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NOTE

AN EPICCC OVERSIGHT: WHY THE CURRENT BATTLE FOR ACCESS TO CONTRACEPTION WILL NOT HELP REDUCE UNINTENDED PREGNANCY IN THE U.S

Christopher G. Kuhnt*

INTRODUCTION

In 1965, the Supreme Court held there was a fundamental right to privacy, and that right included the freedom to use birth control.¹ Forty years after that decision, women are still fighting a battle to gain access to prescription contraceptives. Many believe that increasing women's access to contraceptives would help women achieve equality in our society.² Since 1965, advocates for a woman's right to control her reproduction have made a good deal of progress through federal and state legislation as well as judicial and administrative processes to increase access to contraception. While these victories have helped make prescription contraceptives more accessible to women, unintended pregnancies still account for nearly half of all pregnancies in the United States.³ These unwanted and mistimed pregnancies have a

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The most recent battle for access to contraception has revolved around health insurance providers' exclusion of coverage for prescription contraceptives. Advocates for access to contraception have won a few federal district court and administrative committee decisions, which have found that failing to provide contraception under insurance is discriminatory. These decisions, combined with lobbying, have led to several state mandates requiring coverage of prescription contraceptives. However, the state mandates are limited in scope and jurisdiction, and there are calls for a more encompassing federal mandate. In order to fill these gaps, several legislators have proposed federal legislation known as the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). The 2006 election resulting in Democratic control of both houses of Congress indicates that EPICC may finally get enough support to get out of the subcommittees in which it has been stuck since first being introduced in 1997.

This Note will take a critical look at EPICC. While the legislation would certainly help to create more equal benefits for women who are insured, it fails to address the women who are in most need of contraception. In fact, while EPICC could help to create equity between men and women who have health insurance, it would further widen the inequality between women who have insurance and those who do not.

Part I discusses the importance of access to contraception. Part II provides a brief history of the access to contraceptives through a summary of major Supreme Court cases, the Title X program, and academic arguments. Part III takes a look at the limitations of recent district court decisions, the EEOC decision, and state mandates. Part IV is an analysis of EPICC and the possible results if it were to be enacted. The conclusion considers statistical data that shows EPICC will probably not help to reduce the high rate of unintended pregnancies in the U.S. Though there has been progress in providing women access to contraception, the underlying factors that correlate with unintended pregnancies are not dealt with by EPICC or any current legislation, and other options should be considered.


5 Democratic leaders Hillary Clinton and Harry Reid have consistently sponsored the Bill.
I. ACCESS TO PRESCRIPTION CONTRACEPTIVES IS IMPORTANT IN MAINTAINING WOMEN'S HEALTH AND SOCIETAL INSTITUTIONS

The main purpose of contraception is to prevent pregnancy. Once a woman becomes pregnant, her life will change. Women who unintentionally become pregnant have no course of action that will not substantially affect their health. Furthermore, unintended pregnancies have a further reaching impact than just upon mother and child. The family unit and society as a whole are also impacted by unintended pregnancies.

Access to prescription contraception has played a substantial role in forming modern American society. In 1992, the Supreme Court recognized that women's ability to control their reproductive lives has increased "[t]he ability of women to participate equally in the economic and social life of the Nation . . . ." The importance of contraceptives has been supported by the U.S. Senate in its recognition that "the ability of women to control their fertility has enabled them to achieve personal, educational and professional goals critical to the economic success of the United States." Some scholars have even suggested that women's ability to control reproduction has led to lower crime rates. While the argument that unintended pregnancy leads to the creation of criminals is a stretch, it is undeniable that unintended pregnancies can have a detrimental effect on women and society as a whole. Besides the overall costs to society and the individual health of women, the impact of unintended pregnancies is heavy upon the family structure upon which our society is based. This impact is not equally spread in our society, with the highest rates of unintended pregnancy occurring among the poor, the uneducated, and the young.

