A STUDY OF THE EFFECTIVENESS OF MANDATED STATE CONTRACEPTIVE COVERAGE IN IOWA AND MISSOURI AND THE CASE FOR A FEDERAL LAW

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I. INTRODUCTION

In the wake of reproductive rights advocacy and the rise of insurance coverage for Viagra, many states have passed laws requiring individual group insurance providers to cover prescription contraceptives when other prescription drugs are covered. A federal bill requiring such contraceptive coverage has repeatedly failed in Congress. Women in this country are subject to a “gender tax”—meaning they earn less pay for comparable work, earn lower social security benefits because they spend time out of the workforce to raise a family, and face higher healthcare costs. The Equity in Prescription Insurance and Contraceptive Coverage Act of 2003 (EPICC) seeks to amend the Employee Retirement Income Security Act (ERISA) to prohibit insurance companies from refusing to cover contraceptives when other forms of prescription drugs and devices are covered.

Part II of this Note will examine state laws that currently mandate contraceptive coverage. In addition, it will distinguish between self-insured ERISA plans and those plans that are subject to state regulation. It will also address the arguments in favor of contraceptive coverage, and the


4. H.R. 2727; S. 1396.


6. H.R. 2727 § 3; S. 1396 § 3.
impact of two landmark decisions regarding coverage. Part III will examine the effectiveness of two very different contraceptive coverage laws passed in Iowa and Missouri by analyzing state abortion statistics. Finally, Part IV concludes by offering additional options for relief in those states.

Senators Olympia J. Snowe (EPICC’s original author and subsequent author on re-introduction) and Harry Reid first introduced EPICC in 1997 as part of a bipartisan collaboration. Senator Snowe’s comments reflected a grand vision for insurance and gender equality, yet seven years later the bill is still just that: a vision. She noted that the bill’s introduction reflected a bipartisan effort in spite of differing views on abortion to “agree that something can and must be done to reduce the rates of unintended pregnancy and abortion in this country.” In arguing in support of mandated federal coverage, Senator Snowe asserted that “[i]f prescription contraceptives were covered like other prescription drugs, a lot more Americans could afford to use safe, effective means to prevent unintended pregnancies.” She continued by stating the following:

It is simply not right that while the vast majority of insurers cover prescription drugs, half of large group plans exclude coverage of prescription contraceptives. And only one-third cover oral contraceptives—the most popular form of birth control.

Is it any wonder that women spend 68 percent more than men in out-of-pocket health care costs—68 percent. It does not make sense that, at a time when we want to reduce unintended pregnancies, so many otherwise insured woman [sic] can’t afford access to the most effective contraceptives because of the disparity in coverage.

In fighting to pass the bill, lawmakers sought to send a message that policies placing women at a disadvantage would no longer be tolerated.

7. 143 Cong. Rec. 8267 (1997) (statement of Sen. Snowe) (remarking that she and Senator Reid were “joining forces and introducing bipartisan, landmark legislation to make contraceptives more affordable for Americans”).
10. Id. at 8267–68.
11. Id. at 8268.
Senator Harry Reid joined Senator Snowe in offering testimony in support of the proposal, forcefully asserting that “[i]f men had to pay for contraceptive drugs and devices, the insurance industry would cover them.”12 Among the benefits that he listed in support of the bill were “a reduction in unintended pregnancies [that would] lead to a reduction in infant mortality, low-birth weight, and maternal morbidity,” noting that prevention is the common ground that brings the parties together.13

If state contraceptive laws are successful in meeting proponents’ goals,14 it logically follows that a national mandate of prescription contraceptive coverage will have positive effects as well.15 In addition, if the state laws are not working as extensively as proponents had originally hoped, a federal law would broaden the scope of coverage to reach employees whose plans are not bound by state mandates.

II. THE CURRENT STATE OF CONTRACEPTIVE COVERAGE

A. State Laws

Many states have passed laws requiring coverage of contraceptives.16 Religious employers in Arizona,17 California,18 Delaware,19 Hawaii,20 Maine,21 Maryland,22 Massachusetts,23 Missouri,24 New Mexico,25 New
York, North Carolina, and Rhode Island are exempt from state laws requiring contraceptive coverage. In Connecticut, religious insurers are not exempt from the mandate, but may instead provide for coverage through another entity offering a plan with appropriate coverage under state law. In Missouri, both religious employers and insurers are exempted and may refuse to provide coverage on the above stated grounds. In an effort to reach a middle ground and protect religious interests while at the same time decreasing the cost of prescription contraceptives, Hawaii, Missouri, and New York allow employees whose employer refuses to cover contraceptives to purchase such coverage directly from their insurer.

B. ERISA and Self-Insured Employers

While state laws help to reduce the amount of out-of-pocket expense for contraceptives, the laws are problematic because they apply only to group and individual health plans as a result of ERISA’s federal preemption clause. ERISA applies to health plans established by employers and in some instances will apply to employee benefit plans that “offer benefits through state-licensed insurers.” ERISA’s “savings

29. See generally STATE POLICIES, supra note 1 (summarizing the differences between state contraceptive coverage laws).
30. CONN. GEN. STAT. ANN. § 38a-503e(e) (West Supp. 2005).
33. The United States Code states the following:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.


