HB 313

ALASKA STATE LEGISLATURE

Chair:
LABOR AND COMMERCE

Member:
MILITARY AND VETERANS AFFAIRS
COMMUNITY AND REGIONAL AFFAIRS
LEGISLATIVE COUNCIL
JOINT ARMED SERVICES

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To: Representative Fred Dyson, Chairman, House Health, Education and Social Services Committee

From: Representative Murkowski

Date: February 7, 2002

Re: HB 313

Please schedule House Bill 313 "An Act requiring that the cost of contraceptives be included in certain health care insurance coverage" for a hearing in House Health, Education and Social Services Committee as soon as possible.

Included with the request is:
1) HB 313
2) Sponsor Statement
3) Informational Testimony

Thank you for your consideration.

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Sponsor Statement

HB 313

"An Act requiring that the cost of contraceptives be included in certain health care insurance coverage"

In order to bring Alaska into compliance under Title VII of the Civil Rights Act of 1964, we have introduced HB 313, also referred to as "Prescription Equity". Last year, the Equal Employment Opportunity Commission ruled that an employer's failure to cover prescription contraceptives in employee health benefit plans constitutes unlawful sex discrimination.

While HB 313 calls for contraceptive coverage, it only requires it in a plan already offering prescription drugs and does not require an insurer provide coverage for abortion. In the scope of this bill, a religious employer would be exempt from offering coverage for contraceptives if it is against their doctrine.

Coverage of prescriptive contraceptives can be a point of contention for some. However it is important to realize contraceptive coverage is healthier for the women, the family and society than an unintended pregnancy. In 1996, 42 percent of the live births in Alaska were from unintended pregnancies. Additionally, many doctors will prescribe contraceptives to a woman not for sexual reasons, but for the overall health of the women from regulating menstrual cycles to alleviating dermatology problems and other hormonal imbalances.

The more effective forms of contraception are generally the most expensive. Women and their families who must pay out of pocket may opt for less expensive and sometimes less effective methods, increasing the risk for unintended pregnancies. Women of reproductive age currently spend 68 percent more in out-of-pocket health care costs than men. Much of the gender gap in expenses is due to reproductive health-related supplies and services.

Cost analyses show if health insurance policies were to include coverage for these contraceptive supplies, cost to employers would be minimal – as little as $1.43 per employee per month. In 1998, coverage inequality was brought into the spotlight as Viagra hit the market. Within two months of entering the U.S. market, more than half of all Viagra prescriptions received some insurance reimbursement, while overall coverage for oral contraceptives did not reach this level until they had been on the market for over 40 years.

To date 17 states offer comprehensive coverage for prescription contraceptives, while an additional 15 states offer partial mandates or optional coverage. The sponsors and co-sponsors of HB 313 strongly urge your support of this legislation.

Why Alaska Women Need Equity in Prescription Coverage

Contraception is a basic health care need for women, and a critical contributor to improved maternal and child health.

- Most couples today choose to have 2 or 3 children. Therefore the typical Alaskan woman spends 90% of her reproductive life seeking to avoid pregnancy.[1]
- One-half of the pregnancies that occur each year are unintended, and 41% of these end in abortion.[2]

Contraceptive drugs and devices (approved by FDA for use as contraceptive) are not routinely covered by insurers.

- Most health care providers routinely cover abortion and sterilization.[3]
- Only ½ of large group insurance plans cover reversible contraception.[4]
- 1/3 of large group plans cover oral contraceptives, the most commonly used, reversible method in the U.S.[5]
- A year's supply of oral contraceptives can cost over $300.
- Less than 20% of plans cover all five of the major reversible methods of contraception.[6]

Women pay more out-of-pocket for health care, primarily because of reproductive health care costs.

- Women of childbearing age pay 68% more in out-of-pocket health care costs than their male counterparts and reproductive health care services account for much of this cost differential.[7]

Making contraception more affordable will increase its availability and use, and reduce the number of unintended pregnancies and abortions.

- In any single year, 85 of 100 sexually active women of reproductive health age who are not using contraceptives will become pregnant.[8]
- In contrast, of 100 oral contraceptive users, only three will become pregnant in a given year.[9]

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[1] *Securing American Women's Reproductive Health*: The American Woman 1994-1995. Women's Research and Education Institute, 1994.
[2] Bureau of Vital Statistics, 1998
[3] *Uneven and Unequal: Insurance Coverage and Reproductive Health Services*, The Alan Guttmacher Institute, 1993.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] *Women's Health Insurance Costs and Experience*, Women's Research and Education Institute, 1994.
[8] *The Economic Value of Contraception: A Comparison of 15 Methods*, American Journal of Public Health. April, 1995.
[9] Ibid.

Making contraception more available will save money.

- Every tax dollar spent on contraceptive care saves an average of three dollars in Medicaid funds alone that would have been spent on providing care to pregnant women and newborns.[10]
- Contraceptives cost less than the service related to pregnancy. The average cost of an uncomplicated vaginal delivery is $5,000 and cost of a delivery through a cesarean section is over $10,000.[11]
- The Alan Guttmacher Institute estimates the cost of adding coverage to be quite low: The total costs for contraceptive coverage for employees and dependents would be $21.40 per employee per year -- $17.12 of employers' costs, and $4.28 of employees costs.

There is widespread support for extending prescription coverage to contraceptives.

- The Kaiser Family Foundation found in a recent poll that 78% of privately insured adults support contraceptive coverage, even if their premiums were to increase up to $5 per month, which is an amount far greater than studies have projected.

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[10] *Title X and the U.S. Family Planning Effort*, The Alan Guttmacher Institute, 1997.
[11] *Source Book of Health Insurance Data*, Health Insurance Association of America, 1996.

Talking Points for AK Contraceptive Equity

In the United States, on average, a woman has 2.1 children during the course of her life. A woman who is sexually active and wants only two children will need contraception for more than twenty years of her life.

In 1988, there were 3.2 million unintended pregnancies in the United States.
- 47% in women using reversible contraception
- 53% in women not using contraception

(Source: *The Best Intentions*, Institute of Medicine, 1995)

There are 140,00 Women of childbearing age in Alaska (ages 15- 44), of these, 76,330 women are in need of contraceptive services and supplies.

In Alaska, 84% of women aged 15-44 have either private insurance or Medicaid.

42% of live births in Alaska are from unintended pregnancies.
- (Source: PRAMS 1996)

Unintended pregnancies carry appreciable risks for children, women, man, and families
(Source: *The Best Intentions*, Institute of Medicine, 1995)
Findings include:
- later onset of prenatal care
- higher frequency of inadequate prenatal care
- higher incidence of low birth weight infant (<2500 g)
- higher incidence of infant mortality (death w/i1st year of life)
- higher incidence of child abuse
- higher incidence of physical abuse of mother
- higher subsequent divorce rate (3x)
- fathers more likely to be absent (Children raised by one parent are more likely to drop out of school, to have encounters with the criminal justice system, and more likely to become teen parents)
- higher incidence of economic hardship & failure of parents to achieve educational & career goals

Reducing unintended pregnancy is the key to reducing the number of abortions; almost half of unintended pregnancies end in abortion.
- Each year in Alaska, 120 pregnancies occur per 1,000 women ages 15- 44, 69% of which end in live births, 16% in abortions.

90% of Americans support family planning to prevent unintended pregnancies.

Women who use family planning services in the two years before conception are more likely to receive early and adequate prenatal care.

The National Commission to Prevent Infant Mortality estimates that 10% of infant deaths could be prevented if all pregnancies were planned.

Ready access to contraceptive services increases the likelihood that sexually transmitted infections will be diagnosed and treated.

Less than 20% of traditional health care plans and PPOs and less than 40% of managed care plans cover all of the most commonly used methods of conception (oral contraceptives, the IUD, diaphragm, Norplant, and Depo-Provera).

Talking Points for AK Contraceptive Equity

In any single year, 85% of sexually active women not using contraceptive method will become pregnant. In contrast of 100 oral contraceptive users, only 3 to 6 percent become pregnant in one year.

Although 97% of typical indemnity policies cover prescription drugs in general, only 33% include oral contraceptives in that coverage.

The more effective forms of contraception are generally more expensive. Women who must pay out of pocket often opt for less expensive and effective methods, thus increasing the likelihood of an unintended pregnancy.

