoption services -- whichever she chooses.

The failure to assure women access to the complete range of contraception is both discriminatory, and medically and fiscally unsound. As the United States Supreme Court noted in *Planned Parenthood v. Casey*, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[5] Unwanted childbearing, in many cases, curtails a woman's educational and work opportunities, constricts her social role, and excludes her from full participation in the "marketplace and the world of ideas."[6] In our view, exclusion of any medical service related to contraception or of any FDA-approved, prescription contraceptive drug or device from health insurance coverage that otherwise covers medical services and/or prescription drugs and devices constitutes impermissible gender-based discrimination in violation of the Equal Protection

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(...continued)
MEDICINE, THE BEST INTENTION: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES, 56-58 (Sarah S. Brown & Leon Eisenberg eds., 1995).

[5]505 U.S. 833, 856 (1992).

[6]*See* Stanton v. Stanton, 421 U.S. 7, 14-15 (1975).

Clause of the U.S. Constitution, and (with respect to employer-provided health insurance) Title VII of the Civil Rights Act of 1964. Moreover, such an exclusion from federal grant programs that cover family planning services -- such as Medicaid, Title X, and international family planning programs -- is similarly discriminatory. In addition, we hold that individuals have an international human right to health care, including family planning. Such a human right is contravened when women and men are not provided with a full range of medical services relating to contraception.

The exclusion of FDA-approved, prescription contraceptives or medical services related to contraception from health insurance coverage (whether private or supplied by the federal government through CHAMPUS or FEHBA) is based on outdated sex role stereotypes reflecting the unconstitutional assumption that women's "natural" role is to bear and raise children, as well as the assumption that the burden of preventing pregnancy should be the exclusive responsibility of women. The exclusion also carries on the insurance industry's history of discrimination against women.[7]

Further, excluding insurance coverage for medically appropriate prescriptions and

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[7]*See, e.g.*, Newport News Shipbuilding and Dry Dock Co., 462 U.S. 669 (1983) (health insurance plan that provided less extensive pregnancy benefits for spouses of male employees than for female employees unlawfully discriminated on the basis of sex); E.E.O.C. v. South Dakota Wheat Growers Ass'n, 683 F. Supp. 1302 (D.S.D. 1988) (exclusion of pregnancy-related costs from health benefit plans constituted unlawful sex discrimination); *cf.* Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans, 463 U.S. 1073 (1983) (state pension plan which paid women lower monthly retirement benefits than men who made same monthly contributions unlawfully discriminated on the basis of sex).

devices needed exclusively by women while covering all medically appropriate prescriptions and devices needed by men is an impermissible gender-based classification. Although the Supreme Court has permitted pregnancy/gender-based classifications that purportedly equalize the sexes,[8] the Court has never sanctioned the imposition of burdens on women alone because of their unique procreative abilities.[9] Moreover, this exclusion, when sanctioned by the federal government through the use of federal funds, also violates the obligation of government to remain neutral as to reproductive decision making and to avoid use of its largesse to coerce women into one reproductive decision over another.

Not only is it legally required that health insurance benefits and federally funded programs cover all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices, sound medical practice also so dictates. As the Institute of Medicine of the National Academy of Sciences noted in a recent report:

> there is the virtually undisputed reality that no existing contraceptive method can meet the requirements, intentions, and preferences of all individuals in all circumstances over entire reproductive lifetimes. Nor can any method be totally without side effects, risks, or trade-offs in terms of safety, efficacy, convenience, usability, and appropriateness (Fathalla 1992). . . . Furthermore, for many women it is also important, even vital, that their contraceptive method be "user-controlled," that is, that it permit them to be the primary decision-makers about

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[8]*See, e.g.*, Geduldig v. Aiello, 417 U.S. 484 (1974); Michael M. v. Sonoma County Super. Court, 450 U.S. 464 (1981).

[9]*See, e.g.*, Int'l Union, United Automobile, Aerospace and Agriculture Implement Workers of America, UAW v. Johnson Controls, 499 U.S. 187 (1991).

utilization. All this argues for the broadest possible range of available options.[10] Women with medical conditions that require them to avoid pregnancy have a particularly urgent need for access to all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices because their medical conditions often preclude use of one or more contraceptive methods.

Finally, increasing the availability of effective contraception would create a substantial fiscal savings, as well as improve the health and well-being of women and children. A recent study by the Alan Guttmacher Institute concludes that every tax dollar spent for contraceptive services saves an average of $3.00 in Medicaid costs alone for pregnancy-related health care and medical care for newborns.[11] On an international level, United States government efforts to expand the availability of contraception help to improve the health and survival of women and children and to enable governments to link population to larger issues of development.[12]

A. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN PRIVATE INSURANCE

Despite the dictates of law, public health, and economics, coverage of contraceptives by

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[10]COMMITTEE ON CONTRACEPTIVE RESEARCH AND DEVELOPMENT, CONTRACEPTIVE RESEARCH AND DEVELOPMENT: LOOKING TO THE FUTURE 1-2 (Polly F. Harrison & Allan Rosenfield, eds., 1996).

[11]Jacqueline D. Forrest and Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, Vol. 28 No. 5 FAM. PLAN. PERSP. 188 (1996).