The terms “employee welfare benefit plan” and “welfare plan” mean any
clause,” however, has been interpreted by the courts to allow states to regulate insurance carriers conducting regular insurance business; for example, states may mandate the benefits and coverage that insurance companies must provide. However, while federal preemption has its limits, ERISA further contains a “deemer clause” that prohibits states from regulating self-insured employers who bear the primary insurance risk, “even though by bearing risk [the employers] appear to be acting like insurance companies.”

A self-insured or self-funded insurance plan is created when an employer, rather than buying an employee insurance plan from an outside carrier, elects to pay its employees’ health care claims with employer funds. Because the employer provides for the health care claims of the employee, such payments are considered a benefit to the employee; therefore, they fall under ERISA and are not subject to state mandates. Generally, an employer will either select a health plan to provide to employees or give employees the option to choose different plans at varying costs. Many factors will weigh heavily on an employee’s or

plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.

Id.; see also id. § 1002(3) (“The term ‘employee benefit plan’ or ‘plan’ means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.”).

35. BUTLER, supra note 34, at 3.

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.

Id.

38. Id.
employer’s choice of health plan, and unfortunately, coverage of prescription contraceptives may not be high on the list of priorities.\textsuperscript{40} It is not, however, as simple as an issue of priority. For example, if employers are not automatically offering contraceptive coverage to employees, and because of ERISA are not required to do so by contraceptive equity state laws, why would an employee feel that he or she is entitled to choose a plan with contraceptive coverage?\textsuperscript{41}

\textbf{C. Benefits of Contraceptive Coverage}

A number of economic and social benefits result from increased contraceptive coverage.\textsuperscript{42} For example, employers who choose to offer—or are required to do so by state law—prescription contraceptive coverage in insurance plans will reduce the number of employees in the workforce carrying unwanted pregnancies, thereby reducing the total number of unwanted pregnancies.\textsuperscript{43} Reducing the number of unwanted pregnancies would also act as a cost-saving device for employers:

A recent study calculated that for an average employer, the total indirect cost of pregnancy-related absences per year per 1,000 covered female employees would be $542,000. It is estimated that the average cost to replace female employees who quit each year due to pregnancy is an additional $14,000 per employee.\textsuperscript{44}

Further, many insurance companies cover abortion services, which cost far more than prescription contraceptives; it does not make sense financially to cover the more expensive services rather than contraception.

\textsuperscript{40} Id. at 388.
\textsuperscript{41} It bears mentioning that “he or she” is used when discussing employee insurance plans because while prescription contraceptives are only available to females, the probability certainly exists that a male employee may have a dependent female on his insurance plan.
\textsuperscript{42} See Richardson, supra note 14, at 157–66 (discussing some of the many benefits that would befall not only society but also the employment world if employers choose to offer prescription contraceptive coverage).
\textsuperscript{43} Id. at 157–58 (noting further that “the increase in costs of contraceptives may be counterbalanced by the decrease in costs of unintended pregnancies”); see also Planned Parenthood, supra note 14 (highlighting both monetary and health benefits of contraceptive coverage); Press Release, American College of Obstetricians and Gynecologists, The Pill at 40: Women Say It’s Safer, Has Extra Benefits, but Not Covered by Insurance (May 2, 2000) (on file with author) (noting several health benefits of birth control pill usage).
\textsuperscript{44} Planned Parenthood, supra note 14.
to prevent the need for such services.\textsuperscript{45} In addition, some social implications for increased contraceptive coverage include fewer health care problems for society, workplace equality, and an increased number of persons able to participate in the workforce.\textsuperscript{46}

One of the primary arguments that advocates for contraceptive insurance coverage cite is that increased coverage will work to reduce the number of abortions.\textsuperscript{47} Indeed, “[c]ontraceptive use is a key predictor” in a woman having to resort to an abortion.\textsuperscript{48} In her initial proposal of EPICC, Senator Snowe remarked, “[a]s someone who is pro-choice, I firmly believe that abortions should be safe, legal, and rare. Through this bill, I invite both my pro-choice and pro-life colleagues to join with me in emphasizing the rare.”\textsuperscript{49} According to the United States’ 2000 abortion statistics, one in three women will have an abortion by the time she reaches the age of forty-five.\textsuperscript{50} Further, forty-six percent of those women seeking an abortion in 2000 were not using contraceptives.\textsuperscript{51} It therefore follows that if more women are given access to contraceptives through insurance coverage, the number of abortions sought in the United States or a given state will decline.\textsuperscript{52}

D. Erickson v. Bartell Drug Co.\textsuperscript{53}

In 2001, the District Court for the Western District of Washington ruled that under Title VII of the Civil Rights Act of 1964 (Title VII),\textsuperscript{54} as amended by the Pregnancy Discrimination Act (PDA),\textsuperscript{55} self-insured health care plans must include prescription contraceptives.\textsuperscript{56} The
defendant-employer, Bartell Drug Co. (Bartell), chose not to include contraceptive coverage in employees’ prescription drug plans, even though the employer covered other types of prescription drugs and devices.57 The court relied heavily on Title VII, which makes it unlawful for an employer “to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin.”58

Congress further clarified its commitment to eradicating discrimination on the basis of sex in 1978 when the PDA directed that discrimination “because of or on the basis of pregnancy, childbirth, or related medical conditions” constituted discrimination based on sex.59 Unfortunately for proponents of coverage, the PDA makes no explicit mention of contraceptive coverage. The court ruled that because prescription contraceptives are only available to and used by women, choosing to exclude them from an insurance plan is discriminatory.60 The court further found that “when an employer decides to offer a prescription plan covering everything except a few specifically excluded drugs and devices, it has a legal obligation to make sure that the resulting plan does not discriminate based on sex-based characteristics and that it provides equally comprehensive coverage for both sexes.”61

1. **Contraceptives “Are Not Truly a Healthcare Issue”**

One argument that Bartell advanced was that “treating contraceptives differently from other prescription drugs is reasonable in

57. Id. at 1268 n.1. The plan, however, also excluded prescription weight loss drugs, infertility drugs, drugs to help individuals quit smoking, drugs used for cosmetic purposes, growth hormones, and experimental drugs. Id.