Women of reproductive age spend 68% more in out-of-pocket expenses than men. Much of the gender gap is due to reproductive health care.

The Health Association of America, a national trade association representing about 270 of the nation's leading health care companies, showed that insurance costs would increase by $16.00 per year per employee in plans covering other prescription medications.

Every dollar spent for contraceptive services saves $3 in public funds that would have been needed to provide prenatal and newborn care alone.

Inadequate and discriminatory coverage of women's health services has a long history in the United States. Insurance policies typically excluded coverage for pregnancy until a federal law was passed in 1978. Similarly, coverage for Pap smears and mammograms was routinely excluded from insurance policies until state and federal laws required it the 90's.

Nationwide, 75% of voters support requiring insurance companies to cover contraceptives.

Contraception is a basic health care need, and critical to maternal, child, and family health.

- Most U.S. couples choose to have 2 to 3 children – therefore Alaskan women spend 90% of their reproductive life seeking to avoid pregnancy.[1]
- Unintended pregnancies for Alaskan families mean higher risks: inadequate prenatal care, higher infant mortality, higher incidence of child abuse, divorce, absent fathers and poverty.[2]
- Spacing children at approximately 2 1/2 years apart is beneficial to the health and welfare of both mother and child.[3]

1 *Securing American Women's Reproductive Health*; The American Women 1994-1195. Women's Research and Education Institute, 1994.
2 The Best of Intentions. Institute of Medicine, 1995.
3. Centers for Disease Control and Prevention, 1996.

Contraception is the only FDA-approved prescription not routinely covered by insurers.

- Less than 20% of traditional health care plans cover all 5 FDA approved methods of contraception.[4]
- 1/3 of large group plans cover oral contraceptives (birth control pills) – the most commonly used, reversible method in the U.S.[5]
- A one year supply of oral contraceptives can cost over $300.

4 *Uneven and Unequal: Insurance Coverage and Reproductive Health Services*, The Alan Guttmacher Institute, 1993.
5 Ibid.

The majority of voters support prescription equity.

- 78% of privately insured adults support covering contraceptives under their prescription plan according to a recent poll by the Kaiser Foundation.

Alaskans Support Prescription Equity

It's an equity issue.

- Women of childbearing age pay 68% more in out-of-pocket health care costs than men.[6]
- Reproductive health care services account for much of this cost differential.[7]
- All prescriptions for men, including Viagra, are covered by most prescription plans.

6 *Women's Health Insurance Costs and Experience*, Women's Research and Education Institute, 1994.
7 Ibid.

Covering contraceptives will save money.

- Contraceptives ($300/year) cost less than pregnancy services ($5000 for an uncomplicated vaginal delivery-$10,000 for cesarean delivery).[11]
- The non-contraceptive benefits of birth control pills include prevention of anemia, osteoporosis, cancer, and approximately 50,000 hospitalizations in the U.S. each year.

11 *Source Book of Health Insurance Data*, Health Insurance Association of America, 1996.

Affordable contraception will decrease unintended pregnancies and prevent abortions.

- 42% of live births in Alaska are unintended (either mistimed or unwanted).[8]
- 85 out of 100 women of reproductive age who are not using contraceptives will become pregnant in a year.[9]
- Each year in Alaska, 120 pregnancies occur per 1000 women ages 15-44. 69% of these pregnancies end in live births; 16% end in abortion.[10]

8 *PRAMS*, State of Alaska, 1996.
9 *The Economic Value of Contraception: A Comparison of 15 Methods*. American Journal of Public Health. April, 1995.
10 Ibid.

THE COALITION FOR PRESCRIPTION EQUITY

Alaskan Contraceptive Coverage Equity Bill
HB 29, SB 82
MESSAGE BOX / TALKING POINTS

The U.S. Equal Employment Opportunity Commission

The following Commission Decision finds reasonable cause to believe that discrimination occured under Title VII of the Civil Rights Act of 1964, as amended, in two charges challenging the exclusion of prescription contraceptives from a health insurance plan. The Decision is a formal statement of Commission policy as applied to the facts at issue in these charges.

Decision

Summary of Charge

The Charging Parties, female employees of Respondents, allege that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e *et seq.* (Title VII). Specifically, Charging Parties challenge Respondents' failure to offer insurance coverage for the cost of prescription contraceptive drugs and devices.

Jurisdiction

Respondents are employers within the meaning of Section 701(b) of the Act. All other jurisdictional requirements have also been met.

Summary of Investigation

Charging Party A, a registered nurse, began working for Respondent A in 1997. Under its health insurance plan, Respondent A covers numerous medical treatments and services, including prescription drugs; vaccinations; preventive medical care for children and adults, including pap smears and routine mammograms for women; and preventive dental care. Respondent A also covers the cost of surgical means of contraception, namely vasectomies and tubal ligations. However, Respondent A's plan excludes coverage for prescription contraceptive drugs and devices, whether they are used for birth control or for other medical purposes.

Charging Party A wishes to use oral contraceptives for birth control purposes. Based on her medical history, Charging Party A also wishes to use oral contraceptives to alleviate the symptoms of dysmenorrhea and pre-menstrual syndrome and to prevent the development of ovarian cancer.

Charging Party B, a registered nurse, began her employment with Respondent B on May 1, 1999. Respondent B is commonly owned with Respondent A, and offers to its employees the same health insurance policy that Respondent A offers to its employees. As a result, Charging Party B is subject to the same exclusions from health coverage as Charging Party A. Charging Party B wishes to use Depo Provera, an injectible prescription contraceptive, for birth control purposes.

Charging Parties both allege that Respondents' failure to offer coverage for prescription contraceptive drugs and devices constitutes discrimination on the bases of sex and pregnancy in violation of Title VII. Respondents deny that the exclusion of prescription contraceptives, which on its face does not distinguish between men and women, is discriminatory.

Discussion

Based on current medical knowledge, individuals who wish to avoid conception may choose from a range of contraceptive alternatives. These alternatives include surgical procedures, like vasectomies and tubal ligations; non-prescription birth control, like condoms; and prescription contraceptive drugs and devices, like birth control pills, diaphragms, intra-uterine devices, and Norplant implants. Prescription contraceptives are available only to women.

Oral contraceptives are also widely recognized as effective in treating certain medical conditions that exclusively affect women, such as dysmenorrhea (menstrual cramps) and pre-menstrual syndrome.(1) Contraceptives are also sometimes prescribed to prevent the development of ovarian cancer. Respondents' insurance plan excludes contraceptives "regardless of intended use."(2)

The Commission concludes that Respondents' exclusion of prescription contraceptives violates Title VII, as amended by the Pregnancy Discrimination Act,(3) whether the contraceptives are used for birth control or for other medical purposes.

I. Exclusion of Prescription Contraceptives Used for Birth Control Purposes

A. The Pregnancy Discrimination Act Applies to Prescription Contraception

To clarify its long-standing intent with regard to Title VII, Congress enacted the Pregnancy Discrimination Act (PDA) to explicitly require equal treatment of women "affected by pregnancy, childbirth, or related medical conditions" in all aspects of employment, including the receipt of fringe benefits.(4) This language bars employers from treating women who are pregnant or affected by related medical conditions differently from others who are similarly able or unable to work. It also prohibits employers from singling out pregnancy or related medical conditions in their benefit plans.

As the Supreme Court has made clear, the PDA's prohibitions cover a woman's potential for pregnancy, as well as pregnancy itself. Recognizing that the PDA prohibits "discrimination on the basis of a woman's ability to become pregnant," the Court concluded that an employment policy that excluded women capable of bearing children from certain jobs was an impermissible classification because it was based on the potential for pregnancy. As the Court held, "[u]nder the PDA, such a classification must be regarded, for Title VII purposes, in the same light as explicit sex discrimination."(5) Under the Court's analysis, the fact that it is women, rather than men, who have the ability to become pregnant cannot be used to penalize them in any way, including in the terms and conditions of their employment.

Contraception is a means by which a woman controls her ability to become pregnant. The PDA's prohibition on discrimination against women based on their ability to become pregnant thus necessarily includes a prohibition on discrimination related to a woman's use of contraceptives. Under the PDA, for example, Respondents could not discharge an employee from her job because she uses contraceptives. So, too, Respondents may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devices.

