

**IMPROVING WOMEN'S HEALTH: WHY
CONTRACEPTIVE INSURANCE COVERAGE MATTERS**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

ON

S. 104

TO REQUIRE EQUITABLE COVERAGE OF PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES, AND CONTRACEPTIVE SERVICES UNDER HEALTH PLANS

SEPTEMBER 10, 2001

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MONDAY, SEPTEMBER 10, 2001

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 3 p.m., in room SD-430, Dirksen Senate Office Building, Senator Mikulski, presiding.
Present: Senators Mikulski, Kennedy and Murray.

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI [presiding]. Good afternoon, everybody. The Senate Committee on Health, Education, Labor, and Pensions is holding a hearing today called "Improving Women's Health: Why Contraceptive Insurance Coverage Matters." We will be really listening to the views of those who are interested in legislation called EPICC, which is Equity in Prescription Insurances and Contraceptive Coverages. The chairman of the full committee, Senator Kennedy, has asked me to chair the meeting, and we are very happy to have him, and other Senators will be joining us as they arrive back in Washington.

I am going to give an opening statement, and then Senator Kennedy, and then we are going to return to our original sponsors, Senator Harry Reid and our colleague, Senator Olympia Snowe. Before we begin, I have statements from Senators Gregg and Collins and I would like to ask unanimous consent that the testimony of Congresswoman Nita Lowey be entered into the record, as she is the lead sponsor in the House. Without objection, that is so ordered.

[The prepared statements of Senators Gregg and Collins follow:]

PREPARED STATEMENT OF SENATOR GREGG

Thank you Madam Chairwoman for holding this hearing on contraceptive coverage. Contraception is obviously an important concern for millions of women of child-bearing age and their families. In addition to the critical role contraception plays in reducing unintended pregnancies, there is also evidence to show it correlates with improved maternal and infant health outcomes. While not every worker wants or needs access to contraceptive benefits, I agree with making it available to those who want it, so long as faith-based plans, employers, and providers are not required to provide services that conflict with their religious doctrine. This should be the issue before the Committee.

Unfortunately, the legislation before this committee takes a different approach to the issue, an approach that I believe will undermine the intended effect of the legislation. EPICC—the “Equity in Prescription Insurance and Contraceptive Coverage Act” (S. 104)—does not seek to make benefit options that include contraceptive coverage available for women who want it. Instead, S. 104 forces every health plan in America and every person enrolled in a private health plan to buy these benefits, whether they want them or not.

Although S. 104 may be well-intentioned, any bill that mandates specific benefits that all consumers must buy directly raises health plan costs for employers and workers. The type of mandate in S. 104 limits an employer’s ability to design benefits that meet the needs and preferences of their employees. Assertions that across-the-board congressional mandates are cost-effective in the private market because they may be other contexts, such as in the public sector or in the Federal Employees Health Benefits Program, are flawed. The private employment-based market bears very little resemblance to Medicaid, or even the choice model established by the FEHBP. Indeed, the cost of the mandate for FEHBP was minimal because nearly every plan was already covering most contraceptive benefits when the mandate was implemented. Workers, and women in particular, will pay the ultimate price of the mandate in this legislation.

Benefit mandates cost money and must be considered in the context of other cost drivers. Employment-based health care costs have been increasing for several years and this year will experience their highest rate increase in nearly a decade. According to new survey data from the Kaiser Family Foundation, small employers are dropping coverage at an alarming rate. The cost of S. 104 will be in addition to premium inflation and a range of other expensive mandates and regulations that are pending, including the patient’s bill of rights, mental health parity, medical privacy regulations and administrative simplification.

I am deeply concerned about our appetite for benefit mandates. Resources for health care not unlimited, and I believe it is inappropriate for the legislative branch to tell consumers what benefits and services they must buy when many people either do not have insurance or at risk of losing their insurance. There is a strong link between increased insurance premiums and the rate of uninsured, particularly when the economy is weak. As it is, women are more likely to be uninsured today. It simply does not make sense to pay for increased contraceptive benefits for a few, at the expense of other women who will lose their coverage entirely or find that they are not adequately insured against a major medical event.

I believe we can, and must, find a better way to give workers and other consumers options that meet their needs and preferences without driving up health care costs and the number of uninsured. For instance, the patient’s bill of rights might offer a better approach. That legislation requires most employers to offer a point of service option so that employees have the ability to use providers and facilities outside the network. Thus, if a patient wants to obtain all health care services from the Mayo Clinic, he or she can pay the additional premium for that option. But other employees

who don't want that option, or can't afford it, can select a lower cost option. While this type of requirement still costs money, it is preferable to the inflexible mandate in S. 104.

In addition to its impact on cost and access, S. 104 as drafted raises other types of concerns. Of particular concern is the fact that, unlike the FEHBP mandate, S. 104 does not contain a conscience clause. FEHBP specifically exempts plans and providers that express religious objections. Under S. 104, faith-based employers and health plans would be forced to provide services that conflict with their religious and moral teachings. In addition, S. 104 would also preempt state insurance law and state parental notification laws.

S. 104 also raises quality concerns because it does not permit a health plan to deny coverage or

require prior authorization for a contraceptive drug or device for quality reasons. Thus, if a health professional mistakenly prescribes a drug that could be harmful to a patient, the plan cannot intervene. By prohibiting a plan from intervening for quality purposes, S. 104 exposes employers and plans to malpractice liability, the mere threat of which can raise insurance premiums.

S. 104 also goes far beyond other benefit mandate proposals by imposing rigid cost-sharing and plan design rules. By linking contraceptive coverage cost-sharing to cost-sharing for "any other drug or outpatient service" it does not appear that employers would be able to have different plan options with in-network benefit differentials. In essence, employers would be required apparently to cover contraceptive benefits at the most generous cost sharing level across all options. For example, if an employer plan offers 100% coverage for immunizations, it would have to offer the same level of coverage for contraceptive benefits.

Based on the serious nature of the access, quality, cost, and moral issues I have outlined, I will oppose S. 104 in its current form. I would hope that the sponsors of the bill would be willing to address these concerns and seek to find a better approach to expanding access to contraceptive services.

PREPARED STATEMENT OF SENATOR COLLINS

Madam Chairman, thank you for calling this hearing this afternoon to examine the issue of contraceptive coverage and whether or not we should require insurers who routinely cover prescription drugs and medical devices to also cover contraceptive care. I am particularly pleased to welcome my colleague, the senior Senator from Maine, Senator Snowe, as well as Senator Reid, both of whom have been such leaders in the Senate on this and other issues important to women's health.

Most American women do use contraception to avoid unintended pregnancy. While women clearly view contraception as basic to their health and to their lives, health insurers in the United States traditionally have not. While health plans routinely cover other prescriptions and outpatient medical services, contraceptive coverage is meager or nonexistent in many health insurance policies. According to a 1994 study by the Alan Guttmacher Institute, while virtually all fee-for-service plans covered prescription drugs, half of these plans fail to cover any prescription contraceptive method.

While 97 percent cover prescription drugs, only 33 percent cover the pill.

This gap in health care coverage has major health implications for American women. Contraceptives have a proven track record of preventing unintended pregnancy, and contraception is basic health care for most women throughout much of their lives. Prescription contraceptives, however, can be expensive and many women may use a less effective method or forgo using contraception at all because of the cost. This places these women at increased risk of unintended pregnancy and abortion.

The Equity in Prescription Insurance and Contraceptive Coverage Act corrects this inequity, and I am please to be a cosponsor. While some may be concerned that this is a mandate, it really is an equity issue. It does not require health plans to cover prescription drugs—it just prohibits them from carving out contraceptive care. Currently, contraceptive drugs and devices are the only class of services that are not routinely covered by health plans that provide prescription coverage.

Again, Madam Chairman, thank you for calling this hearing to explore this issue further.

[The prepared statement of Ms. Lowey may be found in additional material.]

Senator MIKULSKI. Well, I would like to thank everybody for coming to this important hearing on contraceptive coverage, and of course welcome our colleagues and others who are interested. To Senator Reid and Snowe, we want to commend both of you for your strong bipartisan leadership on contraceptive coverage for women. Senators Snowe and Reid have sponsored legislation called the Equity in Prescription Insurance and Contraceptive Coverage Act of 2001. This legislation requires health plans that cover prescription drugs to provide the same level of coverage for prescription contraceptives.

I am a proud co-sponsor of this bill, and the purpose of the hearing today is to shine a spotlight on the issues related to contraceptive coverage, why it is important to women, why it is important to families, and how we can ensure that women have access to the health care they need. Women already pay a gender tax. We pay a gender tax when it comes to getting less pay for comparable work or getting lower Social Security benefits because of the time we take out of the workforce to raise families, and now women face the added gender tax of high health costs. For every dollar spent on men's health care, women during their child-bearing years spend \$1.68. Now, why? Because some insurance plans do not cover birth control pills or other forms of prescribed contraception.

Therefore, most women pay considerable out-of-pocket expenses. The legislation we are talking about today will address this inequity. Since my first days in Congress, I have been trying to lead the charge to make sure we address women's health, whether it was to establish the Office of Women's Health at NIH, to ensure that women are included in the protocols, something then-Congresswoman Snowe and I worked on, with the help of the great guys in the Senate like Senators Kennedy and Reid. We ensured that older women have access to important cancer screenings like

mammograms and pap smears to make sure that women's health needs are a priority for our Nation.

Contraception is a basic part of health care for women. Family planning actually improves the health of both mother and child. Unwanted pregnancies are associated with lower birth weights and can jeopardize maternal health. The American College of OB/GYNs has said contraception is a medical necessity for women during three decades of their lives. We cannot stand by and let insurance plans deny access to this medical necessity any longer.

Some strides had been made, and I know we are going to hear from Jennifer Erickson today, who will tell us why she became an advocate for contraceptive equity and even took her employer to court for refusal to cover contraceptives. I am proud that my own State of Maryland has been a leader on prescription equity. It was the first State in the Nation to require insurers that if you cover prescription drugs, you also have to cover FDA-approved prescription contraceptives. Women in every State should have access to this basic health care tool. It helps create parity between the benefits offered to men and the benefits offered to women.

Mr. Chairman, prescription contraceptives should be available to all women. It is time to end this sex discrimination in insurance coverage, and let's at least reduce the gender tax. We look forward to hearing the witnesses, and now I turn to my colleague and chairman of the committee, Senator Kennedy, for any statement he wishes to make.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. Well, just very briefly, Madam Chairman, I want to thank you for all of your strong leadership on this issue, as well as women's health issues, and thank Senator Snowe, as well, for all that she has done on this issue. Senator Reid has been a real leader in this particular area and in so many other areas, as well, in terms of health issues. Thank you for having this hearing.

I think we will hear today the compelling case for action, and I just want to give you the assurance that I think many of us are looking forward to this hearing because we will have the latest in terms of information as to what is happening out on the crossroads of our country, but I think this is obviously something that all of us are very hopeful that we will move right to the Senate floor and have an opportunity to get action on this year. This is something that is timely and important. I know that is your priority. I know it is, Senator Snowe, as well as Senator Reid, because they have spoken about this on many occasions.

So I thank all of you for all the good work that you have done. Just to mention again, contraceptive insurance coverage is essential for women's health. We should have passed the legislation long ago to deal with this pressing issue. The pending bill is a responsible solution to a problem facing millions of American women, and I thank all of you for your leadership. Family planning improves women's health and reduces the number of unintended pregnancies and abortions. Access to prescription contraceptives is a vital part of such planning. Women have the right to decide when to begin their families and how to space their children. Access to such cov-

erage is also essential in reducing infant mortality and the spread of sexually-transmitted diseases.

In spite of these benefits to women and their families, only half of all the health plans today cover prescription contraceptives, which may well be the only prescription a woman needs. Without the help of insurance coverage, many women are unable to meet this basic health need, or may decide to choose a less-expensive, less-effective method. Largely as a result of the lack of this coverage, women on average pay 68 percent more than men for health care. This bill is urgently needed to increase the number and variety of contraceptive methods available to all women.

More than three-quarters of Americans support this coverage. According to a study in 1998, 78 percent of Americans support requiring health plans to include coverage for contraceptives even if it means increasing their out-of-pocket expenses by more than five dollars, which is much more than the actual cost of the coverage. The cost to employers of including this coverage in their health plans should not be an issue. In fact, the Washington Business Group on Health estimates that not providing the coverage would cost an employer 15 to 17 percent more than providing the coverage.

Many States have successfully begun to require this coverage in their basic health bills. The Equal Employment Opportunity Commission has ruled that employers who do not include such coverage in their health plans, while covering other prescriptions, are in violation of Title 7. Recently, a Federal court agreed on this point, as our panelists will discuss. But Federal legislation is clearly needed to see that all women throughout the Nation have fair access to the family planning services they need. I commend our witnesses who are here today and look forward to the testimony and to this bill becoming law this year.

I thank the chair.

Senator MIKULSKI. Well, thank you very much, Mr. Chairman, and really your leadership has been important. I know when we were working on including women in clinical trials, had it not been for your leadership, working with then myself and the women of the House, women would not have been included in that. We would have never had that Office of Women's Health at NIH, and I do not think Bernadine Healy would have ever been head of NIH. It is time now to break even additional ground.

Having said that, I would like to be able to turn to Senator Olympia Snowe, who has been really a very strong advocate of comprehensive women's agenda, and has been a leader, working with our colleague, Senator Harry Reid, on this prescription contraceptive coverage. Senator Snowe, we really welcome you.

**STATEMENTS OF HON. OLYMPIA SNOWE, A U.S. SENATOR
FROM THE STATE OF MAINE; AND HON. HARRY REID, A U.S.
SENATOR FROM THE STATE OF NEVADA**

Senator SNOWE. Thank you, Madam Chair, and it is certainly a pleasure to be here today and before you. You certainly have been a longtime leader of women's health issues and it has been a privilege to work with you over the last 20 years on so many pieces of

groundbreaking legislation, as you indicated, in creating the Office of Women's Health.

Senator Kennedy, I thank you as chair of this committee for setting aside time to address this most important issue, and more significantly to highlight the continuing inequity in prescription drug coverage that excludes the coverage for prescription contraceptives. I introduced this legislation with Senator Reid back in 1997, and we now have 42 co-sponsors on this legislation once again. I consider it my good fortune to have been joined in this effort, to have as my partner in advancing this legislation, Senator Reid, who has done so much to advocate on behalf of this legislation and the need to address this discriminatory problem within coverage of prescription drugs and overall health insurance policies.

We have agreed that this is a common-sense public policy whose time has long since come. It really does get down to a matter of basic fairness, fairness to half of the Nation's population, fairness in how we treat and view women's reproductive health care versus every other health care need that is addressed through prescription drug coverage. Make no mistake about it, the lack of coverage for prescription contraceptives in our health insurance policy has a very really impact on the lives of women in America, and certainly on our society as a whole. This is not an overstatement. It is a basic fact and it is basic reality.

Frankly, it confounds logic as to why the Congress has been reluctant, reticent, resistant to the idea of passing this legislation so that we can have a national law, a national standard by which women could be assured that they are going to receive this coverage. It has been four long years since we introduced this legislation, and according to the Alan Guttmacher Institute, in each of those 4 years, women have been paid \$350 for prescription oral contraceptives. That is a total of \$1,500. Why? Because health insurance plans exclude prescription contraceptives when they when they provide coverage for other prescription benefits. How can we continue to deny this fundamental coverage that is so critical, so key to women's reproductive health?

All we are saying in this legislation is that if health insurance plans provide coverage for prescription drugs, that that coverage has to extend to FDA-approved prescription contraceptives. It is that simple. It is a matter, as I said earlier, of basic fairness that really underscores law and jurisprudence. We only have to look at the case that was issued by the U.S. District Court in the Western District of the State of Washington back in June. I guess it should come as no surprise to us that a court should issue a ruling, but it was a very significant ruling in the case of Jennifer Erickson versus Bartell Drug Company, in which they indicated that employer's failure to include prescription contraceptives in an otherwise comprehensive prescription drug benefit program constituted gender discrimination under Title 7 of the Civil Rights Act.

We are very fortunate to have with us here today—and I am delighted that you were able to get Jennifer Erickson, who is the plaintiff in this case, to testify here today, so that we can hear firsthand from her of her willingness to wage this lawsuit, and I am thankful and we are all grateful to Jennifer Erickson for her willingness to do that, for her fortitude, her perseverance, her per-

sistence, and her courage in doing so, because this is the first case of its kind that establishes a legal precedent for the legality of our position and really does speak to the reasons as to why we need to have national legislation.

We also know the EEOC issued rulings preceding this court decision that really underscored the same premise, that employers were violating gender discrimination laws under Title 7 of the Civil Rights Act if they did not include prescription contraceptives when otherwise their health insurance plans included prevention devices, prescription drugs, or other preventive health services.

So we have, in these two decisions, a one-two punch approach that favors the legislation and the approach that we have embraced in that legislation, as well. So have 16 States, as you indicated, Madam Chair, in your own State of Maryland, same is true of my State of Maine. There are 16 states who have already passed this legislation, 20 other States are considering similar legislation. But the fact of the matter is women should not be held hostage by virtue of where they live, to geography, but that is exactly what would happen if we just relied on the States enacting this legislation. But furthermore, that legislation can only address State-regulated plans. So it cannot reach all the Federal plans, ERISA plans, for example, or other group plans. So it is very, very important that we have national standard.

It is not only a matter of fairness. It is a matter of what we must consider the primary objective of this legislation, and that is to reduce unintended pregnancies. Frankly, that is why Senator Reid and I came together, to bridge the chasm between pro-life and pro-choice positions on this very significant challenge in our society today. There are three million unintended pregnancies in America, over half of which result in abortions. What better way than to prevent these unintended pregnancies than through this legislation, giving access to women to the most effective means of birth control?

So that is what it is all about, Madam Chair and Chairman Kennedy, in this legislation. There are numerous ramifications by omitting this kind of coverage in our health insurance policies. We know that, to be sure. When we talk about cost, talk about the cost of unintended pregnancies, the ramifications to a woman's health, to the children's health, to low birth weights and infant mortality, to mention a few, but very significant consequences as a result of unintended pregnancies. Women do not seek prenatal care in many of these instances of unintended pregnancy.

So there are numerous consequences, and then you look at what health insurances provide for. They provide for surgical procedures such as sterilization, tubal ligation, vasectomies; and yet here in this instance, are providing the minimal support for coverage for the most effective means of birth control. It simply is not fair, and it is inequitable. Ask any woman in America, who would not say that reproductive health care is a vital component of overall health care. How do you divorce that issue from overall health care and issues that affect women's health?

So those are the major reasons why we have introduced this legislation. The American people see the common-sense approach to this. That is why they overwhelmingly support requiring health in-

insurance companies to provide this coverage, even if it were to increase the cost of their premiums from one to five dollars. There was a survey that was conducted a couple of years ago which indicated that 73 percent of American people would support that even if it increased premium cost, but we know that there will not be any cost. We have seen that with the extension of that coverage that we were able to provide to Federal employees in the 1998 Treasury-Postal appropriations. In fact, we heard that argument over and over and over again, "It is going to increase the cost of the premiums. It is going to increase the cost of that insurance."

Well, guess what? OPM issued a statement in January of this year that emphatically declared otherwise. It said there was no obstacles to extending this coverage to Federal employees; there were no net increases in the premium costs; there were no increased costs as result of this contraceptive coverage. So that is a plain fact, and we know that, because we know that if you have unintended pregnancies, there are greater costs. There are costs—the pregnancy-related medical costs that can range from \$5,000 to \$9,000, or a premature baby up to \$500,000. So we know that ultimately this legislation is going to reduce costs, not only for the employer, but also for the insurers in America today.