58. 42 U.S.C. § 2000e-2(a)(1). In an interesting lesson in history, the court acknowledged the difficulty in determining what protections Congress expressly intended to be afforded on the basis of sex, as Representative Howard Smith of Virginia added gender as a classification, assuming that it would kill the Act and therefore civil rights based on race would still lack federal protection. Even though Representative Smith voted against the entire act, both the race and sex provisions prevailed. See Erickson, 141 F. Supp. 2d at 1268–69.


60. Erickson, 141 F. Supp. 2d at 1271–72.

61. Id. at 1272.
that contraceptives are voluntary, preventative, do not treat or prevent an illness or disease, and are not truly a ‘healthcare’ issue.”\(^{62}\) The court refused to accept this rationale, declaring that one of the significant benefits of contraceptive coverage was a reduction in the number of unintended pregnancies, and thus a decrease in the burdens that women bear, as “the adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the ‘marketplace and the world of ideas.’”\(^ {63}\)

The court further pointed out that the preventative nature of contraceptives was an irrelevant point made by the defendant because other preventative drugs were covered by the company’s health plan, and, like other preventative drugs, contraceptives help to postpone unwanted bodily changes.\(^ {64}\)

Beyond preventing unintended pregnancies, contraceptives offer other benefits to the women who use them. One specific non-contraceptive benefit of the birth control pill is the prevention of gynecologic malignancies such as ovarian cancer.\(^ {65}\) In addition, the pill can help to prevent benign breast disease, pelvic inflammatory disease, and ectopic pregnancy.\(^ {66}\) Finally, the birth control pill produces many menstrual improvements including regularity, predictability, and a reduction of days in a cycle.\(^ {67}\) Thus, while Bartell viewed contraceptives solely as preventing pregnancy and, therefore, being an unnecessary preventative drug, contraceptives provide clear health benefits outside of pregnancy prevention that serve to better women’s health. Furthermore, “by helping families to adequately space their pregnancies, contraceptives contribute to healthy pregnancies and healthy births, reducing rates of maternal complications, and low-birth weight.”\(^ {68}\)

Likewise, employers will benefit from a healthier workforce.

\(^{62}\) Id.
\(^{63}\) Id. at 1273 (quoting Stanton v. Stanton, 421 U.S. 7, 14–15 (1975)).
\(^{64}\) Id. The plan covered a number of preventative drugs, “such as blood-pressure and cholesterol-lowering drugs, hormone replacement therapies, prenatal vitamins, and drugs to prevent allergic reactions, breast cancer, and blood clotting.” Id. at 1268 n.1.
\(^{65}\) Press Release, American College of Obstetricians and Gynecologists, supra note 43 (noting the effectiveness of the birth control pill in providing health benefits when used correctly).
\(^{66}\) Id.
\(^{67}\) Id.
2. **Control of One’s Fertility Is Not an Issue Covered Under the PDA**

Bartell next sought to claim that “control of one’s fertility is not ‘pregnancy, childbirth, or related medical conditions’ as those terms are used in the PDA.” The court spent little time disposing of this claim, noting that the absence of the words “contraception” or “control of one’s fertility” in the PDA is irrelevant in light of Congress’s decision to enact the PDA to overrule previous case law. Here, the court made a firm affirmation that control of one’s pregnancy is very much within the domain of the PDA.

3. **Employers Should Be Allowed to Control Costs**

Perhaps the least salient argument that Bartell proposed was that “employers must be permitted to control the costs of employment benefits by limiting the scope of coverage.” The court unwaveringly declared, however, that “[c]ost is not . . . a defense to allegations of discrimination under Title VII,” and further, that a company, while it may be allowed to make some arrangements for lowering costs, may not punish women in the process. Even if cost were a valid reason for discriminating against women in insurance coverage, the argument that not covering contraceptives saves employers money is flawed. On average, the cost for one pregnancy for a mother and her infant is $10,000; the average cost for a first trimester abortion is $450. Furthermore,

> [p]roviding full contraceptive coverage in employment-based health care plans would cost employers, at most, only $21.40 per employee per year. For employers with plans that currently provide no contraceptive coverage, the average cost of adding it—if employers contributed 80 percent of the cost—would be $17.12 per year or $1.43

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70. *Id.* at 1274; see also *id.* at 1272 n.8 (reiterating that Congress’s enactment of the PDA was a decisive overruling of *Gilbert*).
71. *Id.* at 1271 (finding that Bartell’s exclusion of contraception from its prescription plan is contrary to the requirements of Title VII).
72. *Id.* at 1272.
73. *Id.* at 1274 (“[E]mployers may cut benefits, raise deductibles, or otherwise alter coverage options to comply with budgetary constraints, [however,] the method by which the employer seeks to curb costs must not be discriminatory.”).
per month [per employee].