This conclusion is supported by additional language in the PDA that specifically exempts employers from any obligation to offer health benefits for abortion in most circumstances.(6) Congress understood that absent an explicit exemption, the PDA would require coverage of medical expenses resulting from a woman's decision to terminate a pregnancy.

The same analysis applies to the question of whether the PDA covers prescription contraceptives. As just

discussed, the PDA's prohibition of discrimination in connection with a woman's ability to become pregnant necessarily includes the denial of benefits for contraception. Had Congress meant to limit the applicability of the PDA to contraception, therefore, it would have enacted a statutory exemption similar to the abortion exemption. Such an exemption, of course, does not exist for contraceptives.

Further, construing the PDA to cover contraception implements Congress' clearly expressed intent in enacting the PDA. Congress wanted to equalize employment opportunities for men and women, and to address discrimination against female employees that was based on assumptions that they would become pregnant.(7) Congress thus prohibited discrimination against women based on "the whole range of matters concerning the childbearing process,"(8) and gave women "the right ... to be financially and legally protected before, during, and after [their] pregnancies."(9) It was only by extending such protection that Congress could ensure that women would not be disadvantaged in the workplace either because of their pregnancies or because of their ability to bear children.

In sum, the Commission concludes that the PDA covers contraception based on its plain language, the Supreme Court's interpretation of the statute, and Congress' clearly expressed legislative intent.

B. The PDA Requires Coverage of Prescription Contraceptives in this Case

The PDA requires that expenses related to pregnancy, childbirth, or related medical conditions be treated the same as expenses related to other medical conditions.(10) Because Respondents have failed to provide such equal treatment in this case, they are liable for discrimination under the PDA.

Contraception is a means to prevent, and to control the timing of, the medical condition of pregnancy. In evaluating whether Respondents have provided equal insurance coverage for prescription contraceptives, therefore, the Commission looks to Respondents' coverage of other prescription drugs and devices, or other types of services, that are used to prevent the occurrence of other medical conditions. In Respondents' plan, such drugs, devices, and services include:

- vaccinations;
- drugs to prevent development of medical conditions, such as those to lower or maintain blood pressure or cholesterol levels;
- anorectics (weight loss drugs) for those 18 years of age and under;
- preventive care for children and adults, including physical examinations; laboratory services in connection with such examinations; x-rays; and other screening tests, like pap smears and routine mammograms; and
- preventive dental care (including oral examinations, tooth cleaning, bite wing x-rays, and fluoride treatments).(11)

Respondents have made three arguments to justify their exclusion. First, Respondents allege that their plan covers treatment of medical conditions only if "there is something abnormal about [the employee's] mental or physical health,"(12) and thus that the above-listed drugs and services are not appropriate comparators for evaluating Respondents' coverage of contraceptives. However, this argument reflects a misunderstanding about the nature of pregnancy. It is widely recognized in the medical community that pregnancy is a medical condition that poses risks to, and consequences for, a woman.(13)

In addition, Respondents' argument is also belied by the explicit terms of their health plan, which is not, in fact, restricted to coverage of "abnormal" conditions. First, Respondents cover contraception through

surgical forms of sterilization - vasectomies and tubal ligations -- without requiring any showing of the reasons individuals are undergoing the procedures. More broadly, Respondents cover numerous treatments and services that are designed to maintain current health and prevent the occurrence of future medical conditions, whether or not there is something "abnormal" about the employee's current health status. It is appropriate, for example, to compare Respondents' coverage of vaccinations or physical examinations to that of contraceptives, because both serve the same preventive purposes. Because Respondents have treated contraception differently from preventive treatments and services for other medical conditions, they have discriminated on the basis of pregnancy.(14)

Respondents also claim that Charging Parties' claims are preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1144(a), 1191.(15) This claim is without merit. ERISA preempts certain *state* laws that regulate insurance, but explicitly exempts federal law from preemption.(16) Moreover, the fact that ERISA does not require health plans to "provide specific benefits" does not mean that other statutes - namely Title VII - do not impose such requirements where necessary to avoid or correct discrimination.

Finally, Respondents state that they have excluded contraception for "strictly financial reasons."(17) Respondents' motivation is, however, legally irrelevant. Although Congress clearly anticipated that an employer's insurance costs would likely increase once the PDA required employers to cover pregnancy and related medical conditions,(18) it wrote no cost defense into the law.(19)

II. Exclusion of Prescription Contraceptives Used for Birth Control and/or Other Medical Purposes

The analysis set forth above applies to Charging Parties' claims that Respondents' exclusion unlawfully interferes with their ability to use prescription contraceptives for birth control purposes. Charging Party A has further claimed that Respondents' exclusion applies not only to her use of contraceptives for birth control purposes, but also to her use of contraceptives to treat dysmenorrhea and menstrual cramps. Respondents have violated Title VII's basic nondiscrimination principles regardless of the purpose of Charging Parties' use of contraceptives.

Respondents assert that their exclusion does not constitute sex discrimination because it does not explicitly distinguish between men and women.(20) However, prescription contraceptives are available *only* for women. As a result, Respondents' explicit refusal to offer insurance coverage for them is, by definition, a sex-based exclusion. Because 100 percent of the people affected by Respondent's policy are members of the same protected group - here, women -- Respondent's policy need not specifically refer to that group in order to be facially discriminatory.(21)

Moreover, Respondents' other efforts to mount a defense are unavailing. Respondents may not rely on arguments that coverage of contraception is precluded by ERISA or may be denied based on cost concerns. Nor can Respondents successfully argue that contraception is not medically necessary, whether used for birth control or other medical purposes. *See* Section I(B), *supra.*

The inequality in treatment is apparent whether Charging Parties wish to use contraceptives to prevent conception or for other medical purposes. This is because Respondents have circumscribed the treatment options available to women, but not to men. Respondents' health plan effectively covers approved, non-experimental treatments for employees' medical conditions *unless* those treatments involve contraceptives. This is unlawful.(22)

Conclusion

There is reasonable cause to believe that Respondents have engaged in an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act, by failing to offer insurance coverage for the cost of prescription contraceptive drugs and devices. Charging Parties are entitled to reimbursement of the costs of their prescription contraceptives for the applicable back pay period. In addition, the District Office is instructed to determine whether any cognizable damages have resulted from Respondents' actions.

In order to avoid violating Title VII in the future:

- Respondents must cover the expenses of prescription contraceptives to the same extent, and on the same terms, that they cover the expenses of the types of drugs, devices, and preventive care identified above. Respondents must also offer the same coverage for contraception-related outpatient services as are offered for other outpatient services. Where a woman visits her doctor to obtain a prescription for contraceptives, she must be afforded the same coverage that would apply if she, or any other employee, had consulted a doctor for other preventive or health maintenance services. Where, on the other hand, Respondents limit coverage of comparable drugs or services (*e.g.,* by imposing maximum payable benefits), those limits may be applied to contraception as well.

- Respondents' coverage must extend to the full range of prescription contraceptive choices. Because the health needs of women may change -- and because different women may need different prescription contraceptives at different times in their lives -- Respondents must cover each of the available options for prescription contraception. Moreover, Respondents must include such coverage in each of the health plan choices that it offers to its employees. *See* 29 C.F.R. part 1604, App. Q&A 24; *Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1081-82 n.10 (1983).

The charges are remanded to the field for further processing in accordance with this decision.

FOR THE COMMISSION:

12/14/00
Date

/s/
Executive Officer
Executive Secretariat

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1. *See, e.g.*, Kaunitz, *Oral Contraceptive Health Benefits: Perception v. Reality*, Contraception 1999, 59:29S-33S (January 1999); Sulak, *Oral Contraceptives: Therapeutic Uses and Quality -of-Life Benefits - Case Presentations*, Contraception 1999, 59:35S-38S (January 1999).