[12]U.S. AID, THE IMPACT OF DELAYING U.S. AID POPULATION FUNDING FROM MARCH TO JULY 1997: JUSTIFICATION FOR A PRESIDENTIAL DETERMINATION ON SECTION 518(A) OF THE FY97 FOREIGN OPERATIONS, EXPORT FINANCING AND RELATED PROGRAMS APPROPRIATIONS ACT 5-6 (Jan. 1997).

private insurance is woefully inadequate. According to a recent study by the Alan Guttmacher Institute ("the AGI insurance study") of private insurance coverage, 49 percent of large-group plans do not routinely cover any contraceptive method at all.[13] In fact, oral contraceptives, the most commonly used reversible contraceptive method in the United States, are routinely covered by only 33 percent of large-group plans, although 97 percent of those plans provide prescription coverage for other drugs.[14] Similarly, while 92 percent of typical large-group plans routinely cover medical devices in general, only 18 percent routinely cover IUDs, 15 percent cover diaphragms and 24 percent cover the Norplant device.[15] A recent study by the Women's Research and Education Institute reveals that women between the ages of 15 and 44 pay 68 percent more in out-of-pocket expenditures for health care services than men, and reproductive health services account for much of that difference.[16] Indeed, almost 5 million privately insured women have out-of-pocket health care expenses in excess of 10 percent of their income.[17] Yet the majority of health plans fail to cover drugs and devices used by over 21 million women each

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[13]THE ALAN GUTTMACHER INSTITUTE, UNEVEN AND UNEQUAL, INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 12 (1995).

[14]*Id.* at 17.

[15]*Id.*

[16]WOMEN'S RESEARCH AND EDUCATION INSTITUTE, WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES 2-3 (1994).

[17]*Id.* at 2.

year.[18]

The ad hoc system of contraceptive coverage and exclusion is irrational as well as discriminatory. For example, according to the AGI insurance study, 26 percent of large group plans covered IUD insertion, but only 18 percent of those plans covered the IUD device; 28 percent covered Norplant insertion, but only 24 percent covered the Norplant device.[19] Notably, 32 percent covered Norplant removal.[20] In addition, of those large group plans, despite the low levels of coverage for reversible contraception, approximately 66 percent pay for abortion and approximately 86 percent pay for male and female sterilization.[21]

Exclusion of contraceptive coverage from private insurance can create real financial burdens for low-income, working class and even middle-class women. In 1993, the total cost of Norplant insertion was approximately $700, the total cost of an IUD insertion was approximately $400, and a year's supply of oral contraceptives and the associated physical exam cost approximately $300.[22] In a period of just a few years, many women will spend thousands of dollars in unreimbursed prescription drug and device health care costs as a result of the exclusion

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[18]*Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies, supra* note 11 at 189.

[19]UNEVEN AND UNEQUAL, *supra* note 13 at 9.

[20]*Id.*

[21]*Id.*

[22]James Trussell, et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, Vol. 85, No. 4 AM. J. OF PUB. HEALTH 495-96 (1995).

of contraceptives from their private insurance. From the insurer's perspective, however, contraceptive coverage is far more cost-effective than paying the costs of maternity care.

Not only do health insurers disserve their beneficiaries by failing to cover the complete range of contraceptive services, they do so by failing to assure confidentiality of contraceptive services. Confidentiality is of the utmost importance to women and adolescents seeking insurance coverage for contraceptive services. The concern about confidentiality is particularly acute for women because they are far more likely than men to depend on someone else's insurance,[23] and thus to risk disclosure of medical information to the person (usually a spouse or parent) on whose insurance they rely. The AGI insurance study documented that among those private insurance plans that do cover some contraceptives, many fail to ensure the confidentiality of medical information.[24] According to the AGI insurance study, in 88 percent of large group plans (and similar proportions of PPOs and POS networks), the employee must submit the claim and/or receive the Explanation of Benefits (EOB) form, even if the services were obtained by the employee's spouse or nonspouse dependents.[25] The EOB contains information about services provided and/or the name of the practitioner or medical institution, which in the case of

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[23]In 1990, while 55% of men aged 18-64 were insured through their own employers, only 37% of women in this age group had direct coverage. INSTITUTE FOR WOMEN'S POLICY RESEARCH, WOMEN'S ACCESS TO HEALTH INSURANCE 7 (1994).

[24]UNEVEN AND UNEQUAL, *supra* note 13 at 21-24.

[25]*Id.* at 22.

reproductive health providers could easily reveal the type of service obtained.[26] Thus, for many women who receive indirect insurance coverage, the billing and claims processing procedures deprive them of the ability to confidentially seek insurance coverage for contraceptive care.

Thus, we urge the Administration to take the following steps:

1. Direct the Equal Employment Opportunity Commission ("EEOC") to amend its Guidelines on Discrimination Because of Sex to define the exclusion of any medical services related to contraception (including sterilization) or any FDA-approved, prescription contraceptive drugs or devices from private health insurance that otherwise covers prescription drugs and devices as an unlawful employment practice because it discriminates between men and women with regard to fringe benefits, and thus constitutes "discrimination on the basis of sex" in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e. *See* proposed regulatory language in Appendix A-I.

2. Direct the EEOC to amend its Guidelines on Discrimination Because of Sex to state that the failure of employer-sponsored health insurance plans to ensure that everyone covered by the plan, including those covered indirectly, can receive insurance coverage for contraceptive services without risking disclosure of private medical information constitutes "discrimination on the basis of sex" in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, because it has a disparately adverse impact on women seeking to obtain constitutionally protected medical services. *See* proposed regulatory language in Appendix A-I.

3. Direct the Department of Health and Human Services ("HHS") to promulgate regulations under the Health Maintenance Organizations subchapter of the Public Health Service Act, mandating that "voluntary family planning services" within the meaning of the Act, 42 U.S.C. § 300e-1(1)(H)(iv), include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix A-II.