While Bartell would indeed be allowed to balance insurance coverage costs, it would not be allowed to do so at the expense of female employees.

4. Excluding Contraceptives Is Gender Neutral

Finally, Bartell claimed that because it excluded all “family planning” drugs, the exclusion was nondiscriminatory. The court rejected this argument because other drugs that could be categorized as “family planning” drugs, such as prenatal vitamins, were included in the plan. Bartell further argued that because infertility treatments were excluded for both men and women (for example, Viagra was not covered under the plan), such “family planning” exclusions were gender neutral, and therefore, did not discriminate against female employees. The court noted, however, that while the infertility exclusions were equally applied to both men and women, reducing coverage of contraceptives “reduces the comprehensiveness of the coverage offered to female employees while leaving the coverage offered to male employees unchanged,” thus creating a clear Title VII violation.

5. The Court’s Conclusion

The Erickson decision is a landmark case in gender, healthcare, and insurance equity. The court used very strong language in concluding that the exclusion of contraceptive coverage “creates a gaping hole in the coverage offered to female employees, leaving a fundamental and immediate healthcare need uncovered.” The case is significant because it creates precedent in the Ninth Circuit and allows for attorneys and plaintiffs in other circuits to cite it as support in demanding that self-insured employers provide equal insurance coverage for contraceptives, as the decision was specifically aimed at a self-insured employer. Because the decision is not binding precedent on all courts, however, a federal law is ultimately necessary.

75. Planned Parenthood, supra note 14.
76. Erickson, 141 F. Supp. 2d at 1274.
77. Id. at 1272.
78. Id. at 1275.
79. Id.
80. Id.
81. Id. at 1277.
E. Equal Employment Opportunity Commission Decision

In another case, two female employees charged their employers with discrimination under Title VII for failing to cover contraceptives and submitted the case to the Equal Employment Opportunity Commission (EEOC) for a formal declaration.82 The EEOC analyzed the PDA and concluded that the statute includes contraception because contraception is a way for a woman to control her ability to become pregnant, and the Supreme Court has found that the PDA covers a woman’s ability to become pregnant as well as the pregnancy itself.83 Furthermore, because Congress made an explicit exception that employers would not normally have to cover abortion procedures, the EEOC reasoned that if Congress wanted to exclude contraceptives, it would have done so explicitly in the law.84

1. Other Types of Preventative Services Covered Under Employer’s Plan

In order to determine whether the exclusion of contraceptive coverage was discriminatory, the EEOC first looked at the other types of services covered under the employers’ plans “that are used to prevent the occurrence of certain medical conditions.”85 Those preventative drugs and devices included the following:

- 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

83. Id. at *2 (citing UAW v. Johnson Controls, Inc., 499 U.S. 187, 199, 211 (1991)).
84. Id. at *2–3.
85. Id. at *3.
smears and routine mammograms; and

- preventive dental care (including oral examinations, tooth cleaning, bite wing x-rays, and fluoride treatments).86

The employers argued that the preventative treatments covered in their insurance plans were to prevent “abnormal” health conditions,87 implying that because pregnancy is not an abnormal health condition it need not be covered. The EEOC responded that pregnancy is widely recognized as a medical condition that poses severe risks to a pregnant woman.88 Furthermore, like contraceptives, preventative treatments like vaccinations serve “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.”89 Thus, treating contraceptives differently from other forms of preventative care constituted a violation of the PDA because the employer had discriminated on the basis of pregnancy.90

2. Other Justifications for Excluding Contraceptives Extended by the Employer

In an additional effort to explain the exclusion of contraceptives, the employers argued that they were exempt from outside regulation under ERISA’s provisions.91 The EEOC responded that while the employers were indeed exempted from state laws, they were in no way exempt from federal discrimination statutes.92 The employers also argued that the exclusion of contraceptives was for purely financial reasons and had nothing to do with discrimination on the basis of sex.93 The EEOC rejected that argument as well, noting that Congress did not write a “cost defense into the law.”94 Finally, the employers argued that the lack of contraceptive coverage did not explicitly distinguish between coverage of men and women and therefore did not constitute discrimination.95 The

86. Id.
87. Id.
88. Id.
89. Id. at *4.
90. Id.
91. Id.
92. Id.
93. Id.
94. Id.
95. Id.
EEOC quickly dispensed of this argument by noting that “[b]ecause 100 percent of the people affected by [the employer]’s policy are members of the same protected group—here, women—[the employer]’s policy need not specifically refer to that group in order to be facially discriminatory.”

3. The Conclusion and Implications

The EEOC firmly ruled that the employer was discriminatorily covering preventative drugs and devices and was therefore in violation of Title VII, namely the PDA, because the “health plan effectively covers approved, non-experimental treatments for employees’ medical conditions unless those treatments involve contraceptives. This is unlawful.” The EEOC then detailed what the employer in this case had to do in order to comply with the opinion and avoid further violations of Title VII:

- 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 . . . . 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 . . . Respondents limit coverage of comparable drugs or services, . . . 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 . . . 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.

The decision is another bold affirmation for women attempting to obtain equal coverage in their prescription drug plan, but it does have

96. Id. The commission further noted that whether the employees sought to use contraceptives for pregnancy prevention or the prevention of other health conditions such as dysmenorrhea and menstrual cramps was irrelevant because the employers had excluded the treatment exclusively to men, and not women. Id. at *5.
97. Id. at *5.
98. Id.
limited implications. As an EEOC opinion, it is binding only on the challenged employer. However, it serves as a strong guideline for further employer decisions and gives greater power to other female employees who do not have contraceptive coverage under self-insured plans. That is, if other employers want to avoid litigation, it is in their best interest to follow the mandates in these cases rather than attempt to litigate the issue in court.