Pregnancy and childbirth are major events in a woman's life. They affect her family relationships, her role in the workplace, and also have a serious impact upon her health. A woman's health related to pregnancy has three stages: antenatal (during pregnancy),

7 S. Res. 162, Expressing the Sense of the Senate Concerning Griswold v. Connecticut (June 7, 2005).
8 STEVEN D. LEVITT & STEPHEN J. DUBNER, FREAKONOMICS: A ROGUE ECONOMIST EXPLORES THE HIDDEN SIDE OF EVERYTHING 139 (2005) (contending that Roe v. Wade was directly responsible for reduced crime levels in the 1990s).
10 Id. at 29.
intrapartum (during delivery and pregnancy), and post partum (after delivery). At each stage there are certain health costs that can be significant if there are any complications arising out of the pregnancy. The social and economic costs of pregnancy are huge, and it has been estimated that for every one dollar of public money spent on contraceptive services, three dollars are saved. The private sector also pays large amounts for unintended pregnancies. Furthermore, unintended pregnancy accounts for a substantial majority of all induced abortions. One study found that of all the unintended pregnancies in the United States forty-seven percent end in abortion, forty percent end in birth, and thirteen percent end in miscarriage. This means that the impact of unintended pregnancies on society could double if abortion is made illegal. The possibility of losing the right to an abortion is further pressure to increase the ease with which women can control their reproduction before pregnancy.

A. The Rate of Unintended Pregnancy

Nearly half of all pregnancies in the United States are unintended. This means that in 2004, almost two million births were either unwanted or mistimed. Furthermore, some argue that the tech-

11 Id. at 30.
13 Id. (stating the total cost of poor birth outcomes was $5.6 billion in 1990 and some of these births are unintended pregnancies, of which a portion are covered by private sector insurance companies).
14 Id. at 254 (citing a Georgia study which found ninety-seven percent of pregnancies ending in induced abortions were unintended).
16 Current legislation proposed in some states would restrict the right of abortion to emergencies only. Because of recent changes in the make-up of the Supreme Court, many question if the right established in Roe v. Wade will be upheld. For further discussion, see Joyce Howard Price, Changes in High Court Spur Anti-Abortion Bills; States Banning Procedure to Force Constitutional Confrontation, WASH. TIMES, Mar. 3, 2006, at A2; Roger Hunt, Our Time Has Come, USA TODAY, Feb. 28, 2006, at A11.
17 See CDC REPORT, supra note 3, at 59; see also Fu et al., supra note 3, at 56 (finding that forty-eight percent of pregnancies in the U.S. in 1994 were unintended); Huang, supra note 3, at 122 (finding that forty-six percent of pregnancies were unwanted by non-married men).
niques used to determine the rate of unintended pregnancies are inaccurate and the rate could be higher or lower. The consequences of unintended pregnancies, many of which could be avoided by access to and proper use of contraception, are harmful to both mothers and their children.

B. Use of Contraception

In 2005, the Centers for Disease Control (CDC) and the National Center for Health Statistics (NCHS) released data laying out the statistics for family planning and reproductive health for women in 2002 (hereinafter the “CDC report”). The CDC report shows some interesting trends in the economic and educational status of women who are at the greatest risk of having unintended pregnancies. As discussed infra, the high rates of unintended pregnancies among the poor, the uneducated, and the young indicate that they are not gaining access to contraceptives or are not using them properly.

First, it must be made clear that a large majority of women of reproductive age have had or are having sex. In 2002, there were sixty million women of childbearing age in the United States. The CDC report found that of those women eighty-eight percent overall and nearly seventy-two percent of unmarried women have had sexual intercourse. Of all women who have had sex, ninety-eight percent have used some form of contraception; nearly ninety percent of those had used a condom, eighty-two percent had used the pill (oral contraception), and the third most common method of contraception was the “withdraw” method. The high rate of unintended pregnancy means


20 Women who carry unintended children are more likely to continue to use damaging substances, their children are more likely to have low birth weight and eventually end up as delinquents, and divorce and domestic abuse are three times more likely to occur. Cover My Pills! Fair Access to Contraception: Unintended Pregnancies, http://www.covermypills.org/facts/pregnancies/ (last visited Mar. 5, 2007).

21 CDC Report, supra note 3, at 148 (the survey was based on 12,751 interviews with persons between 15-44 years old and was designed to produce national estimates).

22 See generally id.


24 CDC REPORT, supra note 3, at 71.

25 Id. at 92.
that many women either do not consistently use contraceptives during intercourse or the same few are responsible for all. While there is evidence that women who have one unintended pregnancy are more likely to have another, it is clear that many women do not use contraception regularly even when they do not want to get pregnant. The high rate of women having sex also indicates that abstinence is unrealistic as an effective form of birth control.