Finally, I might add, Madam Chair, there have been some questions about whether or not we should have a conscience clause, and we were able to draft an appropriate conscience clause in the legislation for Federal employees, and I know that we can do the same in this legislation, as well, to address any concerns for those with respect to being able to opt out because of religious beliefs. So, again, Madam Chair and Chairman Kennedy, I thank you for this opportunity to testify. I hope that we will be able to redress this wrong, so that we can work in what is in the best interest of women and children in America.

Thank you.

Senator MIKULSKI. Thank you very much, Senator Snowe.

[The prepared statement of Senator Snowe may be found in additional material.]

Senator MIKULSKI. Now we would like to turn to our colleague, Harry Reid, who has been a champion of women's health and their safety and security, both here and abroad. He has taken a leadership role in international family planning, and he has also been an outstanding international opponent against the trafficking of women, and in those grim-and-gore surgical procedures that are used against women, in terms of their fertility.

So, Senator Reid, the women in the Senate just think you are one of the Gallahads, and we are very happy to hear from you today.

The CHAIRMAN. We think so, too. [Laughter.]

Senator MIKULSKI. We are so grateful for your advocacy, and we turn to you for your comments today.

Senator REID. Madam Chairman, thank you very much—Senator Kennedy.

First of all, let me express to Senator Snowe what a pleasure it has been to work with her over these 4 years, and we have made progress. I appreciate very much being able to work with you, Olympia. Yesterday, all over America, hundreds of thousands of

people watched people playing football, but if we look at panel number two here, these are the real heroes, people who really affect people's lives, different than somebody kicking a football or throwing a football. Jennifer Erickson, Anita Nelson, Kate Sullivan, Marcia Greenberger, I hope those within the sound of our voices, those that are viewing us, will understand that these are the real heroes. These are going to make a change. These people are attempting to make changes in people's lives that really mean something. I have said many, many times that if men suffered from the same illnesses as women, the medical research community would be much closer to eliminating diseases that strike women.

Senator Mikulski, you remember when I came back and reported to you of a meeting I had in Las Vegas with three women who would rather have been anyplace in the world rather than meeting with me. I was all they had. They were there because they had a disease called interstitial cystitis, a disease that afflicts, at that time, 500,000 women—we think much more than that now. But they had no place else to turn because people told them it was all psychosomatic.

Working with you, we were able to get money in an appropriation bill to start a protocol, and we have made great progress; 40 percent of the women who have this dread disease now get relief through a drug that has been developed. So there is no question in my mind that if we had legislatures in the past that had a fair sprinkling of women, we could have done much better in directing some of our resources toward illnesses like interstitial cystitis and many, many other diseases that afflict women. So thank you for working with me in that regard.

I believe the issue before us today is similar. If men had to pay for contraceptives, I believe the insurance industry would cover them. It was hardly surprising that less than 2 months after Viagra went on the market, it was covered by many, many insurance plans. Birth control pills, which have been of the market since 1960, are covered by less than one-third of these insurance companies. The health care industry has done a poor job of responding to women's health needs. According to a study by the Guttmacher Institute, 49 percent of all large group health care plans do not routinely cover any contraceptive method at all, and only 15 percent cover all five of the most common contraceptive methods. But these same insurance companies routinely cover more expensive services, including sterilizations, tubal ligations, and abortions.

Apparently, insurers do not know what women and their doctors have long known, that contraceptives, as has been indicated by both Senators that are presiding over this meeting today, Senator Snowe—have already said that contraceptives are a crucial part of a woman's health care plans. By helping women plan and space their pregnancies, contraceptive use fosters healthy pregnancy and healthy birth by reducing the incidence of maternal complications, low birth weight and infant mortality.

Madam President, sadly—I should say Madam Chair—financial constraints force many women to forego birth control at all. I was on a talk show shortly after Senator Snowe and I introduced this, and frankly I was being abused pretty much on the radio show about this legislation I introduced: “Why are you doing this? Leave

people to their own choices. Leave people alone.” A woman called in. She was from Texas and she said, “Senator, thank you for doing this.” She said, “I’m pregnant now with my third baby. I did not want to get pregnant.” She said, “I have diabetes, and I have real concern about my health and that of my baby-to-be.” She said, “Why am I pregnant? Because I could not afford to get the contraceptives at work. My husband’s insurance does not cover this. We are living hand-to-mouth.”

Well, this is only one example, one real example. What we are talking about here does not deal only with statistics. It deals with real people with real problems. Financial constraints force many women to forego birth control altogether, leading to 3.6 million unintended pregnancies every year. Senator Snowe has covered very ably that we need to do something about this. We introduced this legislation. All we are asking is equitable treatment. We do not want special treatment. We want fair treatment. Senator Snowe and I first introduced this many years ago, as I have indicated. We have made some progress, as we have already talked about.

Along with Ms. Lowey, whose testimony you have already indicated is going to be part of this record, we have a provision that requires health care plans who participate in the Federal Employees Health Benefits Program, the largest employer-sponsored health plan in the world, to cover FDA-approved prescription contraceptives. The Office of Personnel Management, which administers the program, reported in January, as has already been indicated, this benefit did not raise premiums, since there is no cost increase due to contraceptive coverage. I am sorry to report, Madam Chair, in spite of this, this administration has proposed eliminating this benefit in this budget. This past June, United States District Judge Robert Lasznick handed down a landmark decision, and as Senator Snowe indicated, we are so happy to have Jennifer Erickson here. I was fortunate to be able to meet her.

I can remember the day that I got up and read about this decision. It was much more exciting—using the athletic contest—than any ball game that had occurred in the recent past. This kept our legislation alive, and I was so happy for her going her own way to work on this. Her case builds on momentum from a second ruling this past December by the Equal Employment Opportunity Commission that Senator Snowe has also mentioned.

In that case, EEOC ruled that denial of coverage for female contraceptives, if an employer offers other preventive medicine or services, is sex discrimination under the Civil Rights Act. That is the way it should be. In spite of these important advances, women will not have the contraceptive insurance coverage they deserve until Congress passes this legislation. 16 million Americans obtain health insurance from private insurance, rather than employer-provided plans. Only the enactment of this legislation will ensure that contraceptive coverage is offered by insurance providers. Women who receive their health care through work should not have to take their employers to court. We want to make family planning more accessible. We do not want an explosion in lawsuits. We want fairness.

Equity in prescription contraceptive coverage is long overdue. We have lots of sponsors, as Olympia has noted, on both sides of the

aisle. Senator Snowe and I are committed to moving this legislation. We are looking for the right vehicle. Promoting equity and health insurance coverage for American women, while working to prevent unintended pregnancies and improve women's health care, is the right thing to do. I personally would appreciate, as would men and women—it is not only women. Men need this insurance coverage. We are all looking for this committee to report this bill on the floor so it is there, we have a vehicle that is freestanding, that we do not have to worry about attaching to some appropriation bill, but we will do whatever we have to do to get this passed.

Thank you all very much.

Senator MIKULSKI. Thank you very much, Senators Reid and Snowe, for, one, your leadership on this issue and your testimony.

[The prepared statement of Senator Reid may be found in additional material.]

Senator MIKULSKI. I do not have any questions. We know that you are both pressed for time, in the leadership that you are providing.

Senator Kennedy, would you have any questions?

The CHAIRMAN. Just a quick reaction. I think Senator Reid gave it to us. In the budget, there was a proposal to eliminate the Federal employees coverage, too. So Senator Snowe reference that as something that we have witnessed, this course in action over the recent years, and it has proven to be successful. I imagine you are warning us to be alert as to the possibilities of eliminating that existing coverage, and take the lessons from the Federal employees health insurance and to learn from that experience, which has not resulted in the increased cost, which is the principal opposition element in that, and to make sure that others are going to have it included.

I do not know whether there is anything in addition you wanted to add on how successful it has been in the Federal health insurance proposal. I do not want to delay you.

Senator SNOWE. That, I think, is a good predicate for the reasons why this legislation will not raise premiums. In fact, in reading the OPM letter to health insurers, saying that if you have to make adjustments in the premiums, please do so, as a result of this legislation, and it did not happen. We got a response to our letter to OPM, saying very emphatically that does not lead to increases. So we hope that that coverage will be preserved for Federal employees in the Treasury-Postal appropriations in this go-around, but we also should draw from that that we should be able to establish national legislation without raising health insurance premiums, which I know may be cited later on in the testimony here by others, that somehow that may be a possibility. But I do not see that. In fact, I draw the opposite conclusion from this big study trial with Federal employees, of 9 million people in that pool.

The CHAIRMAN. Thank you very, very much.

Senator REID. If I could just say this, too. Again, Olympia and I like to throw these statistics around, and they are important, but think what it would do to individual families if, after the progress we have made, Federal employees no longer had this benefit. It is a shame. We cannot allow that to happen to Federal employees' families. That is why we not only have to protect Federal employ-

ees' families, but we also have to extend this, because it deals with people, making their lives better, doing away with unintended pregnancies. That is what it is about, 3.6 million. We can do so much good for American families by having this legislation apply to everybody.

Senator SNOWE. In fact, Madam Chair, I would like to ask unanimous consent to include in the record the letter from OPM regarding the effects of extending coverage to Federal employees. I think that would be an important part of the record.

Senator MIKULSKI. Without objection, so ordered.

[The OPM letter follows:]

U.S. OFFICE OF PERSONNEL MANAGEMENT,
WASHINGTON, DC, 20415,
January 16, 2001.

Marcia D. Greenberger,
National Women's Law Center,
Washington, DC, 20036.

Dear Ms. Greenberger:

Thank you for your recent inquiry about the Federal Employees Health Benefits (FEHB) Program and the extent to which it covers contraceptive drugs or devices.

As you may know, the Office of Personnel Management administers the FEHB, ensuring that it provides the roughly nine million Federal employees, retirees, and their family members covered by it with the best possible health care options available. It is the largest employer-sponsored health benefits program in the United States, with approximately 300 health plans participating in it and providing over \$18 billion in health care benefits a year.

In 1999, passage of Public Law 105-277, required FEHB plans to cover the full range of FDA-approved prescriptions and devices for birth control. Implementation of the law occurred smoothly and without incident. Because 1999 premiums had already been set when contraceptive coverage was mandated, the increased coverage had no effect on 1999 premiums. We told health carriers we would adjust 1999 premiums, if needed, during the 2000 premium reconciliation process. However, there was no need to do so since there was no cost increase due to contraceptive coverage.

Please do not hesitate to contact us again if you have additional questions about the Federal Employees Health Benefits Program.

Sincerely,

JANICE R. LACHANCE,
Director.

The CHAIRMAN. Thank you very much.

Senator MIKULSKI. Thank you very much, Senators. I look forward to working with you and moving this to the floor.

Senator MIKULSKI. While our colleagues are leaving, we would like to then invite the witnesses for panel two: Jennifer Erickson, a pharmacist who took this issue to the courts; Dr. Anita Nelson, an OB/GYN representing the American College of OB/GYNs; Kate Sullivan, the director of health care policy from the Chamber of Commerce; and Marcia Greenberger, the co-president of the National Women's Law Center, a long-standing advocate of the legal remedies to discrimination against women. I want to first turn to invite Ms. Erickson to give her testimony.

Ms. Erickson, I know you are from the State of Washington, and your Senator, who is also a dear colleague on this committee, Senator Patty Murray, wanted to introduce you personally. Somewhere she is circling some airport, and who knows? She might parachute in here herself, because she was so eager to do this introduction. But let me just let others know who you are. You are a professionally-trained pharmacist. You work for a pharmaceutical com-

pany named Bartell, and you live in Bellevue, WA. That is kind of the data background. But, also, as we understand it, you took a personal situation where you did not have insurance coverage for prescription contraceptives and were so concerned that you decided to move this as a legal challenge. How like the United States of America. We do turn to our courts and we turn to our legislative bodies to redress the remedies and to come up with balanced solutions. So we would like to hear from you today. We would like to hear what you did, why you did it, and why you think we have got to consider some new legislative frameworks. So, a most cordial welcome.

STATEMENTS OF JENNIFER ERICKSON, PHARMACIST, BARTELL DRUG COMPANY, BELLEVUE, WA; ANITA L. NELSON, M.D., CHIEF OF WOMEN'S HEALTH CARE PROGRAMS, HARBOR-UCLA MEDICAL CENTER, TORRANCE, CA, ON BEHALF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; KATE SULLIVAN, DIRECTOR, HEALTH CARE POLICY, U.S. CHAMBER OF COMMERCE, WASHINGTON, DC; AND MARCIA D. GREENBERGER, CO-PRESIDENT, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, DC

Ms. ERICKSON. Thank you. Madam Chair and members of the committee, thank you for allowing me to testify this afternoon. My name is Jennifer Erickson and I am the class representative for the Erickson versus Bartell Drug Company case. I am pleased to have been invited to testify in support of the Equity in Prescription Insurance and Contraceptive Coverage Act. I consider myself in many ways a typical American woman. My husband, Scott, and I have been married for 2 years. We both have full-time jobs in the Seattle area and are working hard to save money. We recently bought our first house, and we spent a lot of time this summer painting and fixing it up. My husband and I are both looking forward to starting a family. However, we want to be adequately prepared for the financial and emotional challenges of parenting.

Someday, when we feel ready, Scott and I would like to have one or two children, but we know we could not cope with having 12 to 15 children, which is the average number of children women would have during their lives without access to contraception. So I, like millions of other women, need and use safe, effective prescription contraception. Like many Americans, I get my health insurance through my employer. I am a pharmacist for the Bartell Drug Company, which is a retail pharmacy chain in the Seattle area. About 2 years ago, shortly after I started working there, I discovered that the company health plan did not cover contraception. Personally, it was very disappointing for me, since contraception is my most important ongoing health need at this time.

For many women, it may be the only prescription she needs. But it was also troubling to me professionally, as a health care provider. As a pharmacist who serves patients every day, I see on a daily basis that contraceptives are central to women's health. Contraception is one of the most common prescriptions I fill for women. I am often the person who has the difficult job of telling a woman that her insurance plan will not cover contraceptives. It is an unenviable and frustrating position to be in, because the woman is

often upset and disappointed, and I am unable to give her an acceptable explanation. Why? Because there is no acceptable explanation for this shortsighted policy.

All I could say was, "I do not know why it is not covered. My pills are not covered, either, and it does not make any sense to me." Oral contraceptives cost approximately \$30 per month, and I know that I am very fortunate. I have a secure job and a good income, but for many women it is a real financial struggle to pay this cost every month year-in and year-out. My perspective from behind the pharmacy counter gives me a clear picture of the burden this policy places on women, especially the low-income women who are the least-equipped to deal with an unplanned pregnancy. I have seen women leave the pharmacy empty-handed because they cannot afford to pay the full cost of their birth control pills, and that really breaks my heart.

I finally got tired of telling women, "No, this is one prescription your insurance will not cover." So I took the bold step of bringing a lawsuit against my employer to challenge its unfair policy. I did it, not just for me, but for the other women who work at my company who are not so fortunate. I thank Planned Parenthood for their outstanding legal counsel in my case. I am proud that the victory in my case will help the women in my company. The court ordered Bartell to cover all available forms of prescription contraception and all related medical services in our health plan, and I am very pleased that the company recently changed its policy to comply with the court's order.

Despite our victory in Federal court, I know that my case is not enough to help all of the American women who need this essential health care. At this point, my case is directly binding only on Bartell. Nearly every day, one of my customers thanks me for coming forward and congratulates me on winning the case, but many of the women I serve at my pharmacy counter still do not have insurance coverage for the contraception they need. I know that some companies are still choosing to ignore the recent legal developments.

Planned Parenthood has created a web site, covermypills.org, with tools to help women whose employers do not cover contraception. But I also know that Title 7, the anti-discrimination law that my case is based on, does not cover all women, and even more important, women should not have to file Federal court lawsuits to get their basic health care needs covered. So, today, I am speaking for millions of American women who want to time their pregnancies and welcome their children into the world when they are ready. On behalf of the women of this Nation, I urge you to enact this comprehensive legislation because every woman, no matter what State she lives in or where she works, should have fair access to the method of contraception she needs.

Thank you very much.

Senator MIKULSKI. Thank you very much, Ms. Erickson, for your testimony. I know it is not easy to—think about going to court. It is an enormous undertaking. The personal stress, the financial enormity, is really something when you go against your employer, and we are going to come back and ask some more questions about that. What we are going to do is listen to everybody testify and

then come back and ask some questions. I anticipate my colleagues will be joining me. It is Monday afternoon and they are trying to get back to Washington, and I think it is more a problem of airlines and delays, which is a whole other hearing. [Laughter.]

[The prepared statement of Ms. Erickson may be found in additional material.]

Senator MIKULSKI. But I would like now to welcome Dr. Anita Nelson. Dr. Nelson is representing the American College of OB/GYNs. She herself is quite distinguished in that field, a professor at the Department of OB/GYN at the University of California-L.A., and she is also the medical director of the Women's Health Care Clinic at Harbor-UCLA. She, in her career, has focused on contraception, menopause, and gynecologic infection, often being the principal investigator of several NIH research grants, writing articles, professional journals, magazines, the kind of news you can use, and authored books on contraceptive methodologies for women.

We look forward to hearing from Dr. Nelson, and we know you speak not only for yourself, but for your field, and we believe that there are other physicians who have also accompanied you here today; is that right? So why don't you just proceed and share with us your profession expertise?

Dr. NELSON. Thank you, Chairman. Chairman Mikulski and members of the committee, I am Dr. Anita Nelson, as was just identified, testifying on behalf of the American College—

Senator MIKULSKI. Dr. Nelson, pick up that microphone a little bit.

Dr. NELSON. I will pick up that microphone. Is that better?

Senator MIKULSKI. There you go.

Dr. NELSON. I am just too tall. There we go.

Senator MIKULSKI. Dr. Nelson, you can never be too tall. [Laughter.]

Dr. NELSON. —testifying on behalf of the American College of Obstetricians and Gynecologists, an organization representing over 41,000 physicians dedicated to improving women's health care. I am pleased to testify in support of S. 104, the EPICC Act, introduced by Senators Harry Reid and Olympia Snowe. EPICC would remedy a long-standing inequity in insurance coverage, not only by providing coverage for prescription methods of birth control, but also for the counseling that is needed for their effective use.

Inadequate health insurance coverage of prescription birth control remains a glaring medical problem for American women. Contraception is a basic health care need. Non-prescription forms of contraception, such as condoms and spermicide and natural family planning, reduce the risk of pregnancy. But prescription birth control methods are dramatically more effective and allow couples more spontaneity in their lives. Sexual expression is obviously an important part of human experience, or there would not be so much interest in Viagra. Biologically, we know that women are at risk for pregnancy for nearly 40 years of their lives. Without contraception, the average woman could have more than 12 pregnancies, a prospect that is unappealing to most women and would place the health of both the woman and her children at risk.

Unfortunately, for far too many American women, their insurance plans do not cover the cost of their birth control. Almost half

of fee-for-service plans have no coverage of any of the five most common prescription contraceptives. HMOs have a better record, but only four out of 10 routinely cover all five common methods. I have known women who have had to skip their pills for months because their finances were tight. Perfect candidates for IUDs have been unable to pay the up-front costs and have had to settle for less-effective methods.