III. CONTRACEPTIVE COVERAGE IN THE STATES: DOES IT WORK?

In order to determine whether state contraceptive laws actually work, it is helpful to examine the arguable benefits of coverage. If abortion rates allegedly will be lowered once contraceptives are made more available to women through insurance plans, has the abortion rate in states mandating coverage declined since the enactment of state laws? This Part examines Iowa and Missouri, two states that mandate contraceptive coverage but whose laws specifically differ. Those states are similar in terms of geographic location, population, and demographics.99 Not only will this Part examine the effectiveness of each state’s laws, but it will also examine legal contraceptive coverage activity in the state.

A. Iowa Law

Iowa law sets out mandates for group policies or contracts providing for third party payment or prepayment of health or medical expenses.100 Insurers may not exclude coverage of contraceptives approved by the Food and Drug Administration if other prescription drugs are covered101 and may not exclude coverage of contraceptive outpatient services if the insurance plan covers other outpatient services.102 In addition, providers may not deny coverage based on contraceptive use, attempt to monetarily induce an individual to accept less than the minimum benefits, penalize a health care provider for prescribing contraceptive drugs or devices or

101. Id. § 514C.19(1)(a).
102. Id. § 514C.19(1)(b).
services, or attempt to monetarily induce a health care provider to withhold contraceptive services to a covered individual. Finally, providers may not make co-payments or deductibles for contraceptive drugs and services greater than those for other covered drugs and services. The law is limited, however, by the fact that it does not apply to self-insured employers.

B. Abortion in Iowa

The Iowa legislature enacted the contraceptive coverage law in 2000, so it is beneficial to examine abortion statistics in previous and subsequent years. One problem, though, is the frequency with which such statistics are reported, published, and released. The Iowa Department of Public Health most recently released figures for pregnancy terminations in Iowa for January 2002 through December 2002. In 1999, providers reported 6,106 induced abortions. In 2000 (the year of the law’s enactment), providers reported 6,059 induced abortions. In 2001, abortion providers reported 5,722 induced abortions. Finally, in 2002, providers reported 6,230 induced abortions. The report concluded that Iowa’s rate is below the national average for both induced and spontaneous pregnancy terminations as compared to live births, as well as induced and spontaneous terminations for women of childbearing age. Overall, however, annual pregnancy terminations in Iowa increased in 2002. Induced terminations increased by 8.9% from 2001 to 2002. Does that
mean that the contraceptive coverage law did not or is not working? The data raises questions to those who argue that an increase in contraception coverage will decrease the number of abortions in a state.\textsuperscript{115} It certainly has not proven to be the case in Iowa. Nonetheless, opponents of mandatory coverage should not be quick to conclude that covering contraceptives does not reduce abortion rates. Rather, what is more probable is that the mandates, while a giant step forward in the fight for women’s health equality, do not apply to enough individuals.

Another possible explanation for the absence of a decrease in abortion rates after enactment of the contraceptive coverage law is that the age group obtaining the greatest number of induced abortions may not have access to insurance coverage \textit{at all}. In Iowa, women between the ages 19–24 obtained the greatest number of induced abortions between the years of 2000 through 2002.\textsuperscript{116} Of the total 6,059 induced abortions performed in 2000, this age group received 2,490; in 2001, the group received 2,451 out of 5,722 induced abortions; and in 2002, they received 2,599 out of 6,230 induced abortions.\textsuperscript{117} Perhaps it is not that the state’s contraceptive law is not working; rather, it could be that the women in the group who obtain the greatest number of induced abortions may be, for example, full-time students or occupying entry-level jobs where, at most, limited benefits are provided.\textsuperscript{118} Therefore, it does not necessarily follow that contraceptive coverage will not reduce abortion.

\textbf{C. Missouri Law}

Missouri law, while still mandating contraceptive coverage, has a much different application than Iowa law. If a health benefit plan covers pharmaceutical benefits, the plan must also provide coverage for contraceptives approved by the Food and Drug Administration at no extra charge or with the same amount of co-payment or deductible as any other prescription drug.\textsuperscript{119} Several exemptions exist that allow non-coverage for religious reasons. First, a health carrier may issue a health benefit plan to a person or entity that excludes coverage for contraceptives if such use is contrary to the person’s or entity’s “moral, ethical or religious beliefs or

\begin{flushleft}
\begin{enumerate}
\item See discussion \textit{supra} Part II.C.
\item 2002 \textbf{Iowa Pregnancy Report}, \textit{supra} note 107, at 12.
\item \textit{Id.}
\item The issue then becomes how to provide affordable contraceptives for those individuals, but that analysis is left for another author.
\item \textit{Mo. Ann. Stat.} § 376.1199(1)(4) (West 2002).
\end{enumerate}
\end{flushleft}
Second, if the enrollee of a health plan that covers contraceptives requests for such coverage to be excluded from the plan because the use of contraceptives is contrary to his or her moral, ethical or religious beliefs, then the health carrier shall issue a policy that excludes such coverage.121 Third, the law provides an exemption for health carriers “owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets” that are opposed to the use of contraceptives.122