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[26] *Id.*

B. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN FEDERAL INSURANCE PROGRAMS

Non-military federal employees are eligible to receive health insurance in accordance with the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901, *et seq.* Pursuant to FEHBA, the Office of Personnel Management ("OPM") oversees the Federal Employees Health Benefits Program ("FEHBP"). Commercial insurance carriers and other organizations that wish to sponsor health plans for federal employees must apply to OPM, which reviews the applications and decides who may offer a FEHBP health plan. OPM enters into annual federal procurement contracts with approved applicants, and has final authority over all benefits, exclusions, and limitations in FEHBP plans. OPM is authorized to contract for such benefits, limitations, and exclusion as it "considers necessary or desirable." 5 U.S.C. § 8902(d).

Federal employees can choose from among any of the health plans offered to them. As with other plans offered by private insurance companies, some of the insurance plans offered to federal employees do not include coverage for all medical services related to contraception (including sterilization) or all FDA-approved, prescription contraceptive drugs and devices. Mandating coverage for these services in FEHBP health plans would greatly benefit federal employees and their dependents. In addition, such a mandate in the largest insurance program in the country would constitute a significant step toward changing the standard benefit package offered to non-federal employees.

Members of the uniformed services and their dependents are eligible to receive health insurance through the Civilian Health and Medical Program of the Uniformed Services

("CHAMPUS"), 10 U.S.C. §§ 1071, *et seq.* Pursuant to regulations promulgated to implement CHAMPUS, some family planning services are specifically covered by CHAMPUS. *See* 32 C.F.R. § 199.4(e)(3)(i). Current regulations, however, do not include coverage for Norplant insertion and removal, cervical caps, or Depo Provera, even though these are FDA-approved contraceptives. In addition, because the regulation is worded so as to exclude from coverage any contraceptive method that is not specifically included, any new contraceptive methods will not be covered unless the regulation is specifically amended.

We urge the Administration to:

1. Direct OPM to change the Request for Proposals for entities applying to provide FEHBP health benefit plans to require that every such plan provide insurance coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices, and that every such plan ensure that everyone covered by the plan, including those covered indirectly, can receive insurance coverage for contraceptive services without risking disclosure of private medical information to third parties.

2. Promulgate regulations under FEHBA mandating that any health plan offered by a private carrier pursuant to an annual procurement contract with OPM to provide health benefits to federal employees must provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix B-I.

3. Direct OPM to notify participants in FEHBP health benefit plans, including dependents and spouses, that all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices are covered by the plan and can be obtained without risking disclosure of private medical information to third parties.

4. Amend the current CHAMPUS regulation to ensure that the CHAMPUS family planning benefit includes coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription

contraceptive drugs and devices. *See* proposed regulatory language in Appendix B-II.

5. Amend the current CHAMPUS regulation to provide that all persons covered by CHAMPUS, including dependents and spouses, may receive coverage for contraceptive services without risking disclosure of private medical information to third parties. *See* proposed regulatory language in Appendix B-II.

6. Direct the Secretary of Defense, the Secretary of Transportation, and the Secretary of HHS to notify all individuals covered by CHAMPUS, including dependents and spouses, that all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices are covered by CHAMPUS and can be obtained without risking disclosure of private medical information to third parties.

C. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN FEDERAL GRANT PROGRAMS

Almost one in four of the 21 million women in the United States who use some form of reversible contraception rely on public funds for their contraceptive care.[27] According to the Alan Guttmacher Institute, each year publicly funded family planning helps 1.3 million women in the United States alone avoid an unintended pregnancy.[28] If not prevented, 632,300 of these pregnancies would be terminated by abortion and 533,800 would result in unintended births.[29] Moreover, expenditures for contraceptive services are highly cost-effective. For example, had there been no public-sector expenditures for contraceptive services in 1987, the federal and state governments would have spent an additional $1.2 billion that year through their Medicaid

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[27] *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies*, *supra* note 11 at 189.

[28] *Id at 192.*

[29] *Id.* at 193.

programs for expenses associated with unplanned births and abortions.[30]

In the United States, direct federal support for subsidized contraceptive services and supplies is available through two major sources:[31] Title X of the Public Health Services Act[32] and Medicaid.[33] Additional federal funding is provided for family planning services with funds appropriated for migrant health centers,[34] community health centers,[35] rural health clinics,[36] Indian health services,[37] health services for the homeless,[38] the Refugee Medical Assistance portion of the Refugee Assistance Program,[39] and others.

In the international arena, substantial direct federal support for contraceptive services and supplies are provided through the U.S. Agency for International Development ("U.S. AID")

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[30] *Id.*

[31] Many states also use significant amounts of federal funds for contraceptive services by using parts of their Maternal and Child Health Block Grant (Title V of the Social Security Act ("SSA")) and Social Services Block Grant (Title XX of the SSA) for family planning services.

[32] 42 U.S.C. §§ 300 *et seq.*

[33] 42 U.S.C. §§ 1396 *et seq.*

[34] 42 U.S.C. § 254b(a)(6)(C).

[35] 42 U.S.C. § 254c(b)(1)(C).

[36] 42 C.F.R. § 405.2448(b)(9).

[37] 25 U.S.C. § 1603(k)(5).

[38] 42 U.S.C. § 256(r)(6).

[39] 8 U.S.C. § 1522; 45 C.F.R. § 400.105.

assistance for family planning projects overseas[40] and assistance for refugees in countries outside the United States.[41] The Foreign Assistance Act of 1961, as amended,[42] authorizes the President to provide financial assistance for voluntary population planning and health programs in nations around the world. These programs have been administered by U.S. AID. U.S. AID population programs currently benefit families in over sixty countries with a combined population of over 2.7 billion people.[43]

It is imperative that the hundreds of thousands of women who seek contraceptive services and supplies through these federally funded programs be provided with all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices so that they are not forced into using medically inappropriate contraception, or denied contraception altogether due to the unavailability of the contraception of their choice.[44] In addition, women must be given the ability to choose a method that best meets their personal needs whether the contraceptive method be available by prescription or over-the-

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[40]22 U.S.C. §§ 2151b and 2362c.