If a woman cannot afford her birth control pills or an IUD, she certainly cannot afford a pregnancy. The lack of appropriate contraceptive choices is one of the greatest barriers to effective contraceptive use. We will be successful in reducing unintended pregnancy when women can obtain the particular contraceptive that best meets their social, economic and health needs, and when they have full access to contraceptive counseling that teaches them how to effectively use their method.

Allow me to briefly discuss the major public health reasons for ensuring that women have access to contraception. First, contraception prevents unintended pregnancies and abortions. Of all the industrialized nations, this country has the highest rate of unintended pregnancies. Every year, approximately 50 percent of all pregnancies in this country are unintended, and 50 percent of these pregnancies are terminated. Perhaps even more importantly, contraception saves and improves the quality of babies' lives. The National Commission to Prevent Infant Mortality estimated that 10 percent of infant deaths could be prevented if all pregnancies were planned.

Contraception gives women an opportunity to prepare for pregnancy, rather than having it happen to them accidentally. We know that women who take folic acid before they conceive reduce their risk of having neural tube defects in their babies by 50 percent. Diabetic women who change their medications before they become pregnant decrease their babies' risk of a major congenital anomaly from nine percent to less than one percent. Interestingly, women who plan their pregnancies are less likely to smoke or to drink alcohol while they are pregnant.

Another important point is that contraception allows women with serious medical conditions to control their fertility. Pregnancy can be life-threatening to women with serious medical conditions such as heart disease, diabetes, lupus, and high blood pressure. Contraception can help these women prevent pregnancy altogether, or can help them postpone pregnancy until they are healthy enough. Contraception improves maternal health. Family planning is critical to improved maternal health by allowing women to control the number and space the timing of their pregnancies. Women who conceive within 6 months of childbirth increase the risk of pregnancy complications.

Very importantly, contraception is cost-effective. Studies in my own State of California demonstrated that for every dollar invested in family planning, over \$14 is saved. The more effective birth control methods are the most cost-effective. For example, every copper IUD placed saves the health care system and society over \$14,000 within 5 years. However, due to rapid turnover of insured individuals, each individual insurance company will not reap these eco-

conomic benefits until all companies are required to play by the same rules and cover all prescription methods.

Contraceptive coverage is a basic health care need, just as is coverage for diabetes and high blood pressure treatments and vaccinations. Federal legislation is critical. ACOG supports S. 104 and urges the members of this committee to support this important legislation. I thank the Chair and this committee for holding this hearing today and for allowing me the opportunity to testify. S. 104 is important to our Nation's women and their families.

Thank you.

Senator MIKULSKI. Thank you very much, Dr. Nelson.

[The prepared statement of Dr. Nelson may be found in additional material.]

Senator MIKULSKI. Now the committee would like to turn to Kate Sullivan, who is the director of health care policy for the Chamber of Commerce. The Chamber of Commerce represents more than 3 million businesses in the United States. First of all, Ms. Sullivan, we welcome you. I know you feel like you are on the hot seat because everybody is for this bill, and you have some flashing yellow lights about it, and we want to hear this. So, relax. We are not going to treat it like a quiz here. We know you have come with really a great background to the Chamber. You were the director of government programs at a nonprofit health system in Chicago, so you have been right out there in the trenches. You have been a health care adviser for members of Congress, a dear friend like Congresswoman Nancy Johnson, as well as Harris Fawell—that is F-A-W-E-L-L, not Reverend Falwell—and that you worked for Governor Jim Edgar, the Washington State women are really represented here. We know that you have an undergraduate degree from Georgetown and a masters of health administration from GW. So let's hear your views on this legislation.

Ms. SULLIVAN. Thank you very much, Madam Chairwoman. I do appreciate the opportunity to provide the perspective of employers who are voluntarily providing health coverage to more than 172 million Americans. Employers do so because having a healthy workforce is essential to productivity, and most Americans would be unable to afford or even access a health plan if they did not have one through their jobs.

Unfortunately, the affordability of this coverage is quickly evaporating. Last week's report that job-based health coverage has increased at the greatest rate in nearly a decade should really be a wake-up call to the Congress. Small employers are once again the hardest hit, reporting health plan inflation rates of 16.5 percent on average. For employers of all sizes, health plan costs are now more than \$2,600 a year for single coverage, and more than \$7,000 a year for family coverage. Given the anemic economy, employers can no longer keep up with the rising cost of their health plans. Employees are making bigger monthly premiums, paying larger copayments for doctors and prescription drugs, and contributing more toward their deductibles and coinsurance. 75 percent of large employers expect to further increase employee costs next year. The result is that more employees are turning down their employer's offer of coverage.

One out of four employees who declines workplace coverage is uninsured, and when asked, they frequently State that it was just too costly to participate. Further increasing the cost of health coverage by imposing mandates of any kind, not just this mandate, really does jeopardize the continued availability of plans for both employers and working families. So while some women may gain under S. 104 coverage for their contraceptive needs, other women may lose their coverage entirely and remain uninsured, not only for predictable, comparatively nominal health care services, but also when they are accidentally injured, require surgery or experience a major illness.

Government mandates also stifle health plans' efforts to provide consumers with a variety of choices and the ability to select the benefits most appropriate for their personal situations. Mandated contraceptive coverage is not the only government mandate the Senate is considering this year. Last month, this committee approved a broad expansion of the current mental health parity mandate. At the end of June, the full Senate passed managed care reform legislation replete with numerous mandates, and now this committee is prepared to further increase health plan cost.

In addition to cost, S. 104 presents other problems for employers. The bill prohibits plans from conducting quality reviews to ensure various forms of contraception are being prescribed safely and appropriately. Plans also face greater risk from medical malpractice—

Senator MIKULSKI. Could you repeat that sentence?

Ms. SULLIVAN. The bill prohibits—there is a specific prohibition in the bill that prohibits plans from conducting quality reviews, which often are used to make sure that plans or providers are prescribing contraception appropriately for a particular patient.

Senator MIKULSKI. I will come back to that as a question. Please continue, Ms. Sullivan.

Ms. SULLIVAN. The plans also face greater risk from medical malpractice by being required to cover contraceptive services ordered by any provider without regard to training or medical expertise. The Chamber understands and appreciates the sponsors' good intentions with this bill, and many a well-intentioned public policy has had unintended consequences. We believe the Congress is tackling the wrong issue. One out of six people in this country are uninsured. Women already face barriers in accessing affordable health coverage because of their work and income status. A Commonwealth Fund study last month reported that younger women are far more likely to be uninsured than older women.

Not only do uninsured women not have contraceptive coverage, they are uninsured in the event of childbirth, a trip to the emergency room, or a diagnosis of cancer. Bit by bit, mandate on top of regulation, on top of more liability, lawmakers threatened the health and economic security of hard-working Americans of both sexes. Rather than enrich the benefits that some already have, Congress needs to reign in its penchant for mandates. It should halt duplicative regulations that raise health system costs. Most importantly, it should act immediately to create new options for private health coverage and new ways to pay for it.

Thank you.

Senator MIKULSKI. Thank you very much, Ms. Sullivan. We appreciate those views and are going to come back to them, those particularly regarding to quality and who prescribes, because as Dr. Nelson said, the counseling and the appropriate method, and, in fact, if any method at all. So, thank you. Actually, you brought up something I did not know about the bill. I appreciate that.

[The prepared statement of Ms. Sullivan may be found in additional material.]

Senator MIKULSKI. Let's turn to Marcia Greenberger now. She is the founder and co-president of the National Women's Law Center. She is an expert on women and the law, fighting for women's rights in employment, health and education for three decades, written many articles on legal issues, participated in key legislative initiatives and litigation, both Federal and State, to advance the cause of women and their families, and has often appeared on various talk shows to say in plain English, without a lot of footnotes and annotations, really the impact sometimes on the law, either for us or against us, but most of all has been a very strong advocate of keeping the courthouse door open to address those grievances so Ms. Erickson could go to court; a graduate of Georgetown Law and a member of the American Bar and many other prominent bars. We welcome you and look forward to your testimony.

Ms. GREENBERGER. Thank you very much, Madam Chair Mikulski. It is a particular pleasure and honor to have the chance to testify before you and this committee. You have been such a leader on women's health. There are countless protections that women of this country and their families now have because of your leadership, and we are very grateful for all that you have accomplished on our behalf, and are especially grateful, too, for your interest in this most important topic that is the subject of the hearing this afternoon.

I would ask that my full statement, with attachments, be included the record, and just say that I actually am a graduate of the University of Pennsylvania Law School. So they have to take me with my accomplishments and my problems, although I am part of a program at Georgetown Law Center.

Senator MIKULSKI. That is where I got off-track.

Ms. GREENBERGER. Yes. So I am proud that I have a connection there, as well. The National Women's Law Center began almost 30 years ago, and as you said, we have been involved in major legal and public policy initiatives to improve the lives of women and their families ever since. So it comes as no surprise that the center's involvement in pregnancy-related discrimination, which is really at the heart of this issue, dates back to our beginning in 1972, and we were also involved, not only in litigation on the issue, but the Pregnancy Discrimination Act of 1978, because it took congressional action to get maternity coverage in health insurance plans covered by employers.

I know that the Chamber of Commerce is opposed to mandates, generally. They were opposed to the Pregnancy Discrimination Act at that point, as well as they are opposed now. But sometimes, unfortunately, mandates are the only way that justice can be served and the ends of fairness can be secured. I believe that that is the case right now. We were honored to be a part and working on the

Erickson case, and had filed a petition with the Equal Employment Opportunity Commission on behalf of 60 organizations, and ultimately the EEOC did, as has been said, find that it is a violation of that Pregnancy Discrimination Act and Title 7 to exclude comprehensive coverage otherwise from employer-provided health insurance plans.

We have taken those legal victories and actually been successful in helping a number of women since who have approach their employers and asked for coverage, and we have a web site, nwlc.org/pillforus, because we care so much about helping women and their families around the country get this essential coverage, as has been described by the other panelists. I want to just add two points very quickly before I turn to the EPICC legislation that we have been talking about. One is there has been a discussion about the importance of protecting women's health and the vital role that contraception plays.

It is essential. We are, in fact, 21st in the world on maternal mortality, not a record that the United States should be proud of, and clearly our record on infant mortality is a record that needs major improvement, as well. It is far past the time when contraceptives and better maternity and health care coverage for women is needed, and we see extended health care coverage, as Ms. Sullivan said, as essential. We know you do, Senator Mikulski, and have dedicated a career to working toward that end. But we also have to be sure, not only that women and their families have insurance, but the insurance they have covers their core health care needs, like contraception.

Now let me turn for a minute to talk about why EPICC is so important, even with some of these victories in the courts and with the EEOC now on our side with Title 7. These laws and also the State laws where they exist—but these Federal laws deal with employer-provided insurance plans that provide prescription drug coverage if an employer is covered by Title 7 and the Pregnancy Discrimination Act, a law that prohibits discrimination in employment and protects women.

Well, employers are only covered if they employ 15 or more employees. Of course, for those employers who do not provide insurance coverage at all, individuals must go to other group plans or buy individual insurance in order to secure health insurance coverage. So millions of women receive their insurance from a source not covered by Title 7. 16 million Americans obtain health insurance from private insurance other than employer-provided plans, people who are self-employed, employed by employers who offer no health insurance, as I said, part-time, temporary, and contract workers, others.

Women are disproportionately represented in a number of these categories, especially part-time, temporary, and contract workers. Moreover, since only those employers with 15 or more employees are covered by Title 7, that leaves out 14 million workers who are employed by entities that fall beneath this threshold. We know from unfortunate experience with maternity coverage after the passage of the Pregnancy Discrimination Act of 1978, that legislation like EPICC is essential to provide protection for those women. Just as is true with contraceptive coverage, before 1978, when Congress

stepped in, it was common for insurance companies to exclude maternity coverage from their plans; basic prenatal delivery services were not in their standard policies.

Now, in looking at what has happened over 20 years later, we see it is commonly covered now in employer-provided plans, but because there is no legal mandate to do so, insurers do not always include this in their standard benefits package. In fact, in some studies cited in my written testimony, we see this is a serious problem for women having to buy their own health insurance even today. In short, the contraceptive coverage problem will not take care of itself, unfortunately, without congressional action.

Finally, I want to respond to a couple of the points that Ms. Sullivan raised. First of all, most of her testimony was based on the premise that this legislation would add to the cost of insurance. The other witnesses described in some detail why that premise is actually faulty. By covering contraceptives, employers will reduce their costs. We saw with the Federal Government no costs were incurred, no budgetary cost, no premium cost, and there have been a series of employer-provided studies that have actually shown—a Mercer study in 1998—that employers would save money, not cost money, if they covered contraceptives.

A study by Gardner and Strader in 1996, that an employer saved 11 percent of its cost in just 1 year after covering contraception. The Washington Business Group did a study in 2000 that talked about what the average cost savings would be; 17 percent of all cost, 14 percent of direct costs would be saved. These cost savings are estimates from business studies, as well as the Federal Government's actual experience.

My last point has to do with what I believe is Ms. Sullivan's misreading of EPICC, that it would interfere in any way with quality reviews or with the ability of insurers to deal with who prescribes. It simply puts those decisions on the same footing as any other decisions that insurance companies make. It protects against having more stringent requirements, but it allows the insurers and the employers to have the same requirements that they would have for any other provider requirements or quality insurance requirements. So I think that was a misreading and should not cause a problem.

So, as a bottom line, this is a piece of legislation that makes bottom-line sense, dollars-and-sense sense, common sense, and sense in terms of human costs that can be so devastating as a result of unintended pregnancy. I will add one final point, that for some employers and some insurance companies, their exclusion of contraception is so extreme that they will even exclude it when it is being prescribed, not to prevent pregnancy, but to deal with other health conditions, dysmenorrhea or other health conditions. Clearly, it takes Federal legislative action to set this problem straight.

Thank you.

Senator MIKULSKI. Thank you very much, Ms. Greenberger.

[The prepared statement of Ms. Greenberger may be found in additional material.]

Senator MIKULSKI. First, I want to note that our colleague, Senator Patty Murray, has landed. I am going to ask questions for

about five minutes and then turn it over to Senator Murray for a statement or whatever.

Senator Murray, you should know, though, you have one current constituent from the State of Washington here, Ms. Erickson, but also Ms. Sullivan is from the State of Washington and actually worked in a community—aren't you from the State of Washington?

Ms. SULLIVAN. I had worked for the Governor, in Chicago. I have a sister on Mercer Island, though, who voted for you and is a big fan. [Laughter.]

Senator MIKULSKI. Also, I want to note that Senator Jeffords, our colleague, has a statement for the record, and we ask unanimous consent that it be included, and it is so ordered.

[The prepared statement of Senator Jeffords follows:]

PREPARED STATEMENT OF SENATOR JEFFORDS

Madam Chairwoman, I am pleased that the full Committee is having this hearing today to discuss the issue of contraceptive insurance coverage. This is especially true given the June decision of a Federal District Court in Washington on this issue. The Court ruled that an employer's failure to cover prescription contraceptives in its otherwise comprehensive prescription drug plan constitutes gender discrimination in violation of Title VI I of the Civil Rights Act of 1964.

As we in Congress have closely examined health insurance coverage, we have seen a growing disparity between men and women. Out-of-pocket health care expenses for women are 68 percent higher than those for men, and most of the difference is due to non-covered reproductive health care. The vast majority of private insurers cover prescription drugs, but many exclude coverage for prescription contraceptives. Most plans do cover abortion and sterilization, but will not provide coverage for reversible contraception. This is an issue that the Congress should and must address.

I am proud to be a cosponsor of S. 104, the Equity in Prescription Insurance and Contraceptive Coverage Act, and am pleased that the sponsors of this important legislation are here with us today. This legislation requires a health insurance plan that provides benefits for Food and Drug Administration (FDA) approved prescription drugs or devices, must also provide benefits for FDA-approved prescription contraceptive drugs or devices. Furthermore, it requires that if a plan covers benefits for other outpatient services provided by a health care professional, it must also cover outpatient contraceptive services.

Thank you again for holding this hearing. I look forward to continuing to work with you and our other colleagues on this important issue.

Senator MIKULSKI. Also, again, our colleagues, I know, are facing these airline situations. For any of our colleagues who wish statements either for or against the legislation, the record will be open for another 2 days to ensure that their statements will be included. The other is—I know Ms. Greenberg challenged you, Ms. Sullivan, and we will give you a chance to respond. One of the things we are going to do with the hearing, though, because the women of the Senate, on a bipartisan basis, are really working hard for what we call the Civility Zone. So we are not going to run it like "Hardball."

We are not going to run it like “Softball,” either. But we will give you a chance, because there are issues related to cost I know you want to comment on, and then we can proceed.

But let me turn first to Ms. Erickson. A young woman, starting her career, her marriage—going to court is an enormous undertaking. First of all, the motivation to go to court, the time that it will take, the money, and then also you were not just suing. You were suing your employer. That obviously required tremendous motivation on your part. Could you tell us what was what you encountered in your day-to-day activity as a professional that so motivated you to take such a very, very big step, and to take it all the way up to the U.S. Supreme Court?

Ms. ERICKSON. Thank you. I just want to say hi to Senator Murray, so I am glad that you are here today.

Well, I guess I was just tired of being yelled at all day long by women. So there are so many women customers that I have that were angry about the fact that their prescription contraception was not covered, and as far as the women that I work with at Bartell Drugs, too, were also upset. The position that I had—I am currently pharmacy manager, and it seemed like I was the only one that was in a position to do anything about this. So I did write a letter to my company. I never imagined that I would have to go as far as making a lawsuit. I thought it would not be that hard to change their policy. But here I am, and they have changed it. Unfortunately, it is not enough. We did have a recent insurance commissioner hearing in Washington State, and there are still a lot of companies in Washington that feel that, “Well, this case is up for appeal, it may not hold. Who knows what is going to happen?” So they do not really feel like they should change their policy yet, and I really thought it was important for me to be here today because of this fact, because there are so many States that still do not have laws that mandate—

Senator MIKULSKI. 34 of them.

Ms. ERICKSON. Yes—mandate laws that cover prescriptions. So that is why I am here, and I feel very strongly about it. I still have women that come into my pharmacy all the time, and they are so happy that someone has done something about it.

Senator MIKULSKI. But, Ms. Erickson, first, if I could, when you went to your employer—I am using you both literally—not using you, but for witness purposes, not only you, but you metaphorically, again—you are a trained health care provider. You are part of the team. When you wrote your letter and tried to go up the chain of command, if you will, at a retail pharmacy, what were the obstacles that you ran into, and why did they say no and continually rebuff you? What was the rationale? What exactly did you encounter, both from a climate standpoint and a content standpoint?

Ms. ERICKSON. Well, when I wrote the letter about a year-and-a-half ago to their human resource department and asked for them to change their policy, their response was just that, “We do not feel that it should be covered at this time,” and it really was not any more than that. The answers that I got from people were, “We just do not feel like it should be part of our policy. It is too expensive. It is going to add cost,” all that kind of thing.

Of course, from the testimony that was heard today, it does not add cost. It saves cost. That was pretty much the response I had from my employer.

Senator MIKULSKI. Well, let me then turn to Dr. Nelson.

Dr. NELSON, we are going to get into cost and so on, but cost/benefit is always not as precise as people think. I want to go back, not to your research or your academic positions, but do you continue to see women in clinical practice?

Dr. NELSON. All the time.

Chairman Dodd. We heard, essentially, how cheap contraceptives are. In your clinical practice, \$30 a month—I am going to be the devil's advocate here—because you know my advocacy for the legislation. What do you hear in your practice about this? Why is it that women cannot afford this? \$30 is less than going to McDonald's once a week, over the course of a month. What is the big deal here?