However, the law allows individuals to purchase their own plan that covers contraceptives:

Except for a health carrier that is exempted from providing coverage for contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan that includes coverage for contraceptives.123

The law also requires written notice to be given to individuals who receive a plan pursuant to subsection 1 (exclusion of contraceptive coverage based on the person’s or entity’s beliefs).124 The written notice, provided on the enrollment form or accompanying materials, must include the following information: (1) whether contraceptive coverage is included; (2) that an enrollee in the plan has the right to exclude contraceptive coverage from the plan if it is contrary to the enrollee’s beliefs; and (3) that an enrollee who is a member of a plan that excludes coverage may purchase coverage of contraceptives.125 The law does not apply, however, to self-insured employers.126

D. Abortion in Missouri

Missouri’s contraceptive coverage law went into effect in 2002,127 so it is useful to look at abortion statistics preceding and subsequent to that year. Missouri abortion statistics are available through the Department of

120. Id. § 376.1199(4)(1).
121. Id. § 376.1199(4)(2).
122. Id. § 376.1199(4)(3).
123. Id. § 376.1199(5).
124. Id. § 376.1199(6).
125. Id. § 376.1199(6)(1)–(3).
126. See discussion supra Part II.B.
Health and Senior Services’ Vital Statistics reports, which are reported annually.\textsuperscript{128} Statistics are available for the given calendar year, with data collection continuing through April of the following year.\textsuperscript{129} Thus, the latest available abortion statistics are for the year 2004, with data collection ending April 15, 2005.\textsuperscript{130} While 2005 provisional statistics are available monthly, the only provisional data available are live births, deaths, natural increase, marriages, dissolutions of marriage, and infant deaths.\textsuperscript{131} The Department reports that in 2000, practitioners performed 12,292 resident abortions.\textsuperscript{132} In 2001, the number decreased slightly to 12,266 resident abortions.\textsuperscript{133} In 2002, the year that the legislature enacted the contraceptive coverage law, the number again decreased to 12,250.\textsuperscript{134} In contrast to the trend of the previous three years, however, the 2003 resident abortion rate jumped to 12,476.\textsuperscript{135} However, abortion rates dropped in 2004, with the number of resident abortions totaling 11,871.\textsuperscript{136}

While the 2003 abortion rate increase is perplexing in light of the argument that providing increased contraceptive coverage will reduce


\textsuperscript{130} Id.


\textsuperscript{133} STATE OF MO. DEP’T OF HEALTH & SENIOR SERVS., RESIDENT ABORTIONS BY AGE & MARITAL STATUS OF WOMAN: MISSOURI 2001 (2001), http://www.dhss.mo.gov/VitalStatistics/MVS01/Table15.pdf [hereinafter 2001 Mo. Abortion Table].


\textsuperscript{135} STATE OF MO. DEP’T OF HEALTH & SENIOR SERVS., RESIDENT ABORTIONS BY AGE & MARITAL STATUS OF WOMAN: MISSOURI 2003 (2003), http://www.dhss.mo.gov/VitalStatistics/MVS03/Table15.pdf [hereinafter 2003 Mo. Abortion Table].

abortion rates, the decrease in the 2004 rate suggests a trend which will lead to decreased abortion rates when states increase contraceptive coverage.\textsuperscript{137} The age of women attaining abortions, useful in the Iowa analysis, is also critical when analyzing the Missouri statistics. In Missouri, like Iowa, women ages 20–24 received the greatest number of abortions as compared to other age ranges: they received 3,970 of the total 12,292 abortions in 2000;\textsuperscript{138} 4,185 of a total of 12,266 abortions in 2001;\textsuperscript{139} 4,094 out of 12,250 total abortions in 2002;\textsuperscript{140} 4,297 abortions out of the total 12,476 in 2003;\textsuperscript{141} and finally 3,993 abortions out of the total 11,871 in 2004.\textsuperscript{142} Thus, while the number of women in the given age group received fewer abortions in 2004 as compared to previous years, the numbers remained high in preceding years despite the enactment of the contraceptive laws, suggesting that perhaps the state laws are not entirely efficient in furthering one of the proponents’ chief goals: to reduce abortion. Women in this age group may not have access to insurance, and as a result the laws do not help them procure affordable contraception. In addition, because self-insured ERISA plans are not required to comply with the state contraceptive coverage laws,\textsuperscript{143} a portion of the state’s population that does have insurance benefits is potentially left vulnerable to absence of coverage. Put simply, the state laws do not cover enough people.\textsuperscript{144}

E. Other Relief

Currently, because no federal law exists to mandate contraceptive coverage with regard to all insurers, individuals whose self-insured employers do not cover contraceptives may be forced to deal with inadequate coverage. For those in certain jurisdictions, however, relief may be available. For example, while no state or federal case law exists in Iowa regarding contraceptive coverage, two district court cases out of the Eighth Circuit might give employees leverage when lobbying employers to