[41]22 U.S.C. § 2601(b).

[42]22 U.S.C. § 2151(a).

[43]THE IMPACT OF DELAYING U.S. AID POPULATION FUNDING FROM MARCH TO JULY 1997, *supra* note 12 at 5.

[44]For example, in 1995, over fifty percent of publicly-funded family planning agencies failed to provide the IUD, emergency contraception, the female condom, sterilization, or the cervical cap. Jennifer F. Frost & Michele Bolzon, *The Provision of Public-Sector Services by Family Planning Agencies in 1995*, 29 FAM. PLAN. PERSP. 6 (1997). A smaller percentage also failed to offer diaphragms or implants. *Id.*

counter. Accordingly, the Administration should take steps to ensure that women who rely on federal grant programs for family planning services have access to all forms of contraception.

Thus, we urge the Administration to:

1. Amend existing regulations and promulgate a new regulation pursuant to Title X, making clear that Title X's requirement that "family planning projects . . . offer a broad range of acceptable and effective family planning methods and services . . . ," 42 U.S.C. § 300(a), mandates that grantees provide *comprehensive* family planning services, including all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. This meaning is consistent with Congressional intent "to establish a nationwide program with the express purpose of making comprehensive family planning services readily available to all persons desiring such services.'" *See Planned Parenthood Federation of America v. Heckler,* 712 F.2d 650, 651 (D.C. Cir.1983), quoting Pub. L. No. 91-572, § 2, 84 Stat. 1506 (1970) (emphasis added) (statement of the "purpose of this Act"). *See* proposed regulatory language in Appendix C-I.

2. Amend existing Medicaid regulations and promulgate new regulations under the Medicaid Act to make clear that Medicaid recipients are entitled to coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-II.

3. Amend existing regulations and promulgate new regulations requiring all other non-block-granted federally funded programs that provide family planning services in the United States to provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-III.

3. Amend existing regulations and promulgate new regulations requiring all federally funded programs that provide family planning services outside the United States to provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-IV.

4. Direct HHS to purchase in bulk non-prescription, medically effective, legally

available contraceptives (including male and female condoms, and spermicides) and to distribute them at no cost to all Title X projects, Medicaid managed care providers, and other providers of federally-funded family planning services for distribution to their patients.

D. PROPOSED ACTION: EXPANSION OF MEDICAID COVERAGE FOR FAMILY PLANNING SERVICES

Between 1984 and 1990, Congress enacted a set of laws that extended Medicaid eligibility to poor pregnant women, regardless of whether they meet other eligibility requirements for Medicaid benefits (the "expanded Medicaid program").[45] Under current Medicaid law, all pregnant women whose income is less than 133 percent of the federal poverty level are eligible to receive Medicaid benefits, and states have the option of extending eligibility to women whose income is higher. Federal matching funds are available for Medicaid benefits for poor pregnant women whose income is less than 185 percent of the federal poverty level. Under current law, the expanded Medicaid program for pregnant women covers post-pregnancy family planning services, but that eligibility terminates 60 days after birth unless the woman qualifies for benefits under the regular Medicaid rules.

This 60-day window for obtaining Medicaid-covered post-pregnancy family planning services is too short, especially given the fact that for medical reasons women usually must wait at least six weeks after giving birth before beginning a contraceptive method.[46] As a result, many

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[45]*See* 42 U.S.C. §§ 1396a(l)(1)(A) and 1396(l)(2)(A)(i).

[46]Several states have extended or have sought to extend the period of eligibility for post-pregnancy family planning services benefits pursuant to § 1115 waivers. As of September 1996, (continued...)

genuinely poor women have few or no means by which to obtain family planning services after a pregnancy. Not only would extending the time-period in which the expanded Medicaid program covers post-pregnancy family planning services greatly assist poor women's ability to space their pregnancies, it would likely reduce the number of low-birth-weight and premature deliveries, and infant deaths attributable to closely spaced pregnancies among women whose poverty limits their access to health services.[47]

While federal matching funds are now available for states that provide Medicaid benefits to pregnant women with incomes up to 185 percent of the federal poverty level, several states have elected to provide Medicaid benefits to pregnant women whose incomes exceed that level, but who are still poor.[48] These states have recognized that most women whose income is 200 percent of the poverty level are unlikely to be able to afford prenatal care or post-pregnancy family planning services without Medicaid benefits.[49] They have thus determined that both as a matter of public health policy and fiscal policy, it makes sense to provide these women with pregnancy-related medical benefits and post-pregnancy family planning services.

(...continued)
the waivers for Illinois, Maryland, Rhode Island and South Carolina were approved; applications were pending from Missouri, New York, and Washington.

[47]*State Family Planning and Abortion Expenditures*, *supra* note 3.

[48]For example, Rhode Island covers pregnant women whose income is up to 250% of poverty, Missouri covers pregnant women up to 200% of poverty.

[49]As of 1996, federal guidelines defined poverty for a family of one as $7,740, and for a family of three as $12,980. *See* 61 Fed. Reg. 8286 (Mar. 4, 1996).

Accordingly, we urge the Administration to take the following steps:

1. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to extend eligibility under the expanded Medicaid program exclusively for purposes of receiving post-pregnancy family planning services from 60 days post-pregnancy to 60 months.

2. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to establish meaningful procedures to inform eligible women of the extended post-pregnancy Medicaid coverage for family planning services.

3. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to extend pregnancy-related Medicaid eligibility, including an extended period of coverage for post-pregnancy family planning services, to women whose family income is up to 200 percent of the federal poverty level.