Dr. NELSON. Because it is a big deal; 30 bucks is 30 bucks, and I work in indigent health care, and for a lot of women, that is a week's worth of food. Ironically, many indigent women are covered by Title 10, pharmacies and programs like that, so we have that. But I have a lot of patients who I see who are working poor, who are working at McDonald's and maybe they can pick up a hamburger there, but they certainly cannot pick up their contraception. So helping them control their fertility is desperately important.

It is not just 30 bucks. It is 30 bucks a month, and that adds up to a lot of money over a year. It is also the IUD up-front cost may look very big, although if you amortize it over the 5 years, she still has to come up with the dollars. I have had patients who could not get their Norplant out because their insurance company did not put it in, so they did not think they needed to take it out. So this whole issue of women being able to control their fertility, either by preventing pregnancy or by enabling it by the removal, is very important to equity and to women's rights overall.

I would like to underscore, if I could, this other issue that was raised. I have patients who are using forms of birth control pills in menopause. There is a birth control pill we use in breast-feeding women that works very nicely to balance the estrogen for menopausal women, and they cannot get that prescription unless I indicate on there that it is not for contraception, and then I still have to write little letters to try to support that. So anything that could possibly be used for contraception will not be covered unless there are three, four or five stars on there, proving that it is not going to be used for contraception, which is a curious position.

Senator MIKULSKI. Well, let me even go farther then. As you know, there are over-the-counter methods for birth control, and spermicides, condoms, etc. Why, if you do not have a lot of money—why can't you just go over-the-counter?

Dr. NELSON. Well, for one thing, it depends upon how often you are having sex. If it is only a dollar an episode, it depends on how many episodes. That could easily be \$30 a month, too. Then you have to put in the issue of they do not work as well, and you are running a bigger risk for pregnancy. The average failure rate for condoms, if women use condoms for a year, an average of 12 out of every 100 women will get pregnant. If you use spermicides alone, just for 6 months, 26 women out of 100 will get pregnant. So there

are huge pregnancy-related costs that do not appear on the up-front cost that we have to factor in when we are figuring the cost-effectiveness of methods of birth control.

Senator MIKULSKI. This will be my last question for this round, because my time is up, and I will turn to Senator Murray. You talked about the counseling, and I know one of the issues Ms. Sullivan raised was the appropriateness of the prescription, if a prescription is appropriate at all. Could you elaborate on what you find? There are those who, for example, some of my providers, and someone who has said, "Senator Mikulski, you would be surprised how little, often, young women know about themselves;" that, second, even when they have been married—and they do not know about themselves, they do not know about their bodies; they do not know if they have had other kinds of medical conditions where one needs to really monitor for preparation for pregnancy and so on.

Could you share with us what the counseling means? Is the counseling about how to practice better birth control, or is the counseling more than that, and is actually a form of primary care? Could you elaborate on that?

Dr. NELSON. Certainly. Contraception will not work unless women know how to use it. To know how to use it, you need to know how your body works. I certainly underscore—in my experience, I was just talking to a group of mothers, adolescent mothers, who told me that they had learned—of course, from their peer groups—that the best method of birth control was to drink a lot of orange soda right after sex. Looking around the room at all the mothers that were there, clearly orange soda was not working. The myths that are out there—it is so important for women to know, yes, how it is that their bodies work so that they can make their method of birth control work, and to know how important it is to plan the conception of their children, not just the delivery, but to know how they need to be in good health. This whole reproductive health counseling is what we are hoping for from this bill for all women.

Senator MIKULSKI. Thank you very much, Dr. Nelson. We will be turning to others for questions.

Senator Murray, our dynamo Senator.

Senator MURRAY. Thank you, Madam Chairman, and really thank you for having this hearing on, I think, a really important issue facing women and men across this country. I really appreciate your having this and I appreciate your holding it until I got here, my flight got in.

Ms. Erickson, I just have to tell you it is great to have you here in the other Washington to share your story with so many others. You really are a hero at home, where you took on an issue that was not easy to take on, including your own employer, including a lot of issues surrounding it, and it took a lot of courage, I know, to do that. But you have made a tremendous difference in the lives of many women in my home State of Washington, and now have the opportunity to do that nationwide, and all of us owe you a great debt of gratitude.

You have not only changed some insurance policies—have the opportunity to change more insurance policies—but I think really have raised an awareness issue about this that was not there be-

fore you took this to court. We always find that you make a difference when you educate people, and so there are a lot of people out there now who have been educated about an important issue, a women's health care issue that they either did not want to think or did not want to go into before. You have made it okay to talk about, and I really want to thank you for that. I think that took a lot of courage, but you have made a difference, and thank you very much from the bottom of my heart, and I know from many of our constituents out in Washington State and across the country.

It took a lot of courage to do this. Did you think a lot about it, or was it just a matter of you were mad and you wanted to do something about it?

Ms. ERICKSON. Like I said, I never thought I would have to file a lawsuit. So as far as—we went through a whole process. We went through the EEOC and this was kind of the next step, but it just seemed like there were so many people who were supporting it, that were supporting me. People I worked with were very supportive. Customers were very supportive. So there were definitely times when it was hard, but just the support of the people I worked with was really helpful.

Senator MURRAY. Has there been any backlash from your employer?

Ms. ERICKSON. No. Bartell Drugs is a great company to work for and I really enjoy working for them. As far as any backlash, no, there has not been any.

Senator MURRAY. Have you heard a lot from women who now come into you to thank you for what you did?

Ms. ERICKSON. Yes, it has been a little weird sometimes, but it has been great. It has been great to have people come and say because of your case—I never would have written a letter to my employer, I never would have done this without someone else doing it. People said I always was mad about it, but I never did anything about it until you did something about it. It is kind of like that bandwagon, especially when you mentioned raising awareness. I remember last summer when we filed the case, there were so many people that said they never knew this was an issue or never knew this was important. And now because of the case, because of the publicity, people are much more aware of it and saying yes, it should be covered.

Senator MURRAY. You are a folk hero and we all appreciate it very much and look forward to continuing to make a difference building on what you have been able to accomplish. Thank you very much.

Ms. ERICKSON. Thank you.

Senator MURRAY. Dr. Nelson, often we hear that moral arguments or the religious arguments are surrounding this, but, to me, this is really a women's health care issue. You started to talk about it a little bit in your response to Senator Mikulski a minute ago, but can you describe for the committee and for our record why it is a women's health care issue, in particular, having equal access to contraceptives?

Dr. NELSON. In basic biology 100 percent of pregnancies occur to women, and the complications of the pregnancy on the woman's health, the complications of the pregnancy outcome, making sure

that women have contraception, so they can plan for pregnancy and most importantly prepare for it—to make sure that they are taking the iron and vitamins, that their nutrition is appropriate, that they had been screened for all the infections that they might inadvertently pass on to the baby when they are pregnant, before they become pregnant. Waiting for accidental pregnancy and catching up with early prenatal care is not enough in the year 2001. We need to make sure that women are prepared for pregnancy, and the way to do that is with effective contraception, and the way to make sure every woman has it, is making sure she has the coverage for it.

Senator MURRAY. There are some women, who because of health care conditions, cannot become pregnant or it is a serious impact to their own health. You mentioned just a minute ago in response to a question that you had to specify that contraception was because of another health care. Did that make a difference? Do some insurance companies provide coverage under those—or are there insurance companies that preclude anyone from covering contraception, even if it has something to do with someone's health care other than becoming pregnant?

Dr. NELSON. I have not personally had that as an issue, but I have heard reports in other States. I come from California, and we have now the Contraceptive Equity Act. But there are still some women who are not covered by that because of the other programs—

Senator MURRAY. Even if it could be a serious consequence to them, say they are a diabetic or have another health care problem; it may not be covered if—

Dr. NELSON. Unless I justify that it is not related to contraception, which leaves you the issue what about the contraception? In the bad old days in California, we still have that as an issue.

Ms. GREENBERGER. Senator Murray, I know outside of California the EEOC dealt, for example, in one of its opinions, with an employer who would not cover the cost of contraceptives, even though it was not being prescribed to avoid pregnancy, but to deal with a health condition of a woman unrelated related to that. So we know, as a matter of fact, that for a number of plans and employers, their exclusion of contraception goes to such extremes that it does not even cover the cost of the contraceptive when being prescribed for a nonpregnancy-related condition.

Senator MURRAY. We have heard some of the economic arguments, which just goes to the reason not to do this is it may cost money, and Ms. Sullivan, I am sorry I missed your testimony, but I assume you went somewhere around that in your testimony. I am curious, when insurance companies make decisions like this, is it based totally on economics? Is this going to cost us too much?

Ms. SULLIVAN. Well, I am here representing employers, not insurance companies, and employers really do feel like they are sort of at the mercy of what insurance companies are telling them what this year or this quarter's premium is going to be. I think that the issue here is—that it really depends—when an insurance company prices insurance for a group, it really depends on what that plan is already covering and what the group looks like. Is there a very high potential that many women would avail themselves of this benefit? If so, the cost for you is going to be that much higher.

Others have cited the FEHBP impact. Many of those plans are already covering at least some form of contraception. I can remember in 1987 being a very low-paid first-year Hill staffer in the House, that the largest plan at the time did not cover contraception or even routine visits to the doctor, and it actually did take a note in order to have it covered for an unrelated condition. Health plans have changed. They are evolving. Many employers do offer a choice of plans, which is hard, so you cannot do it if you are a small business, and small businesses frequently offer a managed care plan because it provides access to so many of these very popular, highly-demanded benefits like preventive health care and greater access to coverage. The more traditional health plans, usually this covers sort of the major medical, those things that you cannot plan for, the really unexpected cases, and often they provide employees the ability to save for these routine, expected, predicted expenditures through a payroll deduction on a tax-free basis, and the money is made available to them on January 1st or the first day of that plan year.

It is a trade-off, and to the extent that we want all plans to look more like HMO plans because they provide a lot of preventive health services up front, but we want them to have the freedom and no restrictions of indemnity plans, those plans are going to start getting really expensive, and our concern is that more people will not be able to continue to afford to participate in their health plans offered at work.

Senator MURRAY. Ms. Greenberger, you talked a little bit about the economic analysis and what you have looked at. What is the economic analysis in terms of what it will cost insurance companies to provide it, and the cost of not providing this kind of coverage?

Ms. GREENBERGER. Well, there have been several studies done actually by employer-based groups that have come to the exact opposite conclusion from Ms. Sullivan, and, in fact, have determined that it will save employers money if they cover contraceptives. So because it is not just a question of the cost of the contraceptive, per se, and those estimates have been about \$1.43 a month. I saw another one, \$1.43, \$1.42 a month; not a very big cost alone. But you balance that against the savings in maternity coverage, in newborn coverage. It can be, in a Mercer study, \$61,000 for prenatal care for a complicated delivery of a newborn. Newborn care can cost from \$2 to \$20,000. There is absenteeism related to pregnancy and unintended pregnancy, loss of productivity, stronger employee morale.

So an employer's cost has to take all of those considerations into account, and that is why each of these studies has found, when you add them all up, there is actually a substantial savings of money to employers. As I mentioned, there was a study of a particular employer who, in just the first year alone, saved 11 percent of costs. The Washington Business Group just last year found that it would lead to a 17 percent savings in cost, all costs, if contraceptives were included, and 14 percent just in direct health insurance cost if contraceptives were included; and that, of course, does not even speak to the cost of women and their families in having the kind of health conditions and unintended pregnancy consequences that not only affect their health, but also their future earnings potential.

There are newspaper stories, unfortunately too much in the news over the last few weeks, about pregnancy discrimination, women being told that they cannot be hired or they cannot go to school if they are pregnant. We see women who have to pay and earn salaries to help support themselves and their families, and it is devastating for these women, just as a human matter, to have to deal with the cost, the human cost as well as the out-of-pocket cost.

While it is fair to look at cost and to be serious in assessing what those costs would be, we see here it is not just a question of cost savings, but as we talked about before, it is so unfair to think and so discriminatory to think that the major FDA-approved contraceptives that are routinely excluded from health insurance plans are contraceptives, and that is plain and simple sex discrimination. We have a principle in this country that cost is not a defense to discrimination. It is not a defense to paying women less, that it will cost employers more to give them equal pay, even though we know employers have sometimes complained about having to give women equal pay. This is really a form of equal pay. This is their compensation. This is part of what they are working for, health insurance benefits, and they deserve the same value from their health insurance plans as their male colleagues have, as well.

Senator MURRAY. I see my time has expired, but I again appreciate all of you coming and testifying on this.

Ms. Erickson, especially to you again, thank you for traveling all the way across the country, and I look forward to working with you as we continue forward.

Madam Chairman, thank you for your leadership on this issue. I look forward to building on what we have done in Washington State across the country.

Senator MIKULSKI. Good. My State is one of the ones that has the law already. [Laughter.]

Let me come back to you, Ms. Sullivan, for a minute. You raised some issues related to quality assurance, etc. Could you restate what you said in your testimony about what the legislation prohibits and your concern about that, please, around quality assurances?

Ms. SULLIVAN. Right. My fellow witness over here said it may be a simple misreading of the bill, and we frequently take care of these things by working to clarify that truly the intent of the bill is actually the way this is spelled out.

Senator MIKULSKI. Sure. We do not see it as—

Ms. SULLIVAN. We certainly want to make sure that because employers are responsible for the health plans—we know that they can be held liable for what those plans do for the networks that are put together—we want to make sure that plans can do the quality review to make sure that contraceptive devices are being prescribed appropriately to someone that would not be considered to be at risk, and that the proper professionals with the right training are the ones who are prescribing these.

Senator MIKULSKI. Well, I would like to instruct the Senate staff working on this, both majority and minority, to meet and discuss this with you and perhaps Ms. Greenberger, to be sure of this, because if we are going to do legislation, we want quality assurance, as well. It is in the interest, not only of the employer, to get value

for their premium, but after working this hard to accomplish the legislative objectives, we, too, believe in quality assurance, though I believe that one of the best cost savings, ultimately, as well as quality assurance, is an item in the Patient's Bill of Rights that would say that access to an OB/GYN for a woman is equated with access to a primary care physician, exactly what we said.

Many of these young women have undetected situations. It could be the beginning of Type II diabetes. We see that now with the weight gains in younger children. You see that. Also, they embark on what they are ready to be embarked upon, both physically and emotionally. So I feel that this is really a significant issue, to give access to the OB/GYN and others within the team, because I am sure you work very closely with the nurse midwifery position. But did you want to comment on that, Dr. Nelson?

Dr. NELSON. I very much appreciate what you just said, but as we are reviewing those finesse points of the legislation, again, according to the support that we had for the Patient's Bill of Rights, to make sure that the health plans are out of the business of second-guessing the physicians in terms of who is the appropriate candidate for an IUD or for birth control pills; that that really ought to be, as much as possible, a decision between the woman and her physician.

The scope of practice within each of the State laws will dictate who can give contraception. I am not thinking that podiatrists are going to try to put in IUDs. That is going to be well taken care of within existing frames; so that as we are talking about quality assurance, certainly that must be done, but not within the intrusions.

Senator MIKULSKI. I will tell you, when we embarked upon mammogram quality standards, we had people doing mammograms using x-ray equipment, the x-ray technicians were not prepared. But let me come back to Ms. Sullivan.

Ms. Sullivan, actually I think we all need to be clear. Ms. Sullivan is representing employers. She is not an insurance company, and I think we have to acknowledge that for our employers, they are caught in the middle between the people who work for them and their needs, and an American health care system that is not a comrade care system, but based on private insurance, Medicare and Medicaid; that is our triad. So it is the needs of the employee and then the escalating cost of private insurance. So what the Chamber is saying is that they are worried about the cost in order to meet their responsibilities.

Is this kind of where we are heading in this?

Ms. SULLIVAN. I just want—and I emphasized this in my oral remarks, as well. It is not just this requirement. Perhaps this will have no cost, depending on what your plan covers now and who is enrolled in your plan. If you are a very large business, such as those who typically belong to the Washington Business Group on Health or who use William Mercer for their consulting services, they tend to be able to absorb cost much more readily, and, in fact, studies like that are very beneficial to employers of all kinds, because they show that while there may be some initial up-front costs here, it is how it will benefit you in the long run.

We do not support a mental health parity mandate, but we do encourage employers to find out how it is that productivity can be

enhanced through the better use of SSRIs to treat depression. It really does come down to cost. It is not just this one. It is not just mental health parity. It is not just the ones that are in the Patient's Bill of Rights. It is sort of all this rising factor that employers are redesigning their health plans to cover more benefits, to give their employees more choice, more access to a broad range of providers. States have been passing a lot of these mandates, and employers have been complying with them when they offer those insured health plans. We have seen the cost of those insured health plans rise at a rate far greater than employers who self-insure, and that is the result of those mandates, those requirements.

Putting all that aside, though, probably the biggest cost driver in health coverage right now is prescription drugs, and Ms. Erickson certainly knows this. Employers have been redesigning their health plans to raise those co-payments when they get those prescription drugs filled. Some have gone from a flat dollar amount to sharing in a percentage of the cost of the drugs. Some of them have increased their co-payments to \$30 per prescription, and at that point, you will have taken away any of the economic effects to the consumer that would be put forth under this bill, or force more employers to go—

Senator MIKULSKI. That is exactly right, and we know that the whole cost of prescription drugs and how to meet our social responsibility will be the subject, also, of what to do in the area of Medicare. That is why I said at the opening of the hearing that women really pay a gender tax, not only on the pay issue, in which gains are being made, not only in the fact that we are penalized in Social Security because of our time out for child-bearing and child-rearing, and this particular issue. Then, when you get old and you are on Medicare, you tend to be the survivor again, and you are paying for prescription drugs there.

We have done a very good job in reducing the marriage penalty. Now I think we have got to really take a look at how to reduce the gender tax and, at the same time, acknowledge that there are other costs. I will tell you a fact that was so disturbing for me—and, Dr. Nelson, I would like your viewpoint on this—that 50 percent of the pregnancies in the United States are unwanted. That is a pretty big number, and of that 50 percent, 25 percent end in abortion.

Dr. NELSON. It is 50 percent of the unwanted pregnancies, unintended; so it is 25 percent overall.

Senator MIKULSKI. Then the other 50 percent are initially unwanted. I know very few people, when the baby is born—of course, adoption is an option—but that often it is not only the unintended, it is the unprepared. It is the low birth weight. It is the premature baby, the significant cost of the dazzling breakthroughs we now have in neonatal care, and it is marvelous what we do, but it is expensive. I think we ought to spend the money. But could you share with us really what you see, both in your practice and in your work with the American College? This issue of abortion because of unintended is really troubling. What is the view from the clinical side here?

Dr. NELSON. I think every one of us would like women to be totally prepared for pregnancy and plan for pregnancy. That is our goal, our image of where we want to be in this century for women.

To let pregnancy happen by accident, whether it is acceptable or unwanted, is really from a medical standpoint unacceptable today, because it encourages so much risk. We know that we get better babies and healthier mothers and better families if women are prepared, not only from a financial and an emotional standpoint, but just from a pure medical standpoint.

Why not get the pap smear on that lady before she gets pregnant so we can treat her cervical dysplasia before she gets pregnant? Why not make sure she does not have chlamydia before the baby catches it, or she has some other infection? That is our goal, and we do not there unless we have access to contraception for women. It is a very important medical issue, as well as the other issues that we have talked about in terms of equity for women and fairness and opportunity.

Senator MIKULSKI. Well, Senator Murray, did you have any other questions?