\begin{itemize}
\item \textsuperscript{137} See discussion \textit{supra} Part II.C.
\item \textsuperscript{138} 2000 MO. ABORTION TABLE, \textit{supra} note 132.
\item \textsuperscript{139} 2001 MO. ABORTION TABLE, \textit{supra} note 133.
\item \textsuperscript{140} 2002 MO. ABORTION TABLE, \textit{supra} note 134.
\item \textsuperscript{141} 2003 MO. ABORTION TABLE, \textit{supra} note 135.
\item \textsuperscript{142} 2004 MO. ABORTION TABLE, \textit{supra} note 136.
\item \textsuperscript{143} See discussion \textit{supra} Part II.B.
\item \textsuperscript{144} For example, nationwide it is estimated that approximately half of all Americans are covered by self-insured plans that do not have to follow state mandates, leaving the possibility that half of all Americans are subject to health care insurance discrimination. \textit{See} Marie Suszynski, \textit{Study Finds More Employers Including Contraceptive Coverage in Health Plans}, BESTWIRE, June 17, 2004.
\end{itemize}
include contraception coverage.\textsuperscript{145} A 2002 study indicated that a greater number of insurers included contraceptives in their plans,\textsuperscript{146} likely because (among other reasons) they wanted to avoid litigation in the wake of court cases ruling favorably for women suing to gain coverage. The Eighth Circuit Court of Appeals has not yet heard a case regarding discriminatory contraceptive exclusion, so no controlling precedent exists that would apply to the entire circuit.\textsuperscript{147}

1. \textit{EEOC v. United Parcel Service, Inc.}\textsuperscript{148}

\textit{EEOC v. United Parcel Service, Inc.} was decided by the District Court of Minnesota, and is a useful tool for residents in Eighth Circuit states trying to argue that a lack of contraceptive coverage violates an employee’s civil rights.\textsuperscript{149} The EEOC brought the suit on behalf of Mark Dugger, a United Parcel Service (UPS) employee who could not obtain coverage for the contraceptive Ortho-Novum for his wife under his insurance plan.\textsuperscript{150} The complaint alleged that in failing to cover oral contraceptives of any kind, UPS’s health benefit plan violated § 703 of Title VII of the Civil Rights Act of 1964\textsuperscript{151} by providing a discriminatory health benefit plan based on sex.\textsuperscript{152} Dugger’s wife sought to use the contraceptives not for contraceptive purposes, but to treat a female hormonal disorder that was at times incapacitating.\textsuperscript{153} While she was not allowed to have the medication covered for that purpose, UPS’s health benefit plan listed no exclusions for


\textsuperscript{146} Suszynski, supra note 144.

\textsuperscript{147} Cooley, 281 F. Supp. 2d at 981 (noting that the case was “an issue of first impression in the Eighth Circuit of whether the selective exclusion of prescription contraceptives from an otherwise comprehensive health care benefits plan constitutes discrimination on the basis of sex”).


\textsuperscript{149} To clarify, those residents who would bring such suits may reside in a state that does in fact mandate contraceptive coverage, but if the individual is covered under a self-insured plan that does not offer coverage, other circuit cases are a useful resource if litigation becomes necessary.

\textsuperscript{150} United Parcel Serv., 141 F. Supp. 2d at 1217. This case offers a unique twist on contraceptive coverage litigation, as the party is not a female or group of females demanding coverage, but a man demanding coverage for his wife.


\textsuperscript{152} United Parcel Serv., 141 F. Supp. 2d at 1217.

\textsuperscript{153} Id.
approved treatments for male hormonal disorders.\footnote{154} In addition to the Title VII claim, the EEOC asserted that the plan had a disparate impact on female employees and spouses, which UPS attempted to negate by arguing that the contraceptive policy was gender neutral.\footnote{155}

The court first laid out the necessary criteria for a disparate treatment claim; that is, that an employer’s less favorable treatment of certain individuals is based on the individuals’ sex.\footnote{156} The EEOC claimed that the lack of contraceptive coverage resulted in disparate treatment because oral contraceptives are prescribed only to women, so even though the benefit plan exclusion applied to women and men, it only burdened females.\footnote{157} The court agreed, finding that the benefit plan was in fact \textit{not} gender neutral, and that the EEOC had made a case worthy of litigation.\footnote{158}

While the case supports the assertion that although the exclusion of contraceptives in insurance coverage may apply to men and women, it uniquely burdens females; the case has its practical limitations for use. The main limitation of the case is that the plaintiffs sought to include contraceptive coverage so that the petitioner’s wife could use them to treat a painful hormonal disorder.\footnote{159} Therefore, it is unclear if the court would have reached the same conclusion if the petitioner’s wife simply would have wanted to use contraceptives for their ordinary purpose: to prevent pregnancy. This could place several parties in problematic situations. First, it could cause some women to feel that they must lie to their doctor or pharmacist in order to get the medication covered by their insurance provider. Second, it may put doctors in an uncomfortable position of either stating that a patient is using the medication for something other than contraception (which would in many cases be in the patient’s best interest), or watching a patient struggle because she cannot afford the medication to which she should be entitled. Nonetheless, the case is a starting point in challenging the exclusionary coverage.

2. \textit{Cooley v. DaimlerChrysler Corp.} \footnote{160}

\textit{Cooley v. DaimlerChrysler Corp.} is beneficial to those Eighth Circuit
employees with self-insured insurance plans that do not cover contraceptives and who wish to challenge that lack of coverage in court. The plaintiffs were a class of full-time female DaimlerChrysler employees who were enrolled in DaimlerChrysler’s prescription benefit plan while using contraceptives. The plan excluded all prescription contraceptives. Like the employees in United Parcel Service, the DaimlerChrysler employees claimed the plan violated Title VII of the Civil Rights Act of 1964, alleging disparate treatment on the basis of sex and disparate impact on female employees. DaimlerChrysler argued the plaintiffs’ claims should be dismissed because such claims were not protected under the PDA.