2. Letter from Respondents to EEOC, June 22, 2000.

3. Numerous states have also addressed policies like Respondents'. To date, thirteen states have passed legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devices. *See* Cal. Ins. Code 10123.196 (California); Del. Code Ann., title 18, 3559 (Delaware); 1999 Conn. Acts 99-79 (June 3, 1999) (Connecticut); Ga. Code Ann. 33-24-59.6 (Georgia); Hawaii Rev. Stat. 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (Hawaii); Iowa Code 514C.19; Me. Rev. Stat. Ann., title 24, 2332-J, Me. Rev. Stat. Ann., title 24-A, 2756, 2847-G, 4247 (Maine); Md. Code Ann., Ins., 15-826 (Maryland); Nev. Rev. Stat. Ann. 689A.0415 *et seq.* (Nevada); N.H. Rev. Stat. Ann., title 37, 415:18-i (New Hampshire); 1999 N.C. Sess. Laws

90 (June 30, 1999) (North Carolina); R.I. Gen. Laws 27-18-57, 27-19-48, 27-20-43, 27-41-59 (Rhode Island); 8 Vt. Stat. Ann. 4099c (Vermont). Insurance plans offered to federal employees must meet similar requirements. P.L. 106-58, 113 Stat. 430 (Sept. 29, 1999).

4. 42 U.S.C. 2000e(k).

5. *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 199, 211 (1991).

6. 42 U.S.C. 2000e(k).

7. H.R. Rep. No. 948, 95th Cong., 2d Sess. 3 (1978) ("[t]he assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs"); *see also id.* at 6-7; 123 Cong. Rec. 29,385 (1977) (statement of Senator Williams, chief sponsor of the Senate bill that led to the PDA) ("[b]ecause of their capacity to become pregnant, women have been viewed as marginal workers not deserving of the full benefits of compensation and advancement . . .").

8. H.R. Rep. No. 948, 95th Cong., 2d Sess. 5 (1978).

9. 124 Cong. Rec. H38,574 (daily ed. October 14, 1978) (statement of Rep. Sarasin, a manager of the House version of the PDA).

10. *See, e.g.*, 29 C.F.R. Part 1604, App. Introduction ("any health insurance provided must cover expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions").

11. *See* Respondents' Summary Plan Description at, *e.g.*, pp. 87, 90, 112, 137.

12. Letter from Respondents to EEOC, June 22, 2000.

13. *See, e.g., Equity in Prescription Insurance and Contraceptive Coverage Act 1998: Hearings on S. 766 before the Senate Committee on Labor and Human Resources*, 105th Cong., 2d Sess. 25 (1998) (statement of Richard H. Schwarz, M.D.); 144 Cong. Rec. S9,194 (daily ed. July 29, 1998) (statement of Senator Snowe) (there is "nothing 'optional' about contraception. It is a medical necessity for women during 30 years of their lifespan. To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable.") (quoting statement by American College of Obstetricians and Gynecologists).

14. In addition, Respondents cover Viagra where patients complain about "decreased sexual interest or energy," whether or not the individual has been diagnosed as impotent. Letter from Respondents to EEOC, August 25, 2000. Respondents' assertion that their plan covers treatments only for abnormal medical conditions is not credible in light of these facts.

15. Letter from Respondents to EEOC, June 22, 2000.

16. 29 U.S.C. 1144(a) (setting forth basic rule of preemption of state law); 1144(d) ("[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law"); *see also Shaw v. Delta Airlines*, 463 U.S. 85 (1983) (state laws that are co-extensive with federal laws are not preempted by ERISA).

17. Letter from Respondents to EEOC, April 19, 2000.

18. *See, e.g.*, Statement of Senator Williams, floor manager of the PDA, *reprinted in* "Legislative History of the Pregnancy Discrimination Act of 1978," at 63, 64 (1980) (identifying "significant cost factor[s]" that would be incurred by employers, but noting that "the committee found that the cost of equal treatment of pregnancy has been greatly exaggerated"); H. Rep. No. 95-948, 95th Cong., 2d Sess. 10 (1978) (discussing anticipated costs of complying with PDA). In any event, the costs of contraception are low. *See* Alan Guttmacher Institute, *Cost to Employer Health Plans of Covering Contraceptives* (June 1998) (estimating that average added cost to employers of covering contraceptives is $1.43 per employee per month). Moreover, studies -- and common sense -- show that the financial costs associated with childbirth are much greater than the costs of many years of contraception. *See* Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 365 & n. 13 (1998) (citing studies). Even if a cost defense were available as a matter of law, therefore, Respondents would be unlikely to be able to cost-justify the exclusion of contraceptives.

19. *See Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1085 n. 14 (1983) (in enacting the PDA, Congress decided "to forbid special treatment of pregnancy despite the special costs associated therewith . . ."); *Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 683 n. 26 (1983) ("no [cost] justification is recognized under Title VII once discrimination has been shown").

20. Letter from Respondents to EEOC, June 22, 2000.

21. This is the rationale that was set forth by the dissenters in *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), and adopted by Congress in passing the PDA. *See Gilbert*, 429 U.S. at 149 (Brennan, J., dissenting) ("it offends common sense to suggest that a classification revolving around pregnancy is not, at the minimum, strongly 'sex related'"); *id.* at 162 (Stevens, J., dissenting) (special treatment of pregnancy is sex discrimination because it is "the capacity to become pregnant which primarily differentiates the female from the male"); H.R. Rep. No. 948, 95th Cong., 2d Sess. 2 (1978) (adopting reasoning of dissenters). *See also Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 676 (1983) ("Congress, by enacting the [PDA], not only overturned the specific holding in [*Gilbert*], but also rejected the test of discrimination employed by the Court in that case"); *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272, 284 (1987) (in enacting the PDA, Congress "unambiguously expressed its disapproval of both the holding and the reasoning of the Court in" *Gilbert*) (citation omitted).

22. Of course, as has been recognized by legal commentators, an employer's exclusion of contraceptives can also be challenged on disparate impact grounds. Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 373-76 (1998). Based on the analysis in text, however, it is unnecessary to address application of the disparate impact theory here.

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Current as of July 2000

Equity in Prescription Insurance and Contraceptive Coverage

Nearly half of all pregnancies in the United States are unintended, and more than half of all unintended pregnancies end in abortion (Henshaw, 1998). Contraceptives have a proven track record of enhancing the health of women and children, preventing unintended pregnancy, and reducing the need for abortion. However, although contraception is part of basic health care for women, far too many insurance policies exclude this vital coverage.

In fact, while most employment-related insurance policies in the United States cover prescription drugs in general, the vast majority do not include equitable coverage for prescription *contraceptive* drugs and devices (AGI, 1994). Similarly, while most policies cover outpatient medical services in general, they often exclude outpatient *contraceptive* services from that coverage (AGI, 1994). This failure is costly, both for insurers who may have to pay for either maternity care or abortion, and the families whose physical and financial well-being is threatened by unintended pregnancy and lack of access to equitable coverage for contraceptives.

Efforts were already underway to address the inequity in prescription coverage for women when Viagra®, a drug used to treat erectile dysfunction, was introduced on the U.S. market in the spring of 1998. Within two months of its entrance into the U.S. market, more than one half of the prescriptions for Viagra received insurance coverage. Such coverage has yet to be extended to intrauterine devices (IUDs) or diaphragms (Goldstein, 1998), prompting national organizations such as the American College of Obstetricians and Gynecologists and Planned Parenthood Federation of America to condemn the gender bias in prescription coverage.

In Congress:

In 1998, PPFA won a major legislative victory with the enactment of a contraceptive coverage requirement in the Federal Employees Health Benefits Plan (FEHBP). This provision is based on amendments to the Treasury-Postal Service appropriations bill (H.R. 4104), sponsored by Representative Nita Lowey (D-NY) in the House and Senators Olympia Snowe (R-ME) and Harry Reid (D-NV) in the Senate. The provision guarantees coverage of prescription contraceptive drugs and devices for federal employees by all plans participating in the FEHBP that cover other prescription drugs and devices. Contraceptive coverage for federal employees was again included in the FY 2000 *Treasury and General Government Appropriations Act* signed into law by President Clinton on September 29, 1999 (PL 106-58).

Last session, Senators Olympia Snowe (R-ME) and Harry Reid (D-NV) and Representatives James Greenwood (R-PA) and Nita Lowey (D-NY) reintroduced the *Equity in Prescription Insurance and Contraceptive Coverage Act* (EPICC) to provide equity in insurance coverage for contraception in the private market. The bill simply seeks to establish parity for contraceptive prescriptions and related medical services within the context of coverage already guaranteed by each insurance plan.