Senator MURRAY. I am done.

Senator MIKULSKI. First of all, we want to thank everyone for their testimony, for the breakthrough people like Ms. Erickson, to Dr. Nelson, to Marcia Greenberger, and you, too, Ms. Sullivan. We acknowledge the issues facing employers, and quite frankly in all that we have done on the tax bill this past year, what I felt was that instead of across-the-board, big-buck tax breaks to other big-buck people, we should have had targeted tax cuts exactly to go to the employers. I am from a family of small business grocers, my grandmother having the best Polish bakery. So I often think, suppose we were still running that bakery, what would be the cost? So we are very mindful of that, and I would really look forward—in addition to while we are looking at how to provide comprehensive coverage to women—how we can also work with the employers, the good-guy employers who, using our tax code and perhaps other government mechanisms to really work with employers, to give help to those that practice self-help, and not only the self-insured, because I think if you are an employer and you are willing to step forward and provide health insurance, that means you are also inviting the mandates. Well, I believe we should not create unfunded mandates and we should be addressing this in the tax code.

Ms. SULLIVAN. I appreciate your saying that, and that is the health care priority for the Chamber. I really do look forward to working with you and the committee members.

Senator MIKULSKI. You mean the tax breaks for health insurance?

Ms. SULLIVAN. Anything possible to get more people affordable health coverage in this country. There is a long range of things and I have got some good—I have got ideas—

Senator MIKULSKI. You started to say, “I have got some good ideas.” Do not be modest. We did not put you in the middle to keep you in the middle. I hope you felt that your views were met with respect, and also we acknowledge the validity of those flashing yellow lights that you have raised.

We are going to also be in a big battle on the prescription drug issue and we really welcome your views on this, because prescription drugs, particularly in the Medicare population—and once we

deal with that, I believe it will drive all frameworks for prescription drugs. Do you agree with that, Ms. Sullivan?

Ms. SULLIVAN. I think it is really important, certainly to—it is a big concern with employers, about their rising drug cost, particularly for the retirees who are on Medicare. They want to continue to be able to provide that coverage to their retirees. They made a promise to them to help them with their health care costs as they rise, and I think it is very important, in addressing this Medicare coverage for prescription drugs, that you continue to work with employers to make sure that they continue to maintain that coverage, or otherwise the price tag just goes way up at that point.

Senator MIKULSKI. I am sure Ms. Erickson is already hearing it from the old-timers; am I right?

Ms. ERICKSON. This is what people complain of, as far as contraception, and I get all the elderly customers about drug prices. That is like the huge complaint I get at the pharmacy counter. I just say, “You know, we do not make money on prescription drugs anymore. We have got a huge photo department and we sell lots of cards. That is how we make money as a pharmaceutical chain.”

Senator MIKULSKI. Before this hearing closes, we have thanked you for your willingness to go to court on behalf of other women, but I want to thank you for the role you play as a retail pharmacist. My own mother, with her diabetes, and my father with Alzheimer’s and so on, the pharmacist was the one that kept everything straight for us, to make sure their drugs were not contraindicated. There was a time when the cumulative effect of one prescription with the other had a negative consequence. In my day, growing up in the neighborhood, we called the pharmacist “Doc,” because they were the first health professional you often went to. We really know that you come with an enormous amount of training and skill, and almost like the employer, you are not the one who sets the price, but you get the grief. So we want to thank you. We want to just thank you for being on the front line. We want to thank you for working with the families, often of moms and dads, like in our own cases, that were too sick or too bewildered sometimes by the contraindications and so on. So we think the pharmacists are just great, and we are very well aware of the pharmacist shortage.

But we will not go there on how we are going to pay for that. [Laughter.] But, again, we want to thank everyone, because here is my observation—I think Senator Murray would agree. Every woman at this table has made a difference in what they are doing, in each and every one of your fields of endeavor. But do you know what? We will work together, we are going to make change, and by the time this sessions adjourns, I think we are going to have a bill that everyone at the table feels good about, but most of all the American women feel secure about.

Thank you very much.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF CONGRESSWOMAN LOWEY

I want to thank Chairman Kennedy, Ranking Member Gregg, my good friend Senator Mikulski, and distinguished members of the Committee for hosting this important hearing. It's an honor to speak in support of the Equity in Prescription Insurance and Contraceptive Coverage Act.

I believe contraception is basic health care for women, and that universal coverage for the full range of contraceptive methods is long overdue.

EPICC was first introduced in 1997 by Rep. Jim Greenwood and I in the House and Senators Olympia Snowe and Harry Reid in the Senate, and would require that health insurance plans cover prescription contraceptives in the same manner that they cover other prescriptions.

My colleagues, now is the time to take action and pass this bill.

Although abortion rates are failing, today—still—nearly half of all pregnancies in America are unintended and half of those will end in abortion. Increasing access to the full range of contraceptive drugs and devices is the most effective approach to reducing the number of unintended pregnancies—a goal we all share.

Furthermore, planned pregnancies are healthier pregnancies. By increasing access to family planning infant deaths will be better prevented, more women will receive adequate prenatal care, and more sexually transmitted infections will get diagnosed and treated.

Support for contraceptive coverage has only grown. According to a recent national survey, 87 percent of Americans support women's access to birth control, and 77 percent support laws requiring health insurance plans to cover contraception.

Their message is clear: If we want fewer abortions and unintended pregnancies, we must make family planning more accessible.

And the truth is, we're making progress. Since we first introduced EPICC, 16 states—including California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Maine, Maryland, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, Rhode Island, Texas, and Vermont—have enacted contraceptive parity legislation.

Beyond requiring plans to cover prescription contraceptives because it is good for women's health and reduces abortions, it is necessary to ensure the fair treatment of employees and their families.

Currently, women of reproductive age spend 68 percent more in out-of-pocket health care costs than men. This inequity persists in large part because the majority of insurers exclude coverage of reproductive health-related supplies and services.

That's why in April, a federal court ruled that Bartell's, a large drug store chain, left a "gaping hole" in health care coverage for its female employees because their health plan excluded contraception. The Equal Employment Opportunity Commission (EEOC) also ruled in 2000 that not covering contraceptives is sex discrimination.

My colleagues, we cannot turn a blind eye to these recent developments. It's time to close our country's health care gender gap.

I was proud to lead the successful fight to add contraceptive coverage for the 1.2 million American women participating in the Federal Employees' Health Benefits plan. It was an important first step.

Before the contraceptive provision was enacted in FY 1999, 81 % of all FEHB plans did not cover the most commonly used types of prescription contraception (oral contraceptives or the pill, IUD, the diaphragm, Norplant, Depo Provera), while a full 10% covered no prescription contraception at all.

Women need the full range of options because not every woman can use every form of birth control. Many women cannot use the pill—its side effects, such as migraines, can be truly disabling for some. Other women choose not to go on the pill because they are at special risk for stroke or breast cancer.

Isn't it clear that women and men who want to have families, and want to plan their pregnancies, need more and better options?

The American public thinks so, the courts think so, Republicans and Democrats alike think so.

Mr. Chairman, we can work together to reduce the need for abortion and help Americans plan their families. Once again, thank you for allowing me to address the Committee. I am so pleased that this hearing is taking place, and strongly believe that this is a move in the right direction.

PREPARED STATEMENT OF SENATOR SNOWE

Madam Chairwoman, Mr. Ranking Member and Members of the Committee, I appreciate the opportunity to address you today on the need for legislation I originally authored back in 1997—the bipartisan Equity In Prescription Contraceptive Coverage act—or EPICC—which currently has 42 cosponsors. I have the good fortune of being joined on this panel by Senator Reid who has been a partner with me in this effort, and I would like to thank him for his ongoing leadership on this issue. We both agree this is common sense public policy whose time has long since come.

Madam Chairwoman, there should be no mistake—this issue boils down the principles of basic fairness—fairness for half this nation’s population, fairness in how we view and treat a woman’s reproductive health versus every other kind of health care need that can be addressed with prescription drugs. The facts are not in dispute—the lack of equitable coverage of prescription contraceptives has a very real impact on the lives of America’s women and, therefore, our society as a whole. This is not overstatement, Madam Chairwoman and members of the committee. This is reality.

It’s been four long years since I first introduced EPICC, and according to the Alan Guttmacher Institute, in each of those four years women have spent over \$350 per year on prescription oral contraceptives—for a total of over \$1,500. Why? Because many insurance companies that already cover other prescription drugs do not cover prescription contraceptives. How can we continue to deny this fundamental coverage for prescription drugs that are a key component in women’s reproductive health?

All we are saying is that if an employer provides insurance coverage for all other prescription drugs, they must also provide coverage for FDA approved prescription contraceptives—it’s that simple, it’s that fair, and it builds on existing law and jurisprudence.

As recently as June, the U.S. District Court for the Western District of Washington ruled in *Erickson v. Bartell Drug Company* that an employer’s failure to cover prescription contraceptives in its otherwise comprehensive prescription drug

plan constitutes gender discrimination, in violation of Title VII of the Civil Rights Act of 1964. I couldn’t be more pleased that the plaintiff, Jennifer Erickson, is here today to share her story with the Committee—her case was the first of its kind, setting a legal precedent as well as bolstering the case for our legislation.

In turn, the foundation for the District Court decision was a ruling by the Equal Employment Opportunities Commission—or EEOC—last December that an employer’s decision to exclude coverage of contraceptives in a health plan that covered other prescription drugs, devices and preventive health care services violated Title VII of the Civil Rights Act regarding gender discrimination.

Together, these two decisions form a “one-two” punch in favor of the approach we advocate today—an approach that’s already been endorsed by a total of 16 states including my home state of Maine—that have passed similar laws since 1998. Today, another twenty states have contraceptive coverage legislation pending. That’s a start, but it’s not enough. Not only are these laws limited to state regulated plans, but this piecemeal approach to fairness leaves many American women at the mercy of geography when it comes to the coverage they deserve.

But fairness is not the only issue. We believe that EPICC not only makes sense in terms of the cost of contraceptives for women, but also as a means bridging, at least in some small way, the pro-choice pro-life chasm by helping prevent unintended pregnancies and thereby also prevent abortions. The fact of the matter is, we know that there are three million unintended pregnancies every year in the United States. We also know that almost half of those pregnancies result from just the three million women who do not contraceptives—while 39 million contraceptive users account for the other 53 percent of unintended pregnancies—most of which resulted from inconsistent or incorrect use.

In other words, when used properly, contraceptives work. They prevent unintended pregnancies—we know that. Yet, according to the Kaiser Family Foundation, while 87 percent of covered workers in conventional health plans receive a prescription drug benefit, only 60 percent have coverage for oral contraceptives -the most popular type—begging the question, what is wrong with this picture?

It certainly shouldn’t be cost. A January 2001 OPM statement on EPICC-like coverage of federal employees under the FEHBP found no effect on premiums

whatsoever since implementation in 1998. Let me repeat—no effect. In fact, some like the Alan Guttmacher Institute—argue that improved access to and use of contraception nationwide would save insurers and society money by preventing unintended pregnancies, as insurers generally pay pregnancy-related medical costs which can range anywhere from \$5,000 to almost \$9,000. Improved access to contra-

ception would eliminate these costs and would reduce the costs to both employers and insurers.

But even if none of this were true, a 1998 Kaiser Family Foundation nationwide survey revealed that 73 percent of those questioned still support insurance coverage of contraception even when told that the coverage would increase insurance premiums by \$1 to \$5. In fact, the survey found that the public is more likely to support insurance coverage of contraceptives, 75 percent, than Viagra—49 percent. That's not so surprising when you consider a June survey by NARAL showing that 77 percent of Americans support laws requiring health insurance plans to cover methods of contraception such as birth control pills . . . and whopping 87 percent of Americans support access to birth control.

Madam Chairwoman, the question before us now is, if EPICC-style coverage is good enough for nine million federal employees and their dependents . . . if it's good enough for every Member of Congress and every Senator—why isn't it good enough for the American people?

Now, I know some will raise the issue of a "conscience clause", and I agree that this is a legitimate concern—one we have worked out before, and I believe can work out again. When the Senate agreed to ensure contraceptive coverage for federal employees, we addressed the concerns of our colleagues who felt that there needed to be a "conscience clause" by amending EPICC to allow religious plans to opt out of this coverage if their beliefs and tenets are not consistent with this coverage. As we look to expand EPICC beyond the FEHB plans, we are willing to work again with those who support the inclusion of a conscience clause in EPICC. The basic fairness of EPICC is simply too important to do otherwise.

Mr. Chairwoman, women should have control over their reproductive health. It is the best interests of their overall health, their children and their future children's health—and when we have fewer unintended pregnancies, we will have a reduced need for abortions. We need to finally fix this inequity in prescription drug coverage and make certain that all American women have access to this most basic health need. Again, I thank the Committee for this hearing and I look forward to working with you to advance this vital issue.

PREPARED STATEMENT OF SENATOR REID

Thank you for inviting me to testify about insurance coverage for prescription contraceptives.

I have said time and time again that if men suffered from the same illnesses as women, the medical research community would be much closer to eliminating diseases that strike women.

The issue before us today is similar. If men had to pay for contraceptives, I believe the insurance industry would cover them. It was hardly surprising that less than two months after Viagra went on the market, it was covered by many insurance plans. Birth control pills, which have been on the market since 1960, are covered by only thirty-three percent of indemnity plans.

The health care industry has done a poor job of responding to women's health needs. According to a study done by the Alan Guttmacher Institute, 49 percent of all large-group health care plans do not routinely cover any contraceptive method at all, and only 15 percent cover all five of the most common contraceptive methods.

Ironically, most insurance companies routinely cover more expensive services, including abortions, sterilizations and tubal ligations.

Apparently, insurers do not know what women—and their doctors—have long known: contraceptives are a crucial part of women's health care. By helping women plan and space their pregnancies, contraceptive use fosters healthy pregnancy and healthy births by reducing the incidence of maternal complications, low birth weight and infant mortality.

Sadly, financial constraints force many women to forgo birth control all together, leading to 3.6 million unintended pregnancies every year. Almost half of those end in abortion. If we are committed to reducing the number of abortions in this country, we need to eliminate the barriers to effective and affordable birth control.

That is why the legislation Senator Snowe (R-ME) and I have sponsored—the Equity in Prescription Insurance and Contraceptive Coverage (EPICC) bill—is so important. In short, our bill would require health plans that provide coverage of prescription drugs to include the same level of coverage for FDA-approved prescription contraceptives. Our bill does not ask for special treatment of contraceptives—only equitable treatment within the context of an existing prescription drug benefit. EPICC will increase fairness, promote women's health, and reduce unintended pregnancies.

Since Senator Snowe and I first introduced this legislation in 1997, we have made some progress that is worth noting.

In 1998, Senator Snowe and I, along with Congresswoman Lowey (D-NY), fought to pass a provision that requires health plans participating in the Federal Employees Health Benefits Program—the largest employer-sponsored health plan in the world—to cover FDA approved prescription contraceptives. The Office of Personnel Management, which administers the program, reported in January that this benefit did not raise premiums “since there was no cost increase due to contraceptive coverage.” In spite of this, President Bush proposed eliminating this benefit in his budget.

Just this past June, US District Judge Robert Lasnik handed down a landmark decision when he ruled that a Seattle company’s policy of excluding prescription contraception from employee health benefits violated Title VII of the 1964 Civil Rights Act. The Judge ordered the company to cover all available methods of prescription contraception in its employee health plan.

I am pleased that the plaintiff in this case, Jennifer Erickson, is here to share her story with us today. Ms. Erickson is the first woman in the nation to initiate sex discrimination charges against her employer based on the company’s policy of excluding prescription contraception from employee health benefits.

Jennifer Erickson’s case builds on momentum from a separate ruling this past December by the Equal Employment Opportunity Commission (EEOC). In that case, the EEOC also ruled that denial of coverage for female contraceptives, if an employer offers other preventive medicines or services, is sex discrimination under the Civil Rights Act of 1964.

In spite of these important advances, women will not have the contraceptive insurance coverage they deserve until Congress passes our EPICC legislation.

An estimated 16 million Americans obtain health insurance from private insurance other than employer-provided plans. Only the enactment of EPICC will ensure that contraceptive coverage is offered by insurance providers.

Women who receive their health care through work should not have to take their employers to court. We want to make family planning more accessible. We do not want an explosion in lawsuits.

Equity in prescription contraception coverage is long overdue. Our bill has 42 co-sponsors from both sides of the aisle and from both sides of the abortion debate. Senator Snowe and I are committed to moving this legislation. Promoting equity in health insurance coverage for American women while working to prevent unintended pregnancies and improve women’s health care is the right thing to do.

PREPARED STATEMENT OF JENNIFER ERICKSON

Madame Chairwoman and Members of the Committee, thank you for allowing me to testify this afternoon. My name is Jennifer Erickson, and I am the class representative for the Erickson v. Bartell Drug Co. case. I am pleased to have been invited to testify in support of the Equity in Prescription Insurance and Contraceptive Coverage Act.

I consider myself in many ways a typical American woman. My husband Scott and I have been married for two years. We both have full time jobs in the Seattle area and are working hard to save money. We recently bought our first house and we spent a lot of time this summer painting and fixing it up.

My husband and I are both looking forward to starting a family. However, we want to be adequately prepared for the financial and emotional challenges of parenting. Someday when we feel ready, Scott and I would like to have one or two children.

But we know we could not cope with having twelve to fifteen children, which is the average number of children women would have during their lives without access to contraception. So I, like millions of other women, need and use safe, effective prescription contraception.

Like many Americans, I get my health insurance through my employer. I am a pharmacist for the Bartell Drug Company, which is a retail pharmacy chain in the Seattle area. About two years ago, shortly after I started working there, I discovered that the company health plan did not cover contraception. Personally, it was very disappointing for me, since contraception is my most important, ongoing health need at this time. For many women, it may be the only prescription she needs.

But it was also troubling to me professionally, as a health care provider. As a pharmacist who serves patients everyday, I see on a daily basis that contraceptives are central to women’s health.

Contraception is one of the most common prescriptions I fill for women. I am often the person who has the difficult job of telling a woman that her insurance plan will

not cover contraceptives. It is an unenviable and frustrating position to be in, because the woman is often upset and disappointed, and I am unable to give her an acceptable explanation. Why? Because there is no acceptable explanation for this shortsighted policy. All I could say was: "I don't know why it's not covered. My pills aren't covered either and it doesn't make any sense to me."

Oral contraceptives cost approximately \$30.00 per month. I know that I am very fortunate—I have a secure job and a good income. But for many women it is a real financial struggle to pay this cost every month, year in and year out. My perspective from behind the pharmacy counter gives me a clear picture of the burden this policy places on women, especially the low-income women who are the least equipped to deal with an unplanned pregnancy. I have seen women leave the pharmacy empty-handed because they cannot afford to pay the full cost of their birth control pills, and it breaks my heart.

I finally got tired of telling women "no this is one prescription your insurance won't cover." So I took the bold step of bringing a lawsuit against my employer to challenge its unfair policy. I did it not just for me, but for the other women who work at my company who are not so fortunate. I thank Planned Parenthood for their outstanding legal counsel on my case.

I am proud that the victory in my case will help the women in my company. The court ordered Bartell to cover all available forms of prescription contraception and all related medical services in our health plan, and I am very pleased that the company recently changed its policy to comply with the court's order.