E. PROPOSED ACTION: PRESERVATION OF MEANINGFUL ACCESS TO CONTRACEPTIVE SERVICES IN MEDICAID MANAGED CARE PLANS

Ensuring meaningful access to all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices for Medicaid managed care enrollees poses special concerns because primary care "gatekeepers" and prior authorization requirements for referrals can be a significant detriment to timely, confidential care. Not only does a gatekeeper requirement necessitate an extra doctor's visit before obtaining family planning services, some primary care providers or "gatekeepers" refuse to provide or refer for the services for religious or conscientious reasons. Moreover, those gatekeepers that do provide family planning services may refuse to refer patients to specialized providers even though for some women, especially for those women with special need for privacy and a supportive environment, family planning clinics are best able to meet their special needs. For

these reasons, access to family planning services is greatly enhanced if women are allowed to go to the family planning provider of their choice, even if their choice of all other medical providers is limited by a managed care system.[50]

Waivers from the general Medicaid requirement that enrollees have freedom to choose their own providers[51] may be granted under either § 1115, 42 U.S.C. § 1315(a), or § 1915(b), 42 U.S.C. § 1396n(b), of the Social Security Act. When originally enacted, the Secretary had discretion under § 1915(b) to waive the choice of provider requirement for all mandated services including family planning services. In recognition of the special access concerns surrounding family planning services, however, Congress enacted legislation in the mid-1980s that exempts family planning services from otherwise applicable restrictions on the ability of Medicaid managed care enrollees to select the provider of their choice. *See* 42 U.S.C. §§ 1396a(23)(B) and 1396n(b); 42 C.F.R. § 431.51(a)(3). Pursuant to this "family planning free access rule," § 1915(b) managed care enrollees are free to self-refer to any provider to receive family planning services. By its terms, however, the free access rule applies only to § 1915(b) Medicaid managed care programs. Although sound legal and policy arguments support the view that the free access rule must also apply to Medicaid managed care waivers granted pursuant to § 1115,[52] this

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[50]*See* CENTER FOR REPRODUCTIVE LAW AND POLICY, REMOVING BARRIERS, IMPROVING CHOICES: A CASE STUDY IN REPRODUCTIVE HEALTH SERVICES IN MANAGED CARE (1995).

[51]42 U.S.C. § 1396a(23)(A).

[52]*See* letter from Center for Reproductive Law and Policy to Bruce Vladeck, dated November 29, 1994, commenting on the proposed § 1115 OhioCare Medicaid waiver.

Administration has repeatedly granted § 1115 waivers without conditioning the waiver on enrollees' ability to self-refer to the family planning provider of their choice.

Therefore, we urge the Administration to:

1. Mandate a free access policy for family planning services as a term and condition of approval of all future § 1115 Medicaid managed care freedom of choice waivers (including renewals and extensions).

2. Require states, as a term and condition of approval of all future § 1115 Medicaid managed care waivers (including renewals and extensions), to educate case workers, providers and patients regarding patients' right to seek family planning services at their provider of choice.

F. PROPOSED ACTION: EMERGENCY CONTRACEPTION

Although emergency contraception is among the FDA-approved, prescription contraceptive drugs and devices that, as discussed above, must be covered in all private insurance plans, federal insurance programs, and federal grant programs funding contraceptive services, the Administration should take additional measures to increase women's access to these safe and efficacious prescriptions.

There are more than fifty brands of oral contraceptives produced by nine pharmaceutical companies approved for daily use in the United States. Of these, six brands --- Ovral, Lo/Ovral, Nordette, Triphasil, Levlen and Tri-Levlen --- are effective as emergency postcoital contraception.[53] Although oral contraceptives have been approved for use as emergency contraception in Europe for several decades, drug manufacturers in the United States have failed

[53]In addition, insertion of an IUD is also a medically effective and safe form of emergency contraception.

to label or market their products for this use, citing in part fear of political retaliation from antichoice forces. Yet, clinical studies have proven that postcoital contraception reduces the risk of pregnancy by approximately seventy-five percent.[54] In the United States, relabeling and broader access to emergency contraception could decrease the number of unintended pregnancies by as much as 1.7 to 2.3 million each year.[55] Consequently, an estimated one million abortions could be avoided each year through the use of emergency contraception.[56]

Until very recently the FDA stood silent while the pharmaceutical manufacturers refused to relabel oral contraceptives to provide information about safe and effective emergency contraception. Relatively few health care providers in the United States are aware of emergency contraception and many of those providers are reluctant to prescribe oral contraceptives for an "off label" use. For the most part, use of emergency contraception has been limited to university health centers, emergency rooms that treat rape victims and family planning clinics.

In 1994, on behalf of nearly two dozen medical groups and health care providers, including the American Public Health Association, the American Medical Women's Association and Planned Parenthood of New York City, the CRLP filed a citizen's petition urging that the FDA mandate relabeling of certain oral contraceptives to indicate their use as emergency contraception. In response, the FDA convened a meeting of its Reproductive Health Drugs

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[54]James Trussell, et al., *Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies*, Vol. 24, No. 6 FAM. PLAN. PERSP. 269 (1992).

[55]*Id.* at 270.

[56]*Id.*

Advisory Committee to consider whether certain oral contraceptives were safe and effective for use in an "emergency" regime. After hearing testimony of a number of experts concerning the safety and efficacy of emergency contraceptive pills and the salutary effect that widespread access to emergency contraception would have on the rate of unintended pregnancy and abortion, the panel found that the oral contraceptives were safe and effective when used for emergency contraception. Although Commissioner Kessler announced that the FDA would publish a formal notice in the Federal Register by early fall of 1996 setting out the panel's finding, the register notice has yet to be published.