Under this legislation, plans already covering prescription drugs and devices would include equal coverage for prescription contraceptive drugs and devices. Also, plans that include coverage for outpatient medical services would include outpatient contraceptive services in that coverage. The bill defines contraceptive services as "consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy." (S. 1200, 1999; H.R.2120, 1999)

In the States:

In 1998, Maryland became the first state to enact a law requiring health insurers to provide comprehensive coverage of all contraceptives approved by the U.S. Food and Drug Administration (Mantius, 1999). Since then, 12 more states — California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Maine, Nevada, New Hampshire, North Carolina, Rhode Island, and Vermont — have enacted contraceptive equity laws. Approximately half of all state legislatures have considered bills to improve insurance coverage of contraception each year since 1998. These bills generally require that insurers providing coverage for prescription drugs include coverage for FDA-approved prescription contraceptive drugs and devices — along with associated medical services such as exams, insertion, and removal.

While plans routinely cover other prescriptions and outpatient medical services, contraceptive coverage is meager or nonexistent in many insurance policies.

- Half of indemnity plans and Preferred Provider Organizations (PPOs), 20 percent of Point of Service (POS) networks, and 7 percent of Health Maintenance Organizations (HMOs) cover *no* reversible contraception (AGI, 1994).

- In 1998, less than two months after Viagra entered the U.S. market, more than half of all prescriptions received some insurance reimbursement. Overall coverage for oral contraceptives did not reach this level until they had been on the market for almost 40 years — coverage for diaphragms and IUDs still lags far behind (Goldstein, 1998).

- Even plans that do provide *some* coverage typically do not cover all of the five most commonly used reversible contraceptive methods (oral contraceptives, the IUD, diaphragm, Norplant® and Depo Provera®). Less than 20 percent of traditional indemnity plans and PPOs, and less than 40 percent of POS networks or HMOs routinely allow women to choose among these five contraceptive methods (AGI, 1994).

- Coverage of prescription drugs usually does not even include coverage for oral contraceptives, the most commonly used reversible contraceptive method in the United States. Although 97 percent of typical indemnity policies cover prescription drugs in general, only 33 percent include oral

contraceptives in that coverage. This leaves two-thirds of typical indemnity plans covering "prescription drugs" but not the prescription so many women need access to — oral contraceptives (AGI, 1994).

Contraception is basic health care for women, and a critical contributor to improved maternal and child health.

- Ready 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 (KFF, 1998).

- As they help women avoid unplanned pregnancies, contraceptive services help women *plan* pregnancies. A study of 45,000 women suggests that women who used family planning services in the two years before conception were more likely than women who had not used such services to receive early and adequate prenatal care (Jamieson & Buescher, 1992).

- The National Commission to Prevent Infant Mortality estimated that 10 percent of infant deaths could be prevented if all pregnancies were planned — in 1989 alone, 4,000 infant lives could have been saved (1990).

Insurers have relied on women and their families paying out of pocket for contraceptive services and supplies, forcing financial decisions that may result in the use of less effective or less medically appropriate contraceptive methods.

- Women of reproductive age currently spend 68 percent more in out-of-pocket health care costs than men (WREI, 1994). Much of the gender gap in expenses is due to reproductive health-related supplies and services.

- The more effective forms of contraception are generally also the most expensive, often costing hundreds of dollars at the onset of patient use (AGI, 1994). Women and their families who must pay out of pocket may well opt for less expensive and sometimes less effective methods, increasing their risk for unintended pregnancies.

- Cost analyses have shown that if health insurance policies were to include coverage for these contraceptive supplies, costs to employers would be minimal — as little as $1.43 per employee per month (Darroch, 1998).

The correlation is clear. Contraception prevents unintended pregnancy, helps women plan their pregnancies, and reduces the need for abortion.

- In any single year, 85 of 100 sexually active women of reproductive age not using a contraceptive method become pregnant. In contrast, of 100 oral contraceptive users, only between 0.1 and 5 percent become pregnant during the first year of use (Trussell *et al.*, 1998).

- Because the likelihood of pregnancy is so great when contraception is not used, 53 percent of all unintended pregnancies in the U.S. occur among the 10 percent of fertile women who use no method and leave pregnancy to chance (Harlap *et al.*, 1991).

- Reducing unintended pregnancy is key to reducing the number of abortions — more than half of unintended pregnancies end in abortion (Henshaw, 1998).

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Public Policy Contact — Washington, DC: 202-785-3351

Pill bills: States that mandate contraceptive equality

By insure.com

All the hubbub over whether or not health insurers should pay for Viagra, the drug that can cure male impotency, has had an unintended side effect: It's brought to light the fact that many health plans do not cover contraceptives.

Only 15 percent of large group insurers cover the five most common reversible forms of contraception — oral contraceptives, diaphragms, Depo Provera, intra-uterine devices (IUDs), and Norplant — according to the Center for Reproductive Law and Policy.

Contraceptive-equity legislation — sometimes known as "pill bills" — improves women's access to contraceptive coverage. Women who are covered under "pill bills" can get health insurance payments for the costs of contraceptive prescriptions and services to the same extent that other medical prescriptions and services are covered.

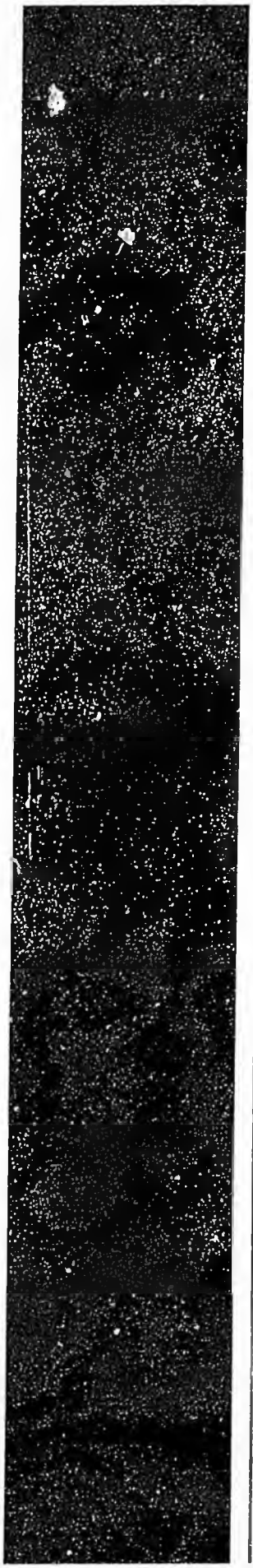
Proposed laws vary from state to state but the best laws do three things:

- Include all types of insurance plans.
- Meet a wide range of contraceptive needs by covering medical appointments and all FDA-approved drugs and devices — including oral contraceptives (birth control pills), injectable contraceptives (i.e. Depo Provera), contraceptive implants (i.e. Norplant), diaphragms, IUDs, cervical caps, and emergency contraception (which prevents pregnancy after unprotected sex).
- Do not contain loopholes that weaken the law and discriminate against women by permitting employers or health insurance plans affiliated with religious organizations to refuse coverage based on

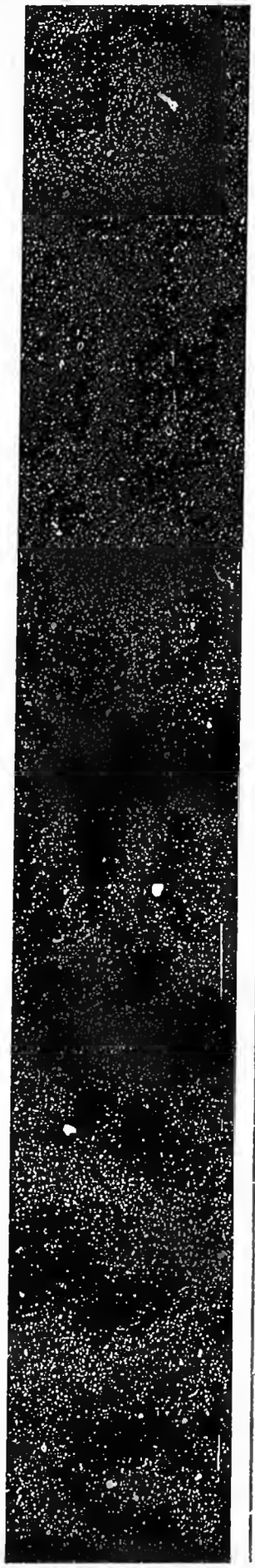
their own anticontraceptive religious dogma.