The court first addressed DaimlerChrysler’s defense that plaintiffs’ claims were not protected by the PDA, stating that “[u]nder the PDA, discrimination on the basis of pregnancy is a per se violation of Title VII.” The court noted that “[b]y definition, such a rule discriminates on account of sex; for it is the capacity to become pregnant which primarily differentiates the female from the male.” Thus, classifications based on pregnancy are never gender neutral, as different treatment on the basis of pregnancy constitutes discrimination on the basis of sex because only women can become pregnant.

On the claim of disparate treatment, the court recognized that classifications of employees based on the potential for pregnancy are to be regarded as classifications based on sex discrimination. The court then tied that to contraceptives by saying that because “prescription contraceptives are only available to women, the exclusion is not gender neutral because it only burdens female employees.” In concluding that complete exclusion of contraceptives did constitute disparate treatment,

161. Id. at 981.
162. Id.
165. Id. at 982.
166. Id.
167. Id. at 983 (quoting Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 161–62 (Stevens, J., dissenting)).
168. Id.
169. Id. at 984.
170. Id. The court further held that “[a]s recognized by the Supreme Court, a woman’s potential for pregnancy is a status protected from discrimination and classifications on such basis must be treated ‘as explicit sex discrimination.’” Id. (quoting UAW v. Johnson Controls, Inc., 499 U.S. 187, 198 (1991)).
the court noted that: (1) such exclusion may treat medications necessary for a sex-specific condition less favorably than others; (2) contraceptives are widely used for purposes other than contraception; (3) under DaimlerChrysler’s plan, men are afforded greater protection from all categories of risk; and (4) DaimlerChrysler’s plan amounted to less comprehensive benefits for women. On the issue of disparate impact, the court found that women face a greater burden because the benefit plan’s exclusions apply to prescriptions available only to women, and that if an employer “wishes to exclude a limited number of benefits . . . it must ensure that such exclusions do not fall more harshly on one group.” The court’s decision carries much more force for litigants, as the court acknowledged that no matter what the purpose of prescription contraceptive use (for example, to treat medical conditions or to use it for contraception), employers may not exclude contraceptives from an “otherwise comprehensive benefit plan.”

IV. CONCLUSION

A vast disparity of insurance coverage exists today. In many states, all insurers are allowed to exclude contraceptive coverage in benefit plans. An even greater concern is the fact that, although some states still mandate coverage, self-insured employers are governed by federal law and, therefore, are not subject to state insurance laws. While many members of Congress have persistently tried to pass EPICC so that all benefit plans would be required to cover contraceptives, the plan has repeatedly failed in committee. Thus, a substantial number of individuals who are covered by self-insured plans—approximately half of all those covered—are at risk of having their policies exclude contraceptive coverage.

Contraceptive coverage is important because use can reduce the number of employees in the workplace who have unintended pregnancies, save employers money because contraceptive coverage costs less than covering abortion procedures, and in general reduce the number of

171. Id. at 985.
172. Id. at 986.
173. Id.
174. See discussion supra Part II.B.
175. See discussion supra Part I.
176. See Suszynski, supra note 144 (reporting survey results of the number of non-self-insured employers covering prescription contraceptives in their prescription drug plans).
abortsions performed. Courts have ruled that excluding contraceptive coverage violates Title VII of the Civil Rights Act of 1964 as sex-based discrimination and that such exclusion amounts to disparate treatment with a disparate impact on women. As such, plaintiffs who have brought their cases to court have either forced their employer to cover contraceptives or have been able to continue into the next phases of litigation.

While inclusion of contraceptives in insurance plans is supposed to reduce abortion rates, the rates in Iowa and Missouri, two states mandating coverage, have increased for the most part. The problem, however, is not that covering contraceptives in benefit plans does not reduce abortion. The problem is that the state laws cannot reach enough individuals. If half of the country is covered by self-insured plans not subject to state control, a great danger exists that those self-insured employers are not voluntarily including contraceptives in their prescription coverage. Thus, the only way to make sure no insurance plan engages in sex discrimination by way of exclusionary coverage is for Congress again to engage in a bipartisan effort to propose and finally pass EPICC.

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177. See discussion supra Part II.C.
178. See discussion supra Parts II.D, III.E.
179. See, e.g., Cooley v. DaimlerChrysler Corp., 281 F. Supp. 2d 979, 985–86 (E.D. Mo. 2003) (ruling that failure to cover prescription contraceptives constituted disparate treatment because only women use them and as such are uniquely burdened); Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1271–72 (W.D. Wash. 2001) (holding that it was a violation of Title VII of the Civil Rights Act of 1964 for an employer not to cover contraceptives where comparable prescriptions used by males are covered in a self-insured plan); EEOC v. United Parcel Serv., Inc., 141 F. Supp. 2d 1216, 1219–20 (D. Minn. 2001) (holding that plaintiff stated a cause of action for a disparate impact claim where employer’s insurance plan failed to cover contraceptives needed by employee’s wife to treat a hormonal disorder); Commission Decision on Coverage of Contraception, 2000 WL 33407187, at *3 (Dec. 14, 2000) (deciding that lack of contraceptive coverage violates the PDA, and that if Congress wanted to exclude contraceptives from the definition of the statute, it would have explicitly done so).
180. See discussion supra Parts III.B, III.D.

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