While the FDA panel's action provides a critical "stamp of approval" for those health care providers who currently prescribe oral contraceptives for emergency contraceptive use, it is only a first step. Ultimately, the pharmaceutical manufacturers must be required to relabel their products to make clear their emergency use. Thus far, the FDA has declined to issue such a mandate. Moreover, the FDA should require relevant companies to package and market oral contraceptives in "emergency" doses as is commonly done in Europe. Finally, the Administration should initiate research to determine whether emergency contraceptive pills can safely be provided on an over-the-counter basis. In addition to initiating actions to achieve these long term goals and the relevant changes advocated in sections A through E of this document, the Administration should take immediate action to ensure that all women have both greater access to and information about the option of emergency contraception.

Specifically, we urge the Administration to:

1. Publish the Federal Register notice regarding the use of oral contraceptives as emergency contraception without further delay.

2. Undertake a comprehensive education campaign to inform the medical profession of the safety and efficacy of emergency contraception. The FDA should prepare a letter signed by the Commissioner describing the action taken by the FDA, the protocol for the postcoital administration of oral contraceptives and the implications for reducing unintended pregnancy and abortion. That letter and the Federal Register notice should be distributed to every health care provider and professional medical association in the country, to every recipient of U.S. AID family planning funds, and to the Secretary of State insofar as she is responsible for medical care for refugees.

3. Prepare a patient information pamphlet about emergency contraception and widely disseminate the pamphlet to private practitioners and all providers of federally funded health care with particular attention to those programs where abortion services have been proscribed by law. Each provider of federally funded health care and family planning services, including recipients of U.S. AID family planning funds and those that serve refugees, should be required to disseminate the pamphlet to their patients.

4. Promulgate a regulation under the federal Crime Awareness and Campus Security Act mandating that the notification of services provided to victims of sexual assault must include information on the effective use of emergency contraception, as well as information on where emergency contraception may be obtained. *See* proposed regulation language in Appendix D.

G. PROPOSED ACTION: CONTRACEPTIVE RESEARCH AND DEVELOPMENT

Today, American women have fewer contraceptive options than women in Europe and much of the industrialized world. Moreover, American women must pay substantially more than their European counterparts for contraceptive services, drugs and devices. Nearly forty years after the "contraceptive revolution," combined political and commercial forces have stalled initiatives in both the public and the private sector. Public investment in contraceptive

development has remained static for some years. This inertia is partially due to both the political controversy surrounding reproductive rights and the lack of recognition of contraception as an urgent public health need. It is also due to the real and perceived fear of product liability law in the United States, which not only discourages development of contraceptives, but is exacerbated by the political climate around contraceptives. Private investment in contraceptive development by pharmaceutical manufacturers has diminished markedly over the past few decades. As a result, by the mid-1980s only one of the nine private U.S. firms that did research related to contraceptive drugs and devices in the 1960s continued to do that work.[57]

Private industry commonly rationalizes its failure to pursue contraceptive development by citing the state of products liability law in the United States. Manufacturers claim the law has made it too costly to pursue research and development in this area and forced some products off the market. The negative publicity and pressure from anti-choice factions has affected manufacturers willingness to pursue further development of contraceptives. The result for American women is severely diminished access to safe and efficacious contraceptive choices, which contributes to the three and a half million unintended pregnancies each year, half of which end in abortion. The Administration must address this by instituting private sector initiatives on research, such as the tax credit for orphan drugs.

The promise of universal access to safe, effective and practical contraception cannot be met unless the barriers now impeding the development and marketing of new contraceptives in

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[57] CONTRACEPTIVE RESEARCH AND DEVELOPMENT, *supra* note 10 at 4-1.

the United States are removed. Removal of barriers will have world-wide implications as all countries will benefit from new contraceptive methods developed here. The Administration should make the removal of obstacles to contraceptive research and development a public health priority.

Among other things, the Administration should:

1. Seek increased funding for contraceptive research and product development at the contraceptive research and development centers currently operating under the auspices of the National Institute of Child Health and Human development, as well as identify other research funds for this purpose.

2. Provide a tax credit -- similar to the credit for orphan drugs -- to private pharmaceutical firms conducting research on contraceptives.

3. Explore models for compensating individuals injured by contraceptive use that could serve as alternatives to traditional product liability litigation (possible models could include the National Childhood Vaccination Injury Act of 1986 or the European compensation system).

4. Convene a one day White House Conference to bring together pharmaceutical manufacturers, women's health advocates, health professionals, medical researchers and experts on product liability to explore new ways that contraceptive development can be encouraged while at the same time rigorously safeguarding women's health.

5. Develop a technology transfer package that would provide federal assistance with research costs to small manufacturers who have completed early stages of development on a new product or permit a partially government-developed drug to be transferred to a private distributor.

6. Examine proposals for the adoption of an "FDA" defense that would shield contraceptive manufacturers from liability or from punitive damages if they were in compliance with all applicable requirements of U.S. food and drug law.

APPENDIX A
Contraceptive Coverage in Private Insurance
Proposed Regulatory Language

I. PROPOSED EEOC REGULATION

The Equal Employment Opportunity Commission should amend 29 C.F.R. § 1604.9 to read as follows:

. . .