Here is a list of current and pending legislation for contraceptive equity as of November 2001.

State	Year passed	Bill description	Effective date
California	1999	Requires individual and group health insurance policies that already cover prescriptions to provide FDA-approved prescription contraception; exempts certain religious employers for whom "the inculcation of religious values is the purpose of entity." The religious entity must also meet the requirements of nonprofit status as defined by the IRS.	Jan. 1, 2000
Connecticut	1999	Requires individual and group health insurance policies that already cover prescriptions to provide FDA-approved prescription contraceptives; exempts certain "religious employers," as defined in IRS Code, from requirement as well as certain insurance companies and providers that are "owned, operated or substantially controlled by a religious organization which has religious or moral tenets that conflict" with contraceptive coverage.	Oct. 1, 1999
Delaware	2000	Requires insurance coverage for all FDA-approved prescription contraceptive drugs and devices. A religious employer may request exemption from coverage under the policy, plan, or contract if the required coverage conflicts with the organization's religious beliefs. A religious employer that obtains an exemption shall provide its employees "reasonable and timely notice" of the exclusion.	June 7, 2000
Georgia	1999	Requires every health benefit	July 1,



		plan that already covers prescriptions to provide FDA-approved prescription contraceptives.	1999
Hawaii	1999	Requires employer group health policies that cover pregnancy-related services to provide FDA-approved prescription contraceptives; exempts all entities within a narrowly defined religious exemption but also requires that employees of exempt organizations be eligible to purchase contraceptive coverage at low cost.	Jan. 1, 2000
Iowa	2000	Requires every health plan benefit plan that already covers prescriptions to provide FDA-approved prescription contraceptives, as well as outpatient contraceptive services.	July 1, 2000
Maine	1999	Requires insurance policies that provide coverage for prescription drugs or outpatient medical services to provide coverage for FDA-approved prescription contraceptives; exempts certain narrowly defined tax-exempt "religious employers," as defined in IRS Code.	March 1, 2000
Maryland	1998	Requires insurance policies that provide coverage for prescription drugs to provide coverage for FDA-approved prescription contraceptives (including removal); exempts religious organizations if such coverage conflicts with its "bona fide religious beliefs and practices."	Oct. 1, 1998
Missouri	2001	Requires health benefit plans that provide coverage for pharmaceutical benefits to provide coverage for all FDA-approved prescription contraceptives; exempts any	Jan. 1, 2002



		health carrier owned, operated, or controlled by an entity that is opposed to the use of contraceptives pursuant to their "moral, ethical, or religious beliefs." Health benefit plans that exclude coverage must provide written notice in informational materials.	
Nevada	1999	Requires insurance policies that provide coverage for prescription drugs to provide coverage for FDA-approved prescription contraceptives and hormone-replacement therapies; exempts insurers "affiliated with a religious organization" if they object to coverage "on religious grounds."	Oct. 1, 1999
New Hampshire	1999	Requires every health benefit plan that already covers prescription drugs to provide FDA-approved prescription contraceptives, as well as outpatient contraceptive services.	Jan. 1, 2000
New Mexico	2001	Requires health insurance policies that provide coverage for prescription drugs to provide coverage for FDA-approved prescription contraceptives; allows "religious entities" that purchase health insurance coverage to elect to exclude prescription contraceptives.	June 19, 2001
North Carolina	1999	Requires insurance policies that provide coverage for prescription drugs to provide coverage for FDA-approved prescription contraceptives; provides religious exemption. Exempts emergency contraceptives.	Jan. 1, 1999
Rhode Island	2000	Requires individual and group health insurance policies that already cover prescriptions to provide FDA-approved prescription contraception and exempts certain "religious	July 8, 2000

		employers." However, every employer invoking the exemption must provide written notice to prospective enrollees, prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious purposes.	
Texas	2001	Requires health benefit plans that provide coverage for prescription drugs to provide coverage for all FDA-approved prescription contraceptives; exempts any health benefit plan issued by an entity associated with a religious organization, or any physicians or health care provider under the health benefit plan if such service "violates the religious convictions of the organization," unless contraceptive coverage is necessary to preserve the life or health of the woman. Health benefit plans that limit or exclude coverage must provide written notice in informational materials.	Sept. 1, 2001
Vermont	1999	Requires insurance policies that provide coverage for prescription drugs to provide coverage for FDA-approved prescription contraceptives, devices, and sterilization.	July 1, 1999
Washington	2001	Requires all plans regulated by the insurance commissioner that offer prescription drug benefits to cover prescription contraceptives. The rule also requires coverage for "medical services associated with prescribing, dispensing, delivery, distribution, administration, and removal" of contraceptives to the same extent as other outpatient services.	Jan. 1, 2002

Source: Center for Reproductive Law and Policy

Last updated Nov. 27, 2001

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THE COALITION FOR PRESCRIPTION EQUITY

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Alaska Emergency Contraception Project

Alaska Health Education Consortium (AHEC)

Alaska Nurse Anesthetists Association

Alaska Nurse Practitioners Association (ANPA)

Alaska Nurses Association (ANA)

Alaska Pharmaceutical Association

Alaska State Medical Association (ASMA)

Alaska Women's Health Services

Alaska Women's Lobby

Alaska Women's Resource Center

American Association of University Women (AAUW)

American College of Obstetrics and Gynecology (ACOG)

Anchorage Education Association (AEA)

Anchorage Women's Commission

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National Alliance for Mentally Ill (NAMI) – Anchorage

National Organization of Women (NOW) – Anchorage

Planned Parenthood of Alaska

Sitka Medical Center

Sitkans Against Family Violence

Standing Together Against Rape (STAR)

YWCA

Subject: [Fwd: HB 313]
Date: Thu, 07 Feb 2002 18:03:29 -0900
From: Representative Fred Dyson <Representative_Fred_Dyson@legis.state.ak.us>
To: Jason Hooley <Jason_Hooley@legis.state.ak.us>

for your records.
~gayle

Subject: HB 313
Date: Wed, 6 Feb 2002 22:18:07 -0900
From: "cmm" <murphylogue@alaskalife.net>
To: <Representative_Fred_Dyson@legis.state.ak.us>

February 6, 2002
2811 Illiamna Ave
Anchorage 99517

Dear Representative Dyson,

I strongly recommend that you bring HB 313 to hearing in the HESS Committee. Please note that the AK State Medical Association is a supportive member of the Coalition for Prescriptive Equity. The ASMA review paper on prescriptive equity is attached above as well as a list of the current Coalition for Prescriptive Equity members.

The American College of Obstetricians and Gynecologists has stated: "A health plan that uniquely excludes women's contraception, but covers other prescription drugs and services, not only makes no medical or economical sense, it is gender biased....B ıt (insurance plans that) unfairly require women to subsidize those savings for them, when they cover prescription drugs and services but specifically exclude women's prescription contraception...is discrimination. It is time to stop dismissing or trivializing women's reproductive health needs as less important than services unique to men, or less important than services in other areas of health care. Control of reproduction is a fundamental health need. The exclusion of prescription contraception from insurance coverage not only discriminates against women, it reflects a deeply flawed and costly health policy."

I respectfully request that you bring HB 313 to a fair hearing. It is an important bill that needs public review.

Thank you.