Despite our victory in federal court, I know that my case is not enough to help all of the American women who need this essential health care. At this point, my case is directly binding only on Bartell. Nearly every day one of my customers thanks me for coming forward and congratulates me on winning the case; but many of the women I serve at my pharmacy counter still do not have insurance coverage for the contraception need. I know that some companies are still choosing to ignore the recent legal developments. Planned Parenthood has created a website with tools to help women whose employers do not cover contraception.

But I also know that Title VII, the anti discrimination law that my case is based on, doesn't cover all women. And, even more important, women should not have to file federal court lawsuits to get their basic health care needs covered.

So today I am speaking for millions of American women who want to time their pregnancies and welcome their children into the world when they are ready. On behalf of the women of this Nation, I urge you to enact this comprehensive legislation because every woman, no matter what state she lives in or where she works, should have fair access to the method of contraception she needs. Thank you.

PREPARED STATEMENT OF ANITA L. NELSON, M.D.

Chairwoman Mikulski, Members of the Committee, I am Anita L. Nelson, MD, testifying on behalf of The American College of Obstetricians and Gynecologists (ACOG) an organization representing over 41,000 physicians dedicated to improving women's health care. I am pleased to testify, in support of S. 104, the Equity in Prescription Insurance and Contraceptive Coverage (EPICC) Act introduced by Senators Harry Reid (D-NV) and Olympia Snowe (R-ME).

I am a Professor in the Department of Obstetrics and Gynecology at the University of California in Los Angeles. Currently, I serve as Medical Director of the Women's Health Care Clinic and Women's Health Care Nurse Practitioner Program at Harbor-UCLA Medical Center in Torrance, California. Also, I am the Program Director of Women's Health Care Teams for the Coastal County Health Centers and the Medical Director for the Research Division of the California Family Health Council in Los Angeles.

While most (90%) health plans cover prescription drugs and devices, many do not cover prescription contraceptives. S. 104 seeks to provide coverage equity for prescription contraceptives and related medical services. Under this legislation, plans already covering prescription drugs and devices would be required to cover FDA approved prescription contraceptive drugs and devices. Also, plans that cover outpatient medical services would be required to include outpatient contraceptive services in that coverage. FDA approved contraceptives include birth control pills, intrauterine devices (IUDs), injections, implants, diaphragms, and the cervical caps.

Inadequate health insurance coverage of prescription birth control remains a glaring medical problem for American women. Contraception is a basic health care need. As women's health care physicians, ACOG knows that access to contraception is critical to achieving healthy families. While some non-prescription forms of contraception play an important role in reducing the risk of sexually transmitted diseases (STDs) and pregnancy prevention, prescription birth control does a significantly su-

perior job of pregnancy prevention and should be readily available to American women. Prescription contraception is also dramatically more effective than natural family planning methods, and allows couples more spontaneity in their lives.

In a 1999 article, the Centers for Disease Control and Prevention (CDC) counted family planning among the “Ten Great Public Health Achievements in the 20th Century.” They reviewed the history of family planning during the past century and discussed the positive impact of contraception on American families. Access to contraception has contributed immensely to the better health of women and children. However, the CDC noted that providing access to the full array of reproductive-health services remains a challenge.

The Equity in Prescription Insurance and Contraceptive Coverage Act would remedy a longstanding inequity in insurance coverage and help improve access to basic health care for millions of American women. EPICC would also guarantee women access to contraceptives that are appropriate to their medical and family history, age, health status, fertility desires, beliefs, and economic circumstances, all of which can change for an individual over time. Almost half (49%) of fee for service plans provide no coverage of any of the five most common prescription contraceptives. While health maintenance organizations (HMOs) have a better record, only 39% routinely cover all five of the most common methods.

I have had patients who had to save up for months to pay for their Norplant removal because their insurance companies claimed they didn't pay for its insertion, so they would not pay for its removal. Perfect candidates for JUDs were unable to pay the upfront costs and settled for significantly less effective methods, such as condoms. If a woman cannot afford an IUD, she certainly cannot afford a pregnancy!

Over the last 16 years, I've helped thousands of women choose the birth control method that is light for them, and I can tell you that men and women really do need an extensive menu of options for contraception to meet their particular needs. Lack of appropriate contraceptive choices is one of the greatest barriers to effective contraceptive use.

Fortunately, there are several distinctly different types of FDA-approved contraceptive methods and newer methods on the horizon, each designed to suit specific aspects of women's health needs. Women must not be limited from choosing the best method because of insurers' arbitrary coverage decisions.

Biologically, most women can become pregnant for nearly forty years of their lives. Without contraception, the average woman could become pregnant more than twelve times, a prospect that is unacceptable to most women and would place a woman's and her children's health at unnecessary risk. Women cannot simply opt out of the need to control their fertility for three or more decades. Sexual expression is obviously an important part of the human experience, or there would not be such interest in Viagra. Access to contraception provides women the opportunity to choose the number as well as the timing of their pregnancies, and to protect their health.

I can assure you that we will be most successful in reducing unintended pregnancy when women can obtain the particular contraceptive that best meets their needs and when they have full access to contraceptive counseling that teaches them how to use their method correctly and consistently.

Allow me to briefly discuss the major public health reasons for ensuring that women have access to contraception.

Contraception prevents unintended pregnancies and abortions. Of all industrialized nations, the United States has the highest rate of unintended pregnancies. Every year, approximately fifty percent of all pregnancies in the United States are unintended and 50% of these pregnancies are terminated.

The consequences of unintended pregnancy are serious and impose tremendous burdens on women and their families. Women who did not intend to become pregnant are more likely to delay seeking early prenatal care and more likely to expose the fetus to poor nutrition and harmful substances. Pregnancy planning and preconceptional preparation are key to optimal pregnancy outcomes. Children from unwanted pregnancies are at greater

risk of poor birth outcomes (e.g. congenital defects, low birth weight, prematurity), abuse, and of not receiving sufficient resources for healthy development. The parents may suffer greater economic hardship.

Contraceptive coverage would place birth control within the financial reach of more American women. An Institute of Medicine (IOM) Committee Report on Unintended Pregnancy in 1995 concluded that one of the reasons for the high rates of unintended pregnancy in the United States was the failure of private health insurance to cover contraceptives and recommended increasing the number of health insurance policies that cover contraceptive services and supplies. The IOM report also

highlighted the need for appropriate contraceptive counseling, in conjunction with contraceptive use in order to reduce the number of unintended pregnancies.

Contraception saves and improves babies' lives. Effective family planning has also been positively correlated with a reduction in infant mortality. The National Commission to Prevent Infant Mortality estimated that 10 percent of infant deaths could be prevented if all pregnancies were planned.

A study published in the February 1999, *New England Journal of Medicine* concluded that pregnancy spacing of 18-23 months dramatically lowered the risks of low birth weight and preterm birth. Contraception gives women an opportunity to prepare for pregnancy instead of having it happen accidentally. Women who take folic acid before they conceive reduce the risk of neural tube defects in their babies by 50%. Diabetic women who change their medications before they become pregnant decrease their baby's risk of major congenital defects from 9% to 1%.

Contraception allows women with serious medical conditions to control their fertility. Pregnancy can be life threatening for women with serious medical conditions such as heart disease, diabetes, lupus, and high blood pressure. For these women, contraception can be life saving. It can help them prevent pregnancy altogether, or it can help these women postpone pregnancy until they are healthy enough to support a pregnancy.

Contraception improves maternal health. Family planning is critical to improved maternal health by allowing women to space the number and timing of their pregnancies. Studies also show that women who conceive within six months following childbirth increase the risk of pregnancy complications. According to the November 2000 *British Medical Journal*, "women who became pregnant less than six months after their previous pregnancy were 70% more likely to have membranes rupture prematurely and had a 30% higher risk of other complications."

Contraception aids in the prevention and treatment of sexually transmitted diseases (STDs): Access to contraceptive-related health services increases the likelihood that the estimated 15 million Americans who contract sexually transmitted infections each year will be diagnosed and treated. Access to contraceptive-related health services enables sexually active individuals to receive prevention counseling and appropriate medical tests from their health care professional.

Contraception is cost effective. Studies in my own state of California demonstrated that for every dollar invested in family planning, over \$14 is saved. The more effective birth control methods are the most cost effective. For example, every copper IUD placed saves the health care system (and society) over \$14,000 within 5 years. However, due to rapid turnover of insured individuals, each individual insurance company will not reap those economic benefits until all companies are required to play by the same rules and cover all prescription methods.

CONCLUSION

In response to strong public support, 16 states have enacted laws requiring prescription equity similar to EPICC. In addition, a federal court in Washington State concluded that an employer's failure to provide contraceptive coverage "to the same extent and on the same terms" as it provides coverage for other prescription drugs constitutes illegal sex discrimination under Title VII of the Civil Rights Act of 1964.

However, even if all the states were to pass laws, and more employees had the courage to stand up in court for their rights, federal legislation would still be necessary. As you are aware, there are many families who are not protected by state provisions because employers insure them in federally governed (ERISA) plans. And we should not continue an inequity that forces individuals to sue in court. The only way to help the millions of woman and families throughout the country who are covered by such plans is to pass federal legislation that uniformly applies to all insurers.

As long as insurers continue to exclude contraceptive coverage and services from their plans, it is clear that the needs of women will not be addressed adequately. Contraceptive coverage is a basic health need, just as is coverage for diabetes and high blood pressure treatments. Federal legislation is critical. ACOG supports S. 104 and urges Members of the Committee to support this important legislation.

I thank the Chair and this Committee for holding this hearing today and for allowing me the opportunity to testify. S. 104 is important to our nation's women and families.

PREPARED STATEMENT OF KATE SULLIVAN

INTRODUCTION

Good afternoon. My name is Kate Sullivan, and I am Director of Health Care Policy for the U.S. Chamber of Commerce. The Chamber is the world's largest business federation, representing more than three million businesses of every size, sector and region. I appreciate the opportunity to present the views of employers who voluntarily provide health care benefits to more than 172 million Americans.

OVERVIEW OF TESTIMONY

1. Job-based health insurance costs this year increased at their highest rate in nearly a decade, represent the fifth straight year of health care inflation and hit small businesses the hardest.

1. Further increasing the cost of health coverage by imposing mandates jeopardizes the availability and affordability of plans for both employers and working families, leaving more people uninsured not only for predictable, comparatively nominal health care goods and services but also for unexpected, major medical events.

1. The U.S. Chamber of Commerce opposes any and all health plan mandates regardless of merit because they directly raise the cost of health plans, limit employers' ability to tailor benefits according to workforce need and demand, and stifle health plans' efforts to provide consumers with a variety of choices and the ability to select the benefits most appropriate for their personal situations.

1. As currently drafted, S. 104 poses quality concerns for health plans, expands the likelihood of malpractice liability and requires that health plans favor contraceptive coverage over other benefits.

EVOLUTION OF HEALTH PLAN DESIGN

Nine out of every ten people with private health coverage in the United States are insured through an employer-sponsored health plan. For decades, employers have voluntarily provided health benefits that were designed to meet the health and financial needs of their workforces and dependents. The availability of employer-provided coverage helps ensure a healthy and productive workforce and alleviates the distraction of financial worry for employees. As employees' needs and wants change, often so do their benefit plans, and as new medical treatment and innovation become available, health plans adapt to finance these advances while continuing to meet enrollees' needs.

Employer health plans for many years were typically indemnity or fee-for-service plans covering treatment for illness or injury but not routine or preventive care. These plans feature a deductible that patients meet before the plan begins sharing payment, and the patient then pays a percentage (not a flat dollar amount) of total charges above and beyond the deductible. Later, larger employers that could offer employees a choice of health plans (most small employers don't have the ability to do so) often gave employees the option of receiving through an HMO or PPO preventive and routine benefits that the company's traditional plan did not cover.

By offering enrollees prepaid coverage for preventive services, managed care alternatives to traditional fee-for-service plans quickly became popular because of the low cost to participants. These plans usually cover routine services without requiring the patient to first satisfy a deductible, and doctor visits and prescriptions are often covered at no cost or for a nominal, fixed dollar amount. Young, healthy workers in particular have been attracted to managed care because their few health care needs each year were often covered for little or no cost out of their own pockets. However, while these plans often readily pay for routine costs, they scrutinize unanticipated, costly claims more closely. Plans—and the employers who pay the bulk of their cost cannot afford to cover both up-front and back-end health care costs and still keep premiums and cost-sharing affordable for participants.

As health plan costs rise and employers are restricted in their ability to sponsor managed care alternatives because of so-called "patients' rights" laws, many employers are turning to—or returning to—indemnity health plans that ensure coverage for unexpected and costly health needs, in combination with a tax-favored health care spending account that make funds available up-front to meet deductible and coinsurance requirements. These health care spending accounts also are frequently used to pay for items and services outside the plan's scope of coverage but that the participant knows will be needed throughout the year. This evolving trend encourages health care consumers to plan for the health costs they anticipate and returns health coverage to the more traditional notion of "insurance"—that is, insuring unanticipated health care events that can financially devastate an uninsured patient.

HEALTH PLAN COST TRENDS

Health plan costs have risen sharply in recent years and are the direct result of state legislatures' mandates on insured health plans offered by employers, as well as the impact of HIPAA and other federal mandates enacted by the U.S. Congress. Health plan costs are also rising due to greater drug utilization, hospital costs that have been shifted to employers due to insufficient Medicare and Medicaid reimbursement, and employers' response to consumer preference and provider demand for more open, flexible service networks and fewer coverage limitations.

The 2001 annual survey of employer health benefits released last week by the Kaiser Family Foundation and the Health Research and Educational Trust reported that job-based health insurance costs increased by 11.0 percent from the spring of 2000 to the spring of 2001, the highest increase since 1992 and the fifth straight year of health care inflation. These rate increases translate to per-employee health plan costs of \$2,650 a year for single coverage (\$221 per month), and \$7,053 a year for family coverage (\$588 per month). Small employers were once again the hardest hit, reporting health plan inflation rates of 14.4 percent (10 to 24 employees) and 16.5 percent (3 to 9 employees).

Employers have absorbed much of the rising cost because the healthy economy brought in more revenue to pay these expenses and the tight labor market made the need for comprehensive, low-cost benefits packages an imperative in order to attract and retain employees. Employers assumed greater responsibility for plan premiums from 1993 to 2001 (paying 68 percent of family coverage in 1993 and 73 percent in 2001), but rising costs have increased employees' average monthly contributions from \$124 to \$150 over the same period (Kaiser Family Foundation/Health Research and Education Trust 2001 Annual Survey).

However, the last year has been a wake-up call to both employers and employees. Health plan costs this year increased at their greatest rate in nearly ten years, and the anemic economy makes absorbing these costs far more difficult. When employers can no longer keep up with the rising cost of their health plans, they increase employee cost-sharing in the form of bigger monthly premiums, larger co-payments for doctor visits and prescription drugs, and higher out-of-pocket payments toward the deductible and coinsurance. Among large employers (200 or more employees), 75 percent are likely to increase employee costs next year, and 42 percent of smaller employers expect to do so (Kaiser Family Foundation/Health Research and Education Trust 2001 Annual Survey).

THE LINK BETWEEN RISING COSTS AND THE UNINSURED

Until this year's economic downturn, employer health coverage had been steadily expanding as more Americans were working and more small employers offered health benefits in order to attract and retain employees. In 1998, 54 percent of small firms (3 to 199 employees) offered health benefits, rising to 67 percent in 2000 before dropping this year to 65 percent (Kaiser Family Foundation and Health Research and Educational Trust, 2001 Annual Survey).

However, even as employer coverage has been expanding in recent years, the number of employees turning down their employers' offer of coverage has been steadily increasing. In many cases, the employee is covered elsewhere (through a spouse, parent a government program), but 26 percent—one out of four—employees who decline coverage are uninsured. When asked, 20 percent of those turning down the offer of health coverage state that it was just too costly to participate (Employee Benefits Research Institute, September 1999).

Furthermore, women already face barriers in accessing affordable health coverage because of their work and income status. A Commonwealth Fund study last month reported that younger women are far more likely to be uninsured than older women. Twenty-three percent of women between the ages of 19 and 34 are uninsured, compared with 15 percent of women between the ages of 35 and 44, 14 percent of women ages 45 to 54, and 16 percent of women ages 55 to 64 (Commonwealth Fund Task Force on the Future of Health Insurance, analysis of March 2000 Current Population Survey).

Increasing the cost of health coverage by imposing mandates jeopardizes the availability and affordability of plans for both employers and employees. So while some women may gain coverage for their contraceptive needs, other women may lose their coverage entirely and remain uninsured when they are accidentally injured, require surgery or experience a major illness.

THE PITFALLS OF "AVERAGE" COST IMPACT ESTIMATES

Many who support S. 104 argue that because it will result—we would say “may result”—in only a fractional increase in health plan premiums, that it is penny-wise and pound-foolish for the business community to oppose this legislation. We urge you to keep in mind that projected cost increases are only averages, and the impact on any given employer depends on what the plan already covers and the likelihood of that particular employer group’s members availing themselves of the new benefit.

Furthermore, cost impact estimates include those employers who already cover the item or service under consideration; for them, there is no cost increase so long as their plan already fully complies with the mandate. However, employers whose plans depart in any way from the strictures of the mandate, only partially cover the benefit, or do not cover it at all, will see their health plan costs increase several times the widely touted “nominal” cost of the new mandate.

MANDATES LIMIT CHOICE, RAISE COSTS, DISPROPORTIONATELY IMPACT EMPLOYERS

Government mandates handed down by the federal and state legislatures have forced health plans of all types—indemnity, PPO, HMO, point-of-service—to look more like one another, diminishing the ability of plans to compete for customers based on consumers’ needs and preferences. Mandates have also increased health plan costs, and surveys of employer health plan costs underscore the effect of state mandates on employers’ insured health plans.

Compared to the rate of inflation for self-insured plans under ERISA, costs for fully insured health plans, which must comply with state mandates, rose 37.1 percent from 1998-2001, while self-insured health plan costs rose 24.8 percent over the same period (Kaiser Family Foundation/Health Research and Educational Trust, 2001 Annual Survey). Moreover, mandated contraceptive coverage is not the only government mandate the Senate is considering this year. Last month, this committee approved a broad expansion of the current mental health parity mandate that will increase premiums an average of 0.9 percent. At the end of June, the full Senate passed managed care reform legislation—replete with numerous mandates—that will increase premiums an average of 4.0 percent.

Pausing barely long enough to catch one’s breath, this committee is now preparing to further increase health plan costs. The total average impact of these mandates will equal more than half the average 11 percent increase in health plan costs this year without these new requirements. And again, for a good portion of employers, the impact on their health plans will certainly exceed those “nominal” average estimates several times over.

Finally, employers have not even begun receiving the bill from their health plans for the cost of complying with the new ERISA claims procedure regulations, costs associated with provider and carrier compliance with medical privacy regulations, and the cost of abiding by administrative simplification requirements imposed by HIPAA. Clearly, there is no end in sight to the current rise in health plan costs, and this is before we begin paying for the rising cost medical services themselves.

COMMENTS SPECIFIC TO S. 104, THE “EQUITY IN PRESCRIPTION INSURANCE AND CONTRACEPTIVE COVERAGE ACT”

Like any and all legislation imposing a mandate on the private health plans that employers voluntarily offer and finance, the U.S. Chamber of Commerce opposes S. 104 and its mandate that employers cover contraceptive coverage. The Chamber opposes mandates because they directly raise the cost of health plans, limit employers’ ability to tailor benefits according to workforce need and demand, and stifle health plans’ efforts to provide consumers with a variety of choices and the ability to select the benefits most appropriate for their personal situations. We make no distinction in our opposition to mandates on the basis of cost, popularity of the benefit, potential indirect benefit to the company, widespread coverage already by employers, or regard for the legislators who support the proposal: The Chamber is an equal opportunity organization when it comes to just saying “No.”