(g) It shall be an unlawful employment practice for an employer to:

(i) Provide employees medical insurance which covers any prescription drug, but which excludes or restricts coverage for any FDA-approved, prescription contraceptive drug or which imposes greater cost-sharing requirements or other limitations or conditions on contraceptive drugs than on other prescription drugs;

(ii) Provide employees medical insurance which covers any prescription device, but which excludes or restricts coverage for any FDA-approved, prescription contraceptive device or which imposes greater cost-sharing requirements or other limitations or conditions on contraceptive devices than on other prescription devices;

(iii) Provide employees medical insurance which covers medical services but which excludes or restricts benefits for medical services related to contraception (including sterilization) or which imposes greater cost-sharing requirements or other limitations or conditions on medical services related to contraception than on other medical services;

(iv) Provide employees medical insurance which does not ensure that every person covered by the medical insurance can receive any available coverage related to contraception without risking disclosure of private medical information by the insurance provider to the insured party (if other than self), the insured party's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment).

II. PROPOSED HHS REGULATION REGARDING HEALTH MAINTENANCE ORGANIZATIONS

The Department of Health and Human Services should promulgate the following regulation clarifying 42 U.S.C. § 300e-1(1)(H)(iv):

> The "voluntary family planning services" to which 42 U.S.C. § 300e-1(1)(H)(iv) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

APPENDIX B
Contraceptive Coverage in Federal Insurance Programs
Proposed Regulatory Language

I. PROPOSED FEHBA REGULATION

The Administration should promulgate a regulation amending 5 C.F.R. § 890.201(b) to read as follows:

Minimum standards for health benefit plans. . . .

(b) To be qualified to be approved by OPM and, once approved, to continue to be approved, a health benefits plan shall not: . . .

(6) Exclude or restrict benefits for:

(i) Any FDA-approved, prescription contraceptive drug, if the health benefits plan provides coverage for any prescription drug;

(ii) Any FDA-approved, prescription contraceptive device if the health benefits plan provides coverage for any prescriptive device;

(iii) Medical services related to contraception (including sterilization) if the health benefits plan provides coverage for any medical services.

(7) Nothing in paragraph (6) of this subsection shall be construed as preventing a health plan from imposing cost-sharing requirements or other limitations or conditions in connection with benefits for contraception; except that --

(i) any such cost-sharing requirements or other limitations or conditions on prescription contraceptive drugs may not be greater or more onerous than those for any other prescription drug; and

(ii) any such cost-sharing requirements or other limitations or conditions on prescription contraceptive devices may not be greater or more onerous than those for any other prescription device; and

(iii) any such cost-sharing requirements or other limitations or conditions on outpatient medical services related to contraception may not be greater or more onerous than those for any other outpatient medical services; and

(iv) it shall not be a condition of coverage for prescription, contraceptive drugs or devices that they be obtained exclusively through mail order.

(8) Fail to ensure that every person covered by the health benefits plan can receive any available coverage related to contraception without risking disclosure of private medical information by the plan provider to the insured party (if other than self), the insured party's or person's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment).

II. PROPOSED CHAMPUS REGULATION

The Administration should promulgate a regulation amending 32 C.F.R. § 199.4(e)(3)(i)(A) to read as follows:

(3) *Family planning.* The scope of the CHAMPUS family planning benefit is as follows:

(i) *Birth control (such as contraception)* -- (A) *Benefits provided.* Except for the exclusions listed in paragraph (B) of this subsection, benefits are available for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. It shall not be a condition of coverage for prescription, contraceptive drugs or devices that they be obtained exclusively through mail order. Further, all persons covered by the CHAMPUS family planning benefit shall be able to receive coverage related to contraception without risking disclosure of private medical information by the benefit provider to the insured party (if other than self), the insured party's or person's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment). ~~Benefits are available for services and supplies related to preventing conception, including the following:~~

~~(1) Surgical inserting, removal, or replacement of intrauterine devices.~~

~~(2) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).~~

~~(3) Prescription contraceptives.~~

~~(4) Surgical sterilization (either male or female).~~

APPENDIX C
Contraceptive Coverage in Federal Grant Programs
Proposed Regulatory Language

I. TITLE X

A. Proposed Amendment of Existing Regulations

1. The Administration should amend 42 C.F.R. § 59.2 to read as follows:

. . .

Family planning means the process of establishing objectives for the number and spacing of one's children and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including all FDA-approved, prescription contraceptive drugs and devices ~~contraceptive methods~~ and all medical services related to contraception (including sterilization and natural family planning and abstinence) and the management of infertility (including adoption). Family planning services includes preconceptional counseling, education, and general reproductive health care (including diagnosis and treatment of infections which threaten reproductive capability). Family planning does not include pregnancy care (including obstetric or prenatal care). As required by section 1008 of the Act, abortion may not be included as a method of family planning in the title X project. Family planning, as supported under this subpart, should reduce the incidence of abortion. . . .

2. The Administration should amend 42 C.F.R. § 59.5(a)(1) to read as follows:

(a) Each project supported under this part must:

(1) Provide or provide referral to a broad range of acceptable and effective medically approved family planning methods (including all FDA-approved, prescription contraceptive drugs and devices and natural family planning methods) and services (including all medical services related to contraception, including sterilization, infertility services and services for adolescents). ~~If an organization offers only a single method of family planning, such as natural family planning, it may participate as part of a title X project as long as the entire title X project offers a broad range of family planning services.~~ For purposes of this subsection, referral means the process of: (1) directing an eligible person to a provider for a family planning method or service after it has been confirmed that the provider is accessible and can provide the method or service to that person without undue delay, (2) conducting a follow-up in a timely manner to determine whether the method or service was obtained and to provide an alternative referral if necessary, and (3) ensuring that the person receives the method or service from the provider at no greater expense than he or she would have incurred had he or she received the method or service from the project.

B. Promulgation of Proposed New Regulation

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 300(a):

> The "broad range of acceptable and effective family planning methods and services" to which 42 U.S.C. § 300(a) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

II. PROPOSED MEDICAID REGULATIONS

A. Proposed Amendment of Existing Regulations

The Administration should amend 42 C.F.R. § 440.210(a)(2)(i) to read as follows:

Required services for the categorically needy.