Colleen Murphy, MD, FACOG (OB-GYN)
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W: 907-770-5432
E:mail: murphylogue@gci.net

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Gender Equity in Coverage of Prescription Drugs.htm	**Name:** Gender Equity in Coverage of Prescription Drugs.htm **Type:** Hypertext Markup Language (text/html) **Encoding:** quoted-printable

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Fred Dyson <Representative_Fred_Dyson@legis.ak.us.>
Representative
State of Alaska
Alaska Legislature

Analysis of Senate Bill No. 15

I. The Problem

A. United States

- On average, a woman has 2.1 children during the course of her life.
- A sexually active woman will need contraception for more than twenty years of her life.
- Over 50% of U.S. pregnancies are unintended; 52% end in abortion
- Unintended pregnancies carry appreciable risks (*The Best Intentions*, IOM, 1995)
  - later onset of prenatal care & higher frequency of inadequate prenatal care
  - higher incidence of low birth weight infant (<2500 g)
  - higher incidence of infant mortality, child abuse, and physical abuse of mother
  - higher subsequent divorce rate (3x) and fathers more likely to be absent
  - Children raised by one parent are more likely to drop out of school, to have encounters with the criminal justice system, and more likely to become teen parents
  - higher incidence of economic hardship & failure of parents to achieve educational & career goals

B. Alaska

- There are 140,00 Women of childbearing age in Alaska (ages 15-44).
- Each year in Alaska, 120 pregnancies occur per 1,000 women ages 15-44, 69% of which end in live births, 15% in miscarriage, and 16% in elective abortions.
- 60% of pregnancies in Alaska are from unintended pregnancies.
- 42% of live births in Alaska are from unintended pregnancies. (Source: PRAMS 1996)

II. The Solution: Increasing Contraceptive Access

A. United States

- 97% of typical insurance policies cover most prescription drugs (Alan Guttmacher Institute, 1994)
- Only 33 percent of insurance plans cover birth control pills (Alan Guttmacher Institute, 1994)
- < 20% of traditional health care plans cover all of the most commonly used methods of contraception.
- Women of reproductive age spend 68% more in out-of-pocket expenses than men- most of this is due to reproductive health care.
- In 1998, the AMA and ACOG recommended that all health insurance policies providing prescription benefits should no longer exempt contraceptive prescriptions.
- At least 13 states, Maryland, California, Connecticut, Delaware, Georgia, Hawaii, Iowa, Maine, Nevada, New Hampshire, North Carolina, Rhode Island, and Vermont — have enacted contraceptive equity - laws.
- State contraceptive equity laws only apply to state-regulated insurance plans.
- The "Equity in Prescription Contraceptive Coverage Act," or EPICC, was reintroduced by Sen. Harry Reid, D-Nev., and Sen. Olympia Snowe, R-Maine in 1/01.
- The Pregnancy Discrimination Act, enacted by Congress in 1978, requires that expenses related to pregnancy, childbirth or related medical conditions be treated the same as expenses related to other medical conditions. The law also protects women against discrimination because they have the ability to become pregnant, not just because they are already pregnant
- On 12/13/00, The U.S. Equal Employment Opportunity Commission (EEOC) issued a Commission Decision finding merit in two charges of discrimination alleging violations of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act of 1978.
- The Commission based its decision on the grounds that the respondents in the charges excluded the cost of prescription contraceptive drugs - available only to women - from their employee health plan while covering a number of other preventive drugs, devices, and services.
- The EEOC rejected arguments based on cost.
- The ruling applies only to firms with more than 15 workers and is specific to the two cases presented to the commission. It stops short of policy guidance that would apply to all employers
- Deborah Brake, a law professor at the University of Pittsburgh, states. "I would advise [companies] to

[expand coverage] immediately rather than being sued. My reading of the ruling is that it is quite broad," she said (Snowbeck, Pittsburgh Post-Gazette, 1/1).

B. Alaska

- A legal opinion from the Alaska State Legislature's Division of Legal Services indicates the EEOC's ruling would be applicable to all "employers," which for legal purposes is defined as all businesses with 15 or more employees.
- The state is considered an employer and is covered under the Civil Rights Act.
- This ruling would include all small business and self-insured plans, including the State of Alaska
- Legislative Attorney, Mike Ford, has reviewed the EEOC ruling. If a plan does not cover prescriptions, then it would not be required to cover contraceptives.

III. Cost of Increasing Contraceptive Access

A. United States

- When women have to pay out of pocket, they will often opt for less expensive and effective contraceptive methods, thus increasing the likelihood of an unintended pregnancy.
- A large number of unintended births are paid for by private insurance -- costs that are eventually distributed to others in the form of higher insurance premiums.
- Every dollar spent for contraceptive services saves $3 in public funds that would have been needed to provide prenatal and newborn care alone
- The Health Association of America, a national trade association representing about 270 of the nation's leading health care companies, showed that insurance costs would increase by $16.00 per year per employee in plans covering other prescription medications.
- Other studies show including contraceptives in prescription programs could cost as little as $1.43 per employee per month to as high as $3.50 per employee per month. The high estimate is slightly more than the price of one month of oral contraceptives.
- The Alan Guttmacher Institute, which supports the expanded coverage, cited the cost of coverage for all five forms of reversible contraceptives -- oral contraceptives, diaphragms, intrauterine devices, injectables and implants -- to be $21 per health plan member per year, or a 0.6% increase in the overall costs of health plans
- A 15 percent increase in the number of oral contraceptive users in a health plan would provide enough savings in pregnancy costs alone to provide oral contraceptive coverage for all users in the plan. (American Journal of Public Health, 1995)

B. Alaska

- Almost half of unintended pregnancies in Alaska are paid for by a government source.
- The prescriptive equity bill just would affect small business plans (2-50 people)
- Total people covered in 4/99 in small business plans: est 30,000 people.
- The bill would exclude private plans, self-insured, and specifically excludes churches.
- Most businesses with more than 100 employees are SELF-INSURED, and many with 50-100 employees are self-insured.
- Self-insurance is regulated by the federal government; the state has no authority to tell policy holders, businesses, or insurance companies what those policies must cover.
- The State of Alaska estimates that employee health insurance costs would increase $3.25- $3.50 per month to add coverage for contraceptives
- The State of Alaska also notes that improved access to and use of contraception would save insurers and society money by preventing unintended pregnancies. .

ACOG NEWS RELEASE

For Release: June 12, 2001

Gender Equity in Coverage of Prescription Drugs

Statement of The American College of Obstetricians and Gynecologists On *Erickson v. Bartell Drug Company* Title VII Case

WASHINGTON, DC -- We applaud a federal district court ruling today that an employer's exclusion of prescription contraceptives from an employee health plan constitutes sex discrimination. Women are the sole users of prescription contraceptives. A health plan that uniquely excludes women's contraception, but covers other prescription drugs and services, not only makes no medical or economical sense, it is gender biased.

Contraception is a medical necessity for women during three decades of their life span. A woman cannot opt out of the need to control her fertility during nearly 30 reproductive years prior to menopause. To do so is to endure multiple, closely spaced pregnancies -- a health risk in and of itself. Unintended pregnancies also carry higher risks of preterm birth, maternal and perinatal morbidity, and higher rates of abortion.

Contraception brings great financial savings to the health care system, since the alternatives to birth control -- maternity care and delivery, neonatal intensive care, or spontaneous or induced abortion -- are so much more costly. Insurers and employers benefit from the significant savings that contraception brings to a health care plan. But they unfairly require women to subsidize those savings for them, when they cover prescription drugs and services but specifically exclude women's prescription contraception. That is discrimination.

It is time to stop dismissing or trivializing women's reproductive health needs as less important than services unique to men, or less important than services in other areas of health care. Control of reproduction is a fundamental health need. The exclusion of prescription contraception from insurance coverage not only discriminates against women, it reflects a deeply flawed and costly health policy.

###

The American College of Obstetricians and Gynecologists is the national medical organization representing nearly 40,000 physicians who provide health care for women.

THE COALITION FOR PRESCRIPTION EQUITY

Febraury 16, 2002

Representatives Murkowski, Guess, James, Wilson, Kapsner,
Cissna, Kerttula, McGuire, and Berkowitz
Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representatives:

The Coalition for Prescription Equity would like to thank you for sponsoring HB 313, an act that would require certain health insurance companies to include contraceptives in their prescription plans. We know HB 313 is a solid bill with incredible support from many Alaskans.

This bill is asking not for preferential treatment but rather "only equitable treatment within the context of an existing prescription drug benefit". We agree that such an aim falls with in the United States Equal Employment Opportunity Commission's decision [under 42 U.S.C. 200(k)] in December 2000, stating that when an employer offers a health insurance plan that includes coverage for medical conditions, that the employer cannot exclude coverage for prescriptive contraceptive drugs. Specifically, expenses related to pregnancy, childbirth, or related medical conditions must be treated the same as expensed for other medical conditions. Failure to do so constitutes discrimination. The adoption of HB 313 would ensure that Alaska is not violating the Civil Rights Act of 1964.

As member-agencies of the Coalition (please see attached list), we would like to encourage you to move this bill forward this legislative session. We have developed talking points to help you support this bill, which above all else is ***a bill in support of women's equity***. Please feel free to contact Anna Franks at 770-9705 or Vicki Halcro at 770-9715 should you have any questions or desire the talking points.