Apart from our stated opposition to any government mandate that raises the cost of health coverage and results in more uninsured people, the Chamber has particular concerns with S. 104.

Inequity of Coverage. While purporting to put contraceptive services and devices on the same footing as other health benefits, S. 104 requires plans to cover prescriptions, outpatient services and devices at no greater cost than “any other drug” or “any other outpatient service.” If a plan covers childhood immunizations at no cost in order to provide the greatest incentive possible to immunize children, or provides free mammograms during October as part of a breast cancer awareness campaign,

contraceptive services and prescriptions would have to be covered on the same basis. In essence, the bill mandates that contraceptive coverage be covered at the most generous level of cost sharing for any other service.

Quality Concerns. The bill creates serious quality concerns by prohibiting a plan from denying coverage or conducting any utilization review based on quality. A plan could not deny coverage if the prescribed drug, device or service puts the patient at serious medical risk because of contraindicated age, weight, behavior or other risk factors.

Malpractice Liability. The bill increases the threat of malpractice liability and poor quality by prohibiting a plan from specifying the type of provider who can prescribe contraception. For example, a plan could not deny coverage if an optometrist were to prescribe an IUD.

No Conscience Clause. Faith-based employers would be required to provide coverage for services that conflict with religious teachings and doctrine. The Congress has long provided such “conscience clauses” protecting against the mandatory provision of services deemed objectionable to Catholic and other faith-based employers. Managed care legislation recently passed by both the U.S. Senate and House of Representatives includes an exclusion clause that would ensure faith-based health plans are free to act in a manner consistent with their religious beliefs, and the current contraceptive coverage mandate in the Federal Employee Health Benefits Program similarly contains such an exemption.

CONCLUSION

The Chamber understands and appreciates the sponsors good intentions with this bill, but many a well-intentioned public policy has had unintended consequences. The Congress is tackling the wrong issue. One out of six people in this country are uninsured. Not only do they not have contraceptive coverage, they are uninsured in the event of childbirth, a trip to the emergency room or a diagnosis of cancer.

Rather than enrich the benefits that some already have, the Congress needs to rein in its penchant for mandates, halt duplicative regulation that raise health system costs and act immediately to create new options for private health coverage and new ways to pay for it. Women who desire more comprehensive coverage for contraception are in danger of losing their health benefits altogether because costs are rising for their companies and themselves, and insurers are withdrawing from the market leaving consumers with fewer alternatives. The prospect of being held liable for unlimited damages in both federal and state court for the actions of health plans they voluntarily sponsor is causing employers to further rethink the wisdom of taking on such risk. Bit by bit, mandate on top of regulation on top of more liability, lawmakers threaten the health and economic security of hard-working Americans.

PREPARED STATEMENT OF MARCIA D. GREENBERGER

My name is Marcia Greenberger, and I appreciate your invitation to testify today. I am Co-President of the National Women’s Law Center, which since 1972 has been at the forefront of virtually every major effort to secure and defend women’s legal rights. I am pleased to have this opportunity to testify about insurance coverage of contraception and the importance of the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC).

The Center’s involvement in pregnancy-related discrimination—which is at the heart of the issue before the committee today—dates back to the Center’s beginning in 1972 and our participation in the litigation and subsequent legislative action that led to enactment of the Pregnancy Discrimination Act in 1978. It now includes the *Erickson v. Bartell Drug Co.* contraceptive coverage case, in which the Center is honored to be serving as part of the legal team representing Jennifer Erickson and the other women in the plaintiff class. Because the Center brings to this work a dual perspective as a longstanding advocate both for women’s health and reproductive rights and for equal opportunities for women in all facets of American life, my testimony will cover the importance of contraceptive coverage both as a matter of women’s health and as a matter of women’s equal rights, and will include some historical and legal background.

I. CONTRACEPTION IS PART OF BASIC HEALTH CARE FOR WOMEN

Access to reliable contraception is essential to women’s health, and the failure of insurers to cover it has far-reaching consequences for the health of women and the health of their children. The court in *Erickson v. Bartell Drug Co.*, 141 F.Supp.2d 1266 (W.D.Wash. 2001), got it exactly right in its June 2001 decision when it said, “the exclusion of prescription contraceptives creates a gaping hole in the coverage

offered to female employees, leaving a fundamental and immediate healthcare need uncovered.”

Pregnancy prevention is central to good health care for women. Most women have the biological potential for pregnancy for over 30 years of their lives, and for approximately three-quarters of her reproductive life, the average woman is trying to postpone or avoid pregnancy. Over half of pregnancies in the United States are unintended. Access to contraception is critical to preventing unwanted pregnancies (and thus also to reducing the number of abortions), and to enabling women to control the timing and spacing of their pregnancies, which in turn reduces the incidence of maternal morbidity, low birth weight babies, and infant mortality.

Despite the importance of contraception to women’s health, private health insurance has failed to provide adequate coverage of prescription contraceptive drugs and devices and related services. Almost half of all fee-for-service large-group plans (those covering over 100 employees) do not cover any form of contraception at all, and only one-third cover oral contraceptives, the most commonly used form of reversible contraceptive in the United States. Although managed care plans typically provide better coverage than traditional fee-for-service plans, only 39% of HMOs routinely cover the five methods of reversible contraception. Only 49% of large-group plans and 39% of small-group plans cover outpatient annual exams—which are essential for women using prescription contraceptive drugs or devices. Before Congress mandated contraceptive coverage for federal employees, 81% of the plans in the Federal Employees Health Benefits Program (FEHBP) did not cover all five reversible methods of contraception, and 10% of the plans did not cover any of these methods. The failure of private insurance plans to cover contraceptives is even more glaring when one considers that 97% of traditional fee-for-service plans cover other prescription drugs.

Women who do not have health insurance coverage for contraception, but who nonetheless wish to avoid pregnancy, are often forced to use a less expensive, but also less effective, method of contraception. A woman without insurance coverage also may not be able to afford to use the contraceptive method that is most appropriate for her medical and personal circumstances. For example, an IUD or implant may be the most appropriate form of contraception for some women (for example, where oral contraceptives are contraindicated for medical reasons), but these devices have the highest initial cost and therefore can be the hardest to pay for out-of-pocket.

Moreover, some insurance plans do not cover oral contraceptives even when they are prescribed for health reasons other than birth control—for example, for medical conditions like dysmenorrhea and pre-menstrual syndrome, or to help prevent ovarian cancer. Thus, in addition to the dangers to women’s health presented by the failure of insurance to cover pregnancy prevention, the exclusion of contraception from insurance coverage causes other harmful consequences for women’s health.

II. INSURANCE COVERAGE OF CONTRACEPTIVES IS A MATTER OF EQUITY FOR WOMEN

Not only is pregnancy a condition that is unique to women, but the only forms of prescription contraception available today are exclusively for women (oral contraceptives, injections like Depo Provera and Lunelle, implants like Norplant, IUDs, and barrier methods like the diaphragm and cervical cap). Thus, the exclusion of prescription contraceptives from health insurance coverage unfairly disadvantages women by singling out for unfavorable treatment a health insurance need that only women have. Failure to cover contraception forces women to bear higher health care costs to avoid pregnancy, and exposes women to the unique physical, economic and emotional consequences that can result from unintended pregnancy.

The most immediate economic consequence for women is the out-of-pocket cost of paying for contraception. American women spend about 68 percent more than men in out-of-pocket health care costs, and much of this disparity can be attributed to the lack of adequate coverage of reproductive health services. Such costs make up one-third of all health care costs for women under private health insurance policies. Moreover, when effective contraception is not used, it is women who bear the risk of unwanted pregnancy. When unintended pregnancy results, it is women who incur the attendant physical burdens and medical risks of pregnancy, women who disproportionately bear the health care costs of pregnancy and childbirth, and women who often face barriers to employment and educational opportunities as a result of pregnancy, even today despite the fact that the law clearly prohibits this form of discrimination in the workplace and in educational institutions.

In short, forcing women to pay out of pocket to cover their contraceptive needs is both harmful to their health and manifestly unfair. It is no wonder that when

many insurance plans agreed to cover Viagra as soon as it received FDA approval—while continuing to exclude prescription contraception—an outcry ensued.

III. MANY EMPLOYERS ARE OBLIGATED TO PROVIDE CONTRACEPTIVE COVERAGE UNDER THE LAWS PROHIBITING SEX DISCRIMINATION IN EMPLOYMENT

Women's ability to receive the contraceptive insurance coverage they need has advanced significantly with two recent interpretations of the federal civil rights laws, one by the Equal Employment Opportunity Commission and one by a federal court. Both held that it is unlawful sex discrimination in the workplace under Title VII of the Civil Rights Act of 1964, and specifically the Pregnancy Discrimination Act of 1978 (PDA) that is incorporated in Title VII, for an employer covered by Title VII to exclude prescription contraceptive drugs and devices and related services from a health insurance plan provided to its employees, when the plan covers other prescription drugs and devices and preventive care generally.

Title VII prohibits all private employers with at least 15 employees, and public employers as well, from discriminating on the basis of sex in the terms and conditions of employment, including in fringe benefits. And Congress made explicit, when enacting the PDA as an amendment to Title VII, that pregnancy-related discrimination constitutes illegal discrimination on the basis of sex in all terms and conditions of employment, including employer-provided insurance. This legislation explicitly overruled the Supreme Court's decision in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), which had held that an otherwise comprehensive short-term disability policy that excluded pregnancy-related disabilities from coverage did not discriminate on the basis of sex in violation of Title VII.

Based on Title VII, and specifically the PDA, both the EEOC and the Erickson federal court have underscored that an employer who singles out pregnancy-related health care—including contraception—for disadvantageous treatment in an employee health benefits plan is committing unlawful sex discrimination. In December 2000, the EEOC issued a formal statement of Commission policy holding that Title VII prohibits employers from excluding prescription contraceptive coverage from an employee health plan that otherwise covers prescription drugs and devices generally as well as a wide range of other preventive health care. The Commission reasoned that Title VII's "prohibition on discrimination against women based on their ability to become pregnant . . . necessarily includes a prohibition on discrimination related to a woman's use of contraceptives." According to the EEOC, this means that employers must cover the expenses of prescription contraceptives and related medical services to the same extent and on the same terms that they cover the expenses of other drugs, devices and preventative services. As the federal agency charged with administering and enforcing Title VII, the EEOC's interpretation of the law is authoritative and entitled to substantial deference. And both Attorney General John Ashcroft and EEOC Chair Cari Dominguez have stated that they will uphold this ruling.

The EEOC's ruling was followed by the decision in *Erickson v. Bartell Drug Co.* in June of this year, in which the U.S. District Court for the Western District of Washington found that the defendant's exclusion of prescription contraceptives from its otherwise comprehensive employee health benefits plan constitutes a violation of Title VII. The court's decision, granting summary judgment to Jennifer Erickson and the plaintiff class she represents, was the first one ever to rule definitively on the merits of this issue—although two other courts have also recently ruled in favor of the plaintiffs in similar cases, denying the defendants' motions to dismiss and allowing the cases to proceed. In the *Erickson* decision, the court carefully reviewed the legislative history of Title VII and the PDA, relevant precedents, the EEOC Decision, and each of the arguments presented by the Defendant. The court concluded:

Bartell's exclusion of prescription contraception from its prescription plan is inconsistent with the requirements of federal law. The PDA is not a begrudging recognition of a limited grant of rights to a strictly defined group of women who happen to be pregnant. Read in the context of Title VII as a whole, it is a broad acknowledgment of the intent of Congress to outlaw any and all discrimination against any and all women in the terms and conditions of their employment, including the benefits an employer provides to its employees. Male and female employees have different, sex-based disability and healthcare needs, and the law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception.

On this basis, the court ordered Bartell Drug Co., the defendant, to cover each of the available options for prescription contraception to the same extent, and on the same terms, that it covers other drugs, devices, and preventive care for its employees, as well as all contraception-related outpatient services. Bartell has subse-

quently notified its employees that these drugs, devices, and services are now covered.

As a result of the EEOC and court rulings, all employers covered by Title VII are now on notice of their legal obligation to include coverage of prescription contraceptives if they are providing health insurance to their employees that otherwise covers prescription drugs and devices and preventive care. We are pleased that some have responded on their own by promptly adding this coverage to their employee health plans. Other employers have added contraceptive coverage after being pressed to do so by their employees. For example, this past April, after several female faculty and staff members at the University of Nebraska urged the university administration to add contraceptive coverage—with legal assistance from the National Women's Law Center—the university Regents agreed.

To help other employees across the country in their efforts to secure the contraceptive coverage to which they are entitled, the Center has published a free pamphlet, *Take Action: Get Your Prescription Contraceptives Covered, A Practical Guide for Employees*, and has launched a new web page on which this pamphlet and other helpful information are available. We are hopeful that, especially as employees learn about their rights and press their case with their employers, more and more employers across the country will add contraceptive coverage to their employee health benefits, and obviate the need for more lawsuits like Jennifer Erickson's.

IV. WHY EPICC IS NEEDED

Although the Title VII rulings represent significant progress for the employer-provided plans covered by Title VII, enactment of the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) is critical to ensuring that all health plans that provide coverage of prescription drugs include the same level of coverage for FDA-approved prescription contraceptives, as well as coverage for outpatient contraceptive services. EPICC does not require special treatment of contraceptives—only equitable treatment within the context of an existing prescription drug benefit. Because the vast majority of insurance plans cover prescription drugs, a large majority of insured women are expected to benefit from the expanded access to contraceptive coverage that EPICC will produce.

EPICC will extend protection beyond that provided by Title VII. It will cover plans not provided by an employer to its employees, such as non-employment group and individual plans, and those employer plans not covered by Title VII. Millions of women receive their insurance from a source not covered by Title VII. An estimated 16 million Americans obtain health insurance from private insurance other than employer-provided plans. This includes people who are self-employed; those employed by employers who offer no health insurance; part-time, temporary, and contract workers; early retirees too young for Medicare; and unemployed or disabled people not eligible for public insurance. Women are disproportionately represented in several of these categories, such as part-time, temporary, and contract workers. Moreover, not everyone who receives health insurance through an employer is protected by Title VII, which applies only to employers with 15 or more employees—this is less than a fifth of all U.S. employers, and some 14 million workers are employed by entities that fall beneath this threshold.

We know from the unfortunate experience with maternity coverage after passage of the PDA that it is critical to guarantee coverage for women who do not receive their health insurance through their employers. Before the PDA's enactment, private health insurance often did not include maternity care—basic prenatal and delivery services—in their standard policies. Following passage of the PDA, which made clear that employers covered by Title VII could not single out for exclusion from an employee health plan the medical expenses related to pregnancy and childbirth, insurers began to include maternity benefits in their standard benefit package for employer-sponsored plans because their customers, the employers, were legally obligated to provide that benefit. But, because there is no legal mandate to do so, insurers do not always include maternity benefits in their standard benefits package for individuals or others not covered through an employer. There is every reason to believe that insurers will respond in a similar way to contraceptive coverage, thereby underscoring the importance of EPICC.

State experience reinforces the wisdom of EPICC's approach. Sixteen states have passed new laws requiring health plans that cover prescription drugs to cover prescription contraceptives. Their passage confirms the growing recognition of the importance of this issue, and the appropriateness of this approach. But women's access to this basic benefit should not depend on where they live.

V. CONTRACEPTIVE COVERAGE IS COST-EFFECTIVE

As is true for other key forms of preventive health care, coverage of contraceptives can actually save money. For every dollar spent to provide publicly funded contraceptive services, an average of \$3.00 is saved just in Medicaid costs for pregnancy-related health care and medical care for newborns. And, studies by business groups and employer consultants have concluded that employers can save money by including contraceptive coverage in their employee health plans, thereby reducing unintended pregnancies and their associated costs, as well as promoting maternal and child health. For example, the Washington Business Group on Health, an organization that represents 160 national and multinational employers, has estimated that failing to provide contraceptive coverage could cost an employer at least 15% more than providing this coverage. Their report concluded, "For health and financial reasons, employers concerned with providing both comprehensive and cost-effective health benefits ought to consider ensuring that they are covering the full range of contraceptive options."

Moreover, any direct premium costs to an employer who adds contraceptive coverage to its benefits plan are at most extremely modest, and likely to be nonexistent. The concrete experience of the Federal Employees Health Benefits Program (FEHBP) is most instructive. It showed that adding contraceptive coverage to the FEHBP caused no increase in the federal government's premium costs. When the FEHBP contraceptive coverage requirement was implemented, the Office of Personnel Management (OPM), which administers the program, arranged with the health carriers to adjust the 1999 premiums in 2000 to reflect any increased insurance costs due to the addition of contraceptive coverage. However, no such adjustment was necessary, and OPM reported that "there was no cost increase due to contraceptive coverage." OPM's letter is attached to my testimony. Another study found that on average, it costs a private employer only an additional \$1.43 per month per employee to add coverage for the full range of FDA-approved reversible contraceptives.

Of course, even if the cost of contraceptive coverage were substantial—which, as shown, it most assuredly is not—such costs could not justify shortchanging women or sacrificing their health. It would be unthinkable to exclude insurance coverage for heart disease or many other conditions that can lead to expensive health care because of cost. Cost is never recognized as a defense to discrimination, as both the EEOC and the court in *Erickson* noted, and it should not be used as a reason—let alone an unsupported assertion, as would be the case here—to penalize women.

VI. THERE IS WIDESPREAD PUBLIC SUPPORT FOR CONTRACEPTIVE COVERAGE

Not surprisingly, there is broad public support for laws requiring contraceptive coverage. One recent poll conducted this June found that 77% of Americans support laws requiring health insurance plans to cover prescription contraception. This support has been steady. A 1998 Kaiser Family Foundation poll found that 75% of Americans believe contraception should be covered by insurers even if such coverage added to the cost. This broad public support is also reflected in the growing number of states that have enacted legislation requiring all health insurance plans to cover prescription contraceptives, and the fact that in many additional states such legislation is now pending. And, of course, the federal government has also recognized the importance of this benefit by providing it to federal employees.

CONCLUSION

Unless Congress acts, women will not have the contraceptive insurance coverage that they need and deserve. EPICC would provide that coverage, and represents a major step forward for women's health. Thank you.

STATEMENT OF WENDY WRIGHT

Equity in Prescription Insurance and Contraceptive Coverage Act of 2001 (EPICC) would force private insurers that provide a prescription drug plan to include coverage of all FDA-approved contraceptives. This bill, establishing the first-ever nationally mandated benefit in health insurance, is unnecessary, both from consumer and societal aspects. It is a precarious step that would result in some employees being denied full, or other, needed prescription benefits due to increased costs. It would place employers in the untenable position of either not offering any prescription plans, or violating their and their employees' consciences. Adding cost, not value, to health insurance to cover drugs and devices, which do not address a disease or illness, is a prescription for harming the poorest of employees.

Extensive mandates in the states is one of the factors contributing to excessive insurance costs and the inability to obtain insurance. Mandated benefits tend, in

general, to inflate the cost of health insurance by forcing everyone to purchase that which only a minority wants. As the first nationally mandated benefit, EPICC would provoke a demand for further mandates as each health-care interest group pushes to have its particular benefit required. It would be a grave mistake to begin at the national level the same process experimented upon and proven harmful at the state level.