(a) A State plan must specify that, at a minimum, categorically needy recipients are furnished the following services: . . .

(2) Pregnancy-related services and services for other conditions that might complicate the pregnancy.

(i) Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices). . . .

B. Promulgation of Proposed New Regulations

1. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396b(a)(5):

The "family planning supplies and services" to which 42 U.S.C. § 1396b(a)(5) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396d(a)(4)(C):

The "family planning services and supplies" to which 42 U.S.C. § 1396d(a)(4)(C) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

3. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396o(a)(2)(D):

The "family planning services and supplies" to which 42 U.S.C. § 1396o(a)(2)(D) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

III. PROPOSED REGULATIONS FOR OTHER NON-BLOCK-GRANTED FEDERALLY FUNDED PROGRAMS THAT PROVIDE FAMILY PLANNING SERVICES IN THE UNITED STATES

A. Proposed Amendment of Existing Regulations

1. Medicare HMOs

The Administration should amend 42 C.F.R. § 417.101(a)(8)(i) to read as follows:

(a) An HMO must provide or arrange for the provision of basic health services to its enrollees as needed and without limitations as to time and cost other than those proscribed in the PHS Act and these regulations, as follows: . . .

(8) Preventative health services, which must be made available to members and must include at least the following:

(i) A broad range of voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices); . . .

2. Rural Health Clinics

The Administration should amend 42 C.F.R. § 405.2448(b)(9) to read as follows:

(b) Preventative primary services which may be paid for when provided by Federally qualified health centers are the following: . . .

(9) Voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices). . . .

3. Migrant Health Services

The Administration should amend 42 C.F.R. § 56.102(l)(3) to read as follows:

(l) *Primary health services* means: . . .

(3) Preventive health services, including children's eye and ear examinations, prenatal and post-partum care, perinatal services, well child care (including periodic screening), immunizations, and voluntary family planning

services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices);
. . .

4. Community Health Services

The Administration should amend 42 C.F.R. § 51c.102(h)(3) to read as follows:

(h) *Primary health services* means: . . .

(3) Preventive health services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post-partum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices);
. . .

B. Promulgation of Proposed New Regulations

1. Migrant Health Centers

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 254b(a)(6)(C):

The "family planning services" to which 42 U.S.C. § 254b(a)(6)(C) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. Community Health Centers

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 254c(b)(1)(C):

The "family planning services" to which 42 U.S.C. § 254c(b)(1)(C) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

3. Health Services for Homeless

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 256(r)(6):

> The "family planning services" to which 42 U.S.C. § 256(r)(6) refers (by reference to 42 U.S.C. § 254c(b)(1)) include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

4. Health Centers

The Administration should promulgate the following regulation clarifying the Health Centers Consolidation Act, Pub. L. No. 104-299, 110 Stat. 3626 § 330(b)(1)(A)(i)(III)(gg) (Oct. 11, 1996):

> The "voluntary family planning services" to which the Health Centers Consolidation Act, Pub. L. No. 104-299, 110 Stat. 3626 § 330(b)(1)(A)(i)(III)(gg) (Oct. 11, 1996), refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

5. Indian Health Services

The Administration should promulgate the following regulation clarifying 25 U.S.C. § 1603(k)(5):

> The "family planning" to which 25 U.S.C. § 1603(k)(5) refers includes all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

IV. PROPOSED REGULATIONS FOR FEDERALLY FUNDED PROGRAMS THAT PROVIDE FAMILY PLANNING SERVICES OUTSIDE THE UNITED STATES

A. Proposed Amendment of Existing Regulations

1. Agency for International Development Funds

The Administration should amend 48 C.F.R. § 752.7016(a)(2) to read as follows:

> (2) Activities which provide family planning services or information to individuals financed in whole or in part under this contract, shall provide a broad range of family planning methods and services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices) available in the country in which the activity is conducted or shall provide information to such individuals regarding where such methods and services may be obtained.

B. Promulgation of Proposed New Regulations

1. Foreign Assistance for Family Planning Projects

The Administration should promulgate the following regulation clarifying 22 U.S.C. § 2151b(b):

> The "voluntary population planning" and "family planning information and services" to which 22 U.S.C. § 2151b(b) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. Foreign Assistance for Family Planning Projects

The Administration should promulgate the following regulation clarifying 22 U.S.C. § 2362(c):

> The "voluntary family planning programs" to which 22 U.S.C. § 2362(c) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

3. Assistance to Refugess and Displaced Persons

The Administration should promulgate the following regulation clarifying the Foreign Relations

Authorization Act, Fiscal Years 1994 and 1995, Pub. L. No. 1103-236 § 501(a)(5), 108 Stat. 382 (Apr. 30, 1994) (United States Policy Concerning Oversees Assistance to Refugees and Displaced Persons):

> The "services in reproductive health and birth spacing" to which Pub. L. No. 1103-236 § 501(a)(5), 108 Stat. 382 (Apr. 30, 1994) (United States Policy Concerning Oversees Assistance to Refugees and Displaced Persons) refers include all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices.

APPENDIX D
Emergency Contraception
Proposed Regulatory Language

The Administration should promulgate the following regulation clarifying 20 U.S.C. § 1092(f)(7)(B)(vi):

> The "notification of students of existing counseling, mental health or student services for victims of sexual assault" to which 20 U.S.C. § 1092(f)(7)(B)(vi) refers shall include information regarding the effective use of emergency contraception, as well as information on where emergency contraception may be obtained (either on-campus or in the community) in a timely manner.