Thank you for your support.

Sincerely,

Sharon Richards

Sharon Richards for
The Coalition for Prescription Equity

Attachment - coalition members

Cc: Representative Brian Porter, Speaker of the House
Representative Fred Dyson, Chair
House Health, Education and Social Services Committee

THE COALITION FOR PRESCRIPTION EQUITY

MEMBER AGENCIES as of 2/15/02

Alaska Chapter - American College of Nurse Midwives (ACNM)

Alaska Emergency Contraception Project

Alaska Health Education Consortium (AHEC)

Alaska Nurse Anesthetists Association

Alaska Nurse Practitioners Association (ANPA)

Alaska Nurses Association (ANA)

Alaska Pharmaceutical Association

Alaska State Medical Association (ASMA)

Alaska Women's Health Services

Alaska Women's Resource Center

American Association of University Women (AAUW)

American College of Obstetrics and Gynecology (ACOG)

Anchorage Education Association (AEA)

Anchorage Women's Commission

Anchorage Women's Political Caucus

Central Peninsula Counseling Services

Kachemak Bay Family Planning Clinic

League of Women Voters of Alaska

Mental Health Association in Alaska

National Alliance for Mentally Ill (NAMI) - Anchorage

National Organization of Women (NOW) - Anchorage

Planned Parenthood of Alaska

Sitka Medical Center

Sitkans Against Family Violence

Standing Together Against Rape (STAR)

YWCA

Tony Knowles, Governor

Alaska Department of Community and Economic Development

Division of Insurance
3601 C Street, Suite 1324, Anchorage, AK 99503-5948
Telephone: (907) 269-7900 • Fax: (907) 269-7910 • Text Telephone: (907) 465-5437
Email: Insurance@dced.state.ak.us • Website: www.dced.state.ak.us/insurance/

BULLETIN B 02-08

TO: ALL INSURERS TRANSACTING HEALTH INSURANCE IN ALASKA AND OTHER INTERESTED PARTIES

RE: COVERAGE OF PRESCRIPTION CONTRACEPTIVES

On December 14, 2000 the U.S. Equal Employment Opportunity Commission (EEOC) issued a decision on coverage of prescription contraceptives. The EEOC concluded that, pursuant to the Pregnancy Discrimination Act, employers may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for other prescription drugs and devices.

On June 12, 2001, U.S. District Court Judge Robert S. Lasnik, issued a summary judgement in *Erickson v. Bartell Drug Company*, 141 F. Supp.2d 1266 (W.D. Wa. 2001) in favor of Erickson finding that exclusion of prescription contraceptives from Bartell's comprehensive prescription drug plan constituted discrimination on the basis of sex in violation of Title VII, of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act.

Based on the EEOC decision and U.S. District Court ruling, in order for employers to avoid violation of Title VII, insurance coverage offered to employees should provide coverage for prescription contraceptives to the same extent that the plan provides coverage for other prescription drugs or devices. The division requests your assistance in spreading the word to employers with whom you do business, thereby assuring that they remain in compliance with Title VII by providing comparable coverage for prescription contraceptives when they cover other prescription drugs and devices.

Dated this 16th day of April 2002, at Anchorage, Alaska.

Robert A. Lohr
Director

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 313
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: An Act requiring that the cost of contraceptives be included in certain health care insurance coverage
BRU: Insurance (116)
Component: Insurance Operations
Sponsor: Representative Murkowski
Requester: House Health, Education & Social Services
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 GF Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2002) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill has no fiscal impact on this component.

Prepared by: Robert A. Lohr, Director — Phone 269-7900
Division: Insurance — Date/Time 4/29/02 11:39 AM
Approved by: Deborah B. Sedwick, Commissioner — Date 4/29/2002
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)

Testimony for House Bill 313
INSURANCE COVERAGE FOR CONTRACEPTIVES
Health, Education and Social Services
Hearing : Tuesday April 30, 2002

Submitted by: Victoria Halcro
Director of Public Affairs and Marketing
Planned Parenthood of Alaska

I would like to state that I am in support of House Bill 313. This bill is asking not for preferential treatment for women but rather only equitable treatment within the context of an existing prescription benefit.

This was confirmed by the EEOC's December 14, 2000 decision that employers may not discriminate in their health insurance plan by denying benefits for prescriptive contraceptives when a plan already provides benefits for other prescription drugs. Doing so would be a violation of the 1964 Civil Rights Act.

Currently, women of childbearing age pay 68% more in out-of-pocket health care costs than men. Reproductive health care services account for much of this differential.

Contraception is a basic health care need for women and a critical contributor to improved maternal and child health. Planned pregnancies are healthier pregnancies. Women with planned pregnancies are more likely to seek early and adequate prenatal care.

For example, for many years, health care services like prenatal care, mammography, and even childhood immunizations were considered non-essential. Now that these services are universally accepted as necessary care, they too are fully covered by insurance saving countless lives everyday.

Increasing the availability of contraception by making it more affordable is key to reducing the number of unintended pregnancy, of which more than half end in abortions. By passing HB 313 you have the ability to indirectly reduce the number of abortions in Alaska.

I urge you to vote for House Bill 313. Passing such legislation brings us one step closer to assuring that the well being of women and their families are the highest priority in Alaska.

Subject: Support HB 313
Date: Mon, 29 Apr 2002 20:33:33 -0800
From: "Diana Rhoades" <alaskadiana@earthlink.net>
To: <Representative_Fred_Dyson@legis.state.ak.us>,
<Representative_Peggy_Wilson@legis.state.ak.us>,
<Representative_John_Coghill@legis.state.ak.us>,
<Representative_Gary_Stevens@legis.state.ak.us>,
<Representative_Vic_Kohring@legis.state.ak.us>

Dear HESS Committee Members:
I am writing in support of House Bill 313, which would secure equal health care coverage for women, in the form of contraceptives. We should all work together to help prevent unwanted pregnancies, and affordable access to contraceptives is a good place to start.

I have been on birth control since I was 17 years old. Though I wasn't having sex at the time, I just wanted to make sure I didn't get pregnant in a moment of passion. Better safe than sorry. I am now 35 years old. I have recently been using depo provera, which averages between $320 and $400 per year, depending on where you get the shot. Regular birth control pills cost about $35 per month. So let's just do a low average of $320 per month (that doesn't include the exam that is required to even get a prescription for birth control). So basically I have spent more than $5500 to be safe. What have men spent to be safe? Very little.

It makes good sense to be safe. It's time for birth control to be covered by health insurance.

Thanks!

Diana Rhoades
1772 Scenic Way #1
Anchorage, AK 99502
274-1274

Blue Cross
Blue Shield of Alaska
A PREMERA HEALTH PLAN

7001 220th St. S.W., Mountlake Terrace, WA 98043-2124
Post Office Box 327, Seattle, WA 98111-0327
425/670-5757 Fax 425/670-5635

Jack C. McRae
Senior Vice President

April 29, 2002

Representative Lisa Murkowski
State Capitol, Room 408
Juneau, AK 99801-1182

BY FAX: 907/465-2293

Dear Representative Murkowski:

I am writing in reference to HB 313, "an act requiring that the cost of contraceptives be included in certain health care insurance coverage." Blue Cross Blue Shield of Alaska is concerned about the availability and affordability of health insurance. We generally oppose new benefit mandates that inevitably impact the cost of coverage.

We must acknowledge, however, that the proposed coverage of contraceptives requires that other factors be taken into consideration, such as recent court decisions, the EEOC interpretation referenced in Section 2 of HB 313, employer demand and marketplace changes in benefits offered. Given these changes in our business environment, Blue Cross Blue Shield of Alaska will not oppose HB 313.

One remaining concern with the current version of the bill (version "L") is that, in absence of a specific effective date, compliance would be required 90 days after enactment. Since we would be adding new coverage or modifying existing benefits in virtually all of our policies, implementation of HB 313 will require significant work from a numbe of operational areas. For example, we will have to revise contract language, complete required regulatory filings, make the necessary computer system changes, and ensure that the rates accurately reflect the new benefit . To make sure that the implementation is successful and the transition occurs with a minimum of disruption to consumers, we would request an effect date no earlier than January 1, 2003.

I greatly appreciate your consideration of this request and will be glad to discuss this issue and provide any additional information you may require.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President