Contraceptives are one of the most heavily subsidized services in the entire health care field with, literally, billions of dollars annually appropriated by federal, state and local government agencies. All poor people and many non-poor have access to free or reduced contraceptive services. Therefore, the dependence on health insurance to provide this benefit is far less than with most other health benefits.

Beyond government-provided contraceptives, numerous health plans cover various forms of contraceptives, which means employees already have a strong probability of obtaining such coverage in their health plan.

Prescription contraceptives do not attend to any of the many kinds of diseases and illnesses that every person is at risk of contracting, and is of only potential interest to a minority of the workforce. Such factors as age, marital status, surgical sterilization, moral conviction, or personal preference for condoms eliminate two-thirds to three-fourths of the workforce from the universe of potential users of prescription methods of contraception.

EPICC requires each plan to cover five different varieties of prescription contraceptive, even though consumers would not use more than one. The annual cost per patient of these benefits is estimated at approximately \$300 to \$400. If approximately one-fourth to one-third of the workforce takes advantage of this benefit, then the increase in premiums for all families will be in the order of magnitude of roughly \$ 100; or to put it another way, employees who are not potential users of prescription contraceptives and their families will be contributing about \$ 100 a year to purchase contraceptives for the minority of their colleagues who choose to take advantage of this benefit.

Now, it could be argued that the very essence of insurance is pooled risk, and this is just another instance of that principle. After all, the employees who do not contract cancer pay through their insurance premiums for the very costly care of those who do.

That principle does not really apply to this situation, however, because there is not really a shared risk. As noted above, there are significant segments of the workforce, altogether totaling a solid majority, who are not and never will be among the future users of prescription contraceptives. Far from representing a shared risk/shared cost pool that follows the classic model of insurance, this scheme is an assessment imposed on one discrete group of workers to subsidize a preference of another group of workers.

Preference is not an ill-chosen word in this context because the use of prescription contraceptives is a matter of discretionary personal preference rather than of medical necessity.

This benefit is purely non-therapeutic, and hence discretionary. Contraception is not necessary as a therapy for any disease or disability, which is the rationale for some insurers in distinguishing between contraceptives and other prescription drugs or devices. Prescription contraception might best be described as preventive medicine, an option that might make health plans more attractive to many consumers and might even reduce overall health care costs in the long run. Such coverage is analogous in this respect to coverage of vitamin supplements. Like contraceptives, vitamin supplements are not intended to cure any undesired conditions, but to prevent them. Like contraceptives, their use is discretionary. By contrast, however, vitamin supplements are not subsidized by government agencies; are not widely available in health insurance plans; and theoretically might be desired by everyone, not just a minority of the population, if they were not costly.

It appears, then, that an even stronger case can be made for mandating coverage of vitamin supplements than of prescription contraceptives. But the same can be said for most health care services, especially for those that are therapeutically necessary.

This is not an argument for excluding insurance coverage of prescription contraception, but rather an argument against mandating such coverage. Ideally, there should be no mandated benefits at all. Benefits should be negotiated to suit the preferences of the insured, and in many instances those preferences might include coverage of prescription contraceptives.

But if the government is going to intrude into that negotiation and impose mandates, then the rational basis for determining which benefits shall be required in each and every insurance plan, regardless of the choices of the particular consumers, then the obvious criteria to apply would be:

1) How widespread is the potential need for the benefit; 2) How expensive is the benefit if the consumer had to pay for it out of pocket; 3) How accessible are alternative sources of the benefit; and 4) How urgent for the health and safety of the beneficiaries is the benefit.

On each one of these criteria, prescription contraceptives rank very low. Indeed, it is difficult even to imagine a rational criterion under which mandating coverage of prescription contraceptives would be a high priority. And yet the legislation before us proposes to make this the one and only nationally mandated benefit in health insurance.

Mandated benefits in the states have forced consumers to pay for benefits that may well be unwanted and unused, simply adding cost rather than value to health insurance plans. The right way to add value is to increase consumer choice. The more closely the health insurance approaches the ideal of an individual consumer choosing among a multiplicity of options, the more cost-efficient and consumer sensitive the system will be. Those consumers for whom contraceptive coverage is important can make that a key point in their purchasing decision. Those for whom it has little or no priority can disregard it as a factor. And those who, for reasons of moral conviction, consider it important not to pay for such a benefit in their health insurance still have the freedom to target their health care dollars in a manner compatible with their consciences—a freedom, by the way, that the legislation under consideration here would snuff out.

The only reason any workers are not getting the benefits they want in their health insurance is that this market model does not prevail. Instead of consumer choice, most workers in the private sector are saddled with an inefficient employers' choice system, and in many states a lengthy list of mandated benefits—many of which are utterly useless to large numbers of workers—are added to the mix, simply running up the cost.

The Federal Employee Health Benefit Program—at least until the first mandated benefit was imposed in 1998—offered an excellent working model of the kind of insurance plan all Americans should have. Each federal employee was able to choose among a range of plans that differed in benefit packages and costs. The only real weakness in the system was that the various plans were still subject to whatever mandates the states imposed on them, and those state mandates were not driven by consumer demand, but by the effectiveness of special interest lobbying. With the legislation before us today we are seeing the beginning of that same disgraceful con game of using the power of government to force people to buy something they neither want nor need.

If workers want insurance coverage for contraception, they should be able to get it. There is a very easy solution to the difficulty that some workers have experienced in obtaining contraceptive coverage: simply assure them the same kinds of consumer choice federal employees have enjoyed for years. By contrast, the solution proposed in this legislation—to force every worker in America to purchase such coverage whether they want it or not—is wasteful, illiberal, and establishes a terrible precedent that will be exploited by every special interest in the health care field.

STATEMENT OF ELIZABETH A. CAVENDISH

NARAL appreciates this opportunity to urge the Senate Committee on Health, Education, Labor, and Pensions to ensure contraceptive equity in insurance plans by enacting S. 104, the Equity in Prescription Insurance and Contraceptive Coverage Act. NARAL's mission is to protect a woman's right to make personal decisions about the full range of reproductive choices; to make abortion less necessary—not more difficult and dangerous. In support of this mission, NARAL and its 27 state affiliates have made ensuring contraceptive coverage for women a top priority.

This bill offers the Senate a prime opportunity to promote women's health, to strike a blow for equity, to advance popular legislation, and, most importantly, to give women real choices over their reproductive lives, so that we may reduce unintended pregnancies. Public opinion polls report that Americans want Congress to enact legislation that will make genuine improvements in their lives; this legislation offers you just such an opportunity. Every month, when a woman who previously paid for birth control pills out of pocket simply pays her usual co-payment, she will be grateful to you. Voters who could not afford the most dependable forms of contraception will appreciate that you recognized this unfairness in insurance coverage.

Contraceptive services are important to women's overall health and in reducing unintended pregnancy, and should be included as part of basic health care coverage. Although most health insurers generally cover prescription drugs, many insurers exclude contraceptives. Nonprescription contraceptive methods such as condoms and spermicides are widely available in the U.S., but the most effective methods such

as oral contraceptives and hormonal implants are more costly and obtainable only through a medical provider. Therefore, some women covered by private health insurance are likely to use less expensive contraceptive methods as an alternative to paying high, out-of-pocket expenses for more effective contraception.

Legislators Recognize the Importance of Insurance Coverage for Contraception.

Congress recognized the importance of contraceptive equity in 1998 by enacting a provision in the Treasury-Postal Appropriations bill which guarantees that Federal Employee Health Benefits plans provide contraceptive coverage to the same extent as coverage for other prescription drugs and devices. The provision has been maintained each year since then, and although the Bush administration targeted it for elimination earlier this year, the full House and the Senate Appropriations Committee rebuffed that attempt with strong bipartisan majorities.

In recent years, state legislators have also begun to recognize the importance of contraceptive coverage. Between 1997 and 2000, state legislatures introduced a total of 135 such bills. Since 1998, 16 states have enacted comprehensive laws to address the imbalance in prescription contraceptive coverage in private insurance, and six other states have laws, policies, or regulations that require some level of insurance coverage for contraception.

The Equal Employment Opportunity Commission (EEOC) and a Federal Court Have Ruled That It Is Sex Discrimination for Employers To Exclude Prescription Contraceptives from Prescription Drug Plans.

Federal law prohibits sex discrimination in employment, including discrimination on the basis of “pregnancy, childbirth, or related medical conditions.” In December 2000, the EEOC issued a decision finding that an employer’s failure to provide coverage for prescription contraceptives, when it covers other preventative drugs and devices, constitutes unlawful sex discrimination under federal law. The decision was issued in response to charges filed by two women, both registered nurses, who were denied equitable coverage for contraception by their employers. These women alleged—and the Commission agreed—that this denial of coverage violated Title VII of the Civil Rights Act of 1964, which bars employers with fifteen or more employees from engaging in sex discrimination.

Prior to the release of the EEOC decision, a lawsuit was filed in federal district court asserting that an employer’s exclusion of prescription contraceptives in its employee health plan violates Title VII. In June 2001, the court, in a case of first impression, echoed the EEOC decision and concluded that the employer’s failure to include prescription contraceptives in an otherwise comprehensive prescription drug plan was sex discrimination under federal law. As a result of this ruling, the court ordered the employer at issue in the case to cover all prescription contraceptive drugs, devices, and services “to the same extent, and on the same terms,” as it provides coverage for other prescription drugs, devices, and services.

Enacting S. 104 would ratify these important rulings of the EEOC and a federal district court, undoubtedly hastening compliance. Moreover, those cases applied to employers, and this legislation would bind insurers; accordingly, with its passage, no doubt would remain about the obligation to treat women’s contraceptive needs equitably.

Without Federal Legislation to Require Contraceptive Parity, Insurance Coverage of Contraceptives is Inadequate

Although state legislatures will continue to take action to ensure contraceptive coverage for some women, they cannot ensure coverage throughout the United States. Not all states will require coverage, and even in states that do, not all women who have private insurance will be covered. In fact, over half of all U.S. workers are covered under a health insurance plan regulated by the Employee Retirement Income Security Act (ERISA) and thus exempt from state regulation. Those employees must of necessity seek equity under federal law.

Congress cannot just sit back and wait for the market to provide these services. Unfortunately, all too few plans offer this coverage and all too few employers demand that women’s health needs be covered in the plans they purchase. Perhaps insurers have decided that women will just pay out of pocket for the most reliable contraceptives; perhaps they assume that going to the drugstore for less effective methods is sufficient. In either case, such thinking is unfair to women. Congress must redress the market failure whereby insurers fail to cover this critical aspect of women’s health care notwithstanding the clear demand of women for effective contraceptives.

S. 104 recognizes that the following state of affairs is unacceptable:

Half of All Traditional Fee-for-Service Insurance Plans Cover No Reversible Contraceptive Methods at All, and Existing Coverage Is Lacking.

Forty-nine percent of all typical large group plans (insured indemnity plans written for 100 or more employees) do not routinely cover any contraceptive methods, and only 15 percent cover the five primary reversible contraceptive methods: oral contraception, IUD insertion, diaphragm fitting, Norplant insertion, and injections (typically Depo-Provera). Fewer than 40 percent of typical large group plans routinely cover any one of these five methods. Coverage of all five methods is critical to women's health, since not all methods are appropriate for all women. For instance, some women cannot take hormonally-based contraceptives such as "the pill," and they must have access to other effective contraception such as diaphragms or the IUD.

By contrast, sterilization is generally covered by 85 percent of large group plans, reflecting the tendency for health insurers to cover surgical services, but not preventive care.

Health Maintenance Organizations (HMOs) Provide Better Contraceptive Coverage, But Fewer Than Half Cover the Five Most Commonly Used Methods.

Although 93 percent of HMOs cover some contraceptive methods, only 39 percent routinely cover the five most commonly used methods.

Coverage of contraceptive devices by HMOs varies. Implant insertions are covered by 59 percent of HMOs and 86 percent of IUD insertions are covered. Coverage of the devices themselves, however, is always lower than for the insertion or fitting.

Preferred Provider Organizations (PPOs) and Point-of-Service (POS) Networks Often Include Some Contraceptive Care, But Contain Significant Coverage Caps.

Forty-nine percent of PPOs and 19 percent of POS networks do not routinely cover any reversible contraceptive methods. Only 18 percent of PPOs and 33 percent of POS networks typically cover the five most commonly used methods.

PPOs provide minimal coverage of contraceptive devices, with only 23 percent for diaphragm fittings, 25 percent for IUD insertion, and 35 percent coverage for injections. Coverage of contraceptive devices by POS networks ranges from 46 percent for IUD insertions and diaphragm fittings to 72 percent for an injection.

Inequities in Insurance Coverage for Prescription Contraception Fall Heavily Upon Women.

Women of reproductive age spend 68 percent more than men on out-of-pocket health care costs, with reproductive health care services accounting for much of the difference.

The most effective forms of prescription contraception are used only by women. Some of these methods are expensive, at least up front, often costing hundreds of dollars at the outset of patient use. Thus, women who pay out-of-pocket may opt for less expensive and sometimes less effective methods, thereby increasing the number of unintended pregnancies.

Recent Polls Indicate that the Public Supports Contraceptive Equity.

In a 2001 NARAL Foundation nationwide poll, 77% of respondents supported legislation requiring health insurance companies to cover the cost of contraception.

A national survey by the Kaiser Family Foundation found that three quarters of those surveyed favored legislation requiring insurers to provide coverage for the full range of contraceptives. Support for insurance coverage of contraception remained high (73 percent) even when participants were told that the coverage could increase insurance premiums by \$1 to \$5. In addition, the survey also found that the public is more likely to support insurance coverage of contraceptives (75 percent) than Viagra (49 percent).

Two state polls found similar support. A Connecticut survey found that 76 percent of those polled support legislation requiring insurance companies to cover contraceptives. In Texas, a Scripps Howard poll found that 70 percent of Texans favor requiring insurance companies to cover prescription contraceptives to the same extent that they cover other prescription drugs.

Improved Access to and Use of Contraception Would Save Insurers and Society Money by Preventing Unintended Pregnancies.

Nearly 50 percent of pregnancies are unintended, including 31 percent of pregnancies among married women. Fifty-four percent of unintended pregnancies end in abortion.

Improved access to and use of contraception would save insurers and society money by preventing unintended pregnancies. Insurers generally pay the medical costs of unintended pregnancy, including ectopic pregnancy (\$4994), induced abortion (\$416), spontaneous abortion (\$1038), and term pregnancy (\$8619). Therefore, access to contraception should actually prevent other, more expensive medical conditions associated with unintended pregnancy that usually are covered by health plans.

A recent cost analysis conducted for The Alan Guttmacher Institute (AGI) indicates that the cost of covering contraception is not significant. The average total cost (including administrative costs) of adding coverage for the full range of reversible prescription contraceptives to health plans that do not currently cover them is \$21.40 per employee per year—\$17.12 of employers' cost and \$4.28 of employees' cost. The added cost for employers to provide coverage of the full range of reversible contraceptives is approximately \$1.43 per employee per month. The cost is significantly lower for health plans that currently cover at least some contraceptives.

Private Health Insurance Coverage of Contraception Will Improve the Health of Women and Families.

The lack of adequate private insurance coverage for contraceptive services makes it more difficult for women to prevent unintended pregnancy and increases the need for abortion. Nearly 50 percent of all pregnancies in the U.S. are unintended, and over one-half of unintended pregnancies result in abortion. The majority of American women and men believe that the cost of birth control and the inability to obtain it contribute to the problem of unplanned pregnancy. The U.S. differs from countries with lower rates of unplanned pregnancy in that highly effective contraceptive care in the U.S. is neither widely available nor easily accessible.

In addition to contributing to high rates of unintended pregnancy, the inaccessibility of more effective contraceptive methods carries appreciable health risks for women and children. Research shows that women with unintended pregnancies are less likely to obtain timely or adequate prenatal care. Moreover, unintended pregnancy increases the likelihood of low birth weight babies and infant mortality. Estimates show that effective family planning could reduce the rates of low birth weight and infant mortality by 12 percent and 10 percent, respectively.

CONCLUSION

Requiring private insurance to cover contraception will increase access to more effective contraceptive methods and will allow a greater number of women to plan, space and time pregnancies, thereby reducing unintended pregnancy and the need for abortion. The impact of contraceptive coverage will be improved health for American women, men and families. This legislation is fair, it is sensible, it is important, it is popular, and it should be enacted promptly.

AMERICAN LIFE LEAGUE,
STAFFORD, VA 22555,
September 12, 2001.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
U.S. Senate,
Washington, DC.

DEAR HONORABLE MEMBERS OF THE COMMITTEE: American Life League opposes passage of any legislation, or the funding of any program, which in any way promotes contraception. This certainly includes the Equity in Prescription Insurance and Contraceptive Coverage Act of 2001 (S. 104). Such a law would require health insurance premium payers to pay for contraceptive drugs and devices, many of which act, some of the time, to prevent the implantation of an already conceived living human embryo by causing the death of that human embryo after her life has begun at fertilization/conception but before she implants herself in her mother's womb. This proposed law, S. 104, thereby requires the subsidizing of chemicals that kill human persons during their first days of life. Furthermore, contraception, in and of itself, even if it consists only of barrier methods that do not cause abortion of embryonic persons, is a grave moral evil that should not be promoted in any way by civil authority. S. 104 legitimizes a practice that destroys God's plan for every sexual act to be open to the procreation of new life within the context of a loving relationship between two married people.

The American public is now more acutely aware of the humanity of the human embryo from the debate over embryonic stem cell research. Most Americans believe that the federal government should not be promoting a program that kills human embryos for stem cell research. Why then does our government promote embryonic killing through "contraceptive" programs such as Title X and why is Congress contemplating a bill (S. 104) that will further promote such killings?

In 1998, Senators Mike Enzi, Tim Hutchinson, John Ashcroft, Sam Brownback, Dan Coats, Jesse Helms, Robert Smith and Don Nickles signed a "dear colleague" letter opposing a Senate amendment requiring that federal employees get coverage for contraceptive drugs and devices. In the letter, they said, "We are concerned with what appears to be a loophole in the legislation regarding contraceptives that, upon failing to prevent fertilization, act de facto as abortifacients."

On January 18, 2001, during the Senate Judiciary Hearing on the appointment of John Ashcroft as Attorney General, the President of Planned Parenthood Federation of America, Gloria Feldt, complained about this 1998 “dear colleague” letter when she testified against John Ashcroft.

She said, “The practical, and intended, result of these and similar efforts would be not only the criminalization of abortion as we know it, but also of some of the most commonly used and effective methods of contraception, such as the birth control pill, which frequently acts to prevent implantation of the fertilized ovum . . .” You see, even Planned Parenthood admits that many of the most common forms of contraception prevent implantation by causing the death [aborting] of the human embryo.

Further, we would also oppose passage of S.104 even if it were to be amended to include a conscience clause that would allow insurers or employers an exemption on the basis of religious belief. Proponents of similar contraceptive coverage acts on the state level have used this so-called compromise tactic to deflect opposition. But the fact is that even with a conscience clause for insurers and/or employers, individual employees can still be stuck paying partial premiums into an employer plan that did not opt out or qualify for the conscience exemption. These individual employees will, in many cases, have no other affordable health insurance option than the one that subsidizes birth control practices even though these employees find such coverage morally objectionable. Logically, it makes no sense for any health insurance plan to pay for birth control prescriptions. Such medications do not treat illness but rather become the cause of physical ailments for women and death for countless numbers of embryonic persons. S. 104 must not become law.

Sincerely yours in the Lord of Life,

JULIE BROWN,
President.

[Whereupon, at 4:43 p.m., the committee was adjourned.]