Women may not use contraception regularly because it is not accessible. For those sixty million women of reproductive age, "[c]ontraception is the single most common prescription that women need," and the high cost of contraception can be a barrier to access. Oral contraceptives cost approximately $540 a year in 2002, while other forms of contraceptives varied from four hundred to seven hundred dollars a year. The average American woman wants two children and will spend five years of her life trying to become pregnant and over twenty years trying to avoid pregnancy. So a woman who wants to use prescription contraceptives (the most reliable form of contraceptive) to avoid unintended pregnancy may spend over ten thousand dollars in her lifetime to pay for those contraceptives. When women spend money on contraception, society saves. One study found that the health care system in general saves between nine thousand and fourteen thousand dollars per woman, when contraception is used to avoid unintended pregnancy. These statistics clearly indicate that a reduction in the costs of contraceptives would result in a financial gain for women and the health care system.

C. Current Health Insurance Coverage of Contraception

Over two-thirds of women in the United States of childbearing age rely on private insurance for their health care, and nearly half of large group plans do not reliably cover any contraceptives. There are four main types of health care plans: HMOs (Health Maintenance

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26 One study found that fifty-three percent of second pregnancies were unintended. Ilene S. Speizer et al., Measuring Factors Underlying Intendedness of Women's First and Later Pregnancies, 36 PERSP. SEXUAL & REPROD. HEALTH 198, 204 (2004).

27 Riley & Snape, supra note 23, at 13-14.

28 Id. at 13.


Organizations), POS (point of service plans), PPOs (Preferred Provider Organizations), and FFS (fee for service). The HMO is the least expensive but also allows the least amount of personal freedom in choice because plan participants are limited to the chosen providers, while the FFS is the most expensive but also provides the most choice by allowing participants to choose any provider they wish. POS and PPO plans are in the middle and allow some choice in provider and plan, compared with slightly lower rates than an FFS plan.\footnote{Insuralane, Health Insurance Explained, http://www.insurelane.com/health/health-insurance-explained.html (last visited Feb. 21, 2007).}

None of these types of insurance plans consistently offer coverage of contraceptives. For women who use FFS or indemnity plans, nearly half do not cover any form of contraception, while only seven percent of HMO plans cover no contraception, and thirty-nine percent do not cover all forms of contraceptives.\footnote{Adam Sonfield et al., U.S Insurance Coverage of Contraceptives and the Impact of Contraceptive Mandates, 2002, 36 PERSP. SEXUAL & REPROD. HEALTH 72, 75 (2004).} Four out of ten people are covered by PPOs.\footnote{Id. at 78.} Some studies show that PPOs are a third less likely to cover contraception in non-mandate states.\footnote{Id. at 76.}

While there are large inconsistencies in the type and extent of contraceptive coverage, many health care providers do provide coverage of some sort of contraception.\footnote{Id. at 75-76.} In fact, one study found that eighty-nine percent of typical employment-based managed health plans covered the five leading prescription methods of contraception.\footnote{Id. at 75.} However, the rate of coverage is much lower where it is not mandated by state laws.\footnote{Id. at 76-77 (plans in with no state mandate were 31-40 percent less likely to cover contraceptives; that study only looked at large employer managed plans, which could be regulated by states).}

The gaps in coverage among all types of plans have led to women of reproductive age paying sixty-eight percent more than men of the same age in out-of-pocket health care costs.\footnote{Id.} These differences are unfair when considered in light of the fact that there are certainly health risks that are unique to men (prostate cancer for example) that do not seem to affect their costs and, more importantly, that contraceptives prevent unintended pregnancies, which are likely to have an effect on both sexes when people are married or living together.
D. Available Types of Contraception

The most popular and reliable form of contraceptives are oral prescription contraceptives. Over the counter barrier methods of contraception are also popular, but they are much less reliable. Another popular form of contraception is female or male sterilization. However, sterilization is non-reversible contraception and ends an individual's capacity to have children, instead of controlling when to have children.

Prescription hormonal contraceptives are over ninety-nine percent effective, while other reversible methods of contraception can vary from sixty to ninety-seven percent in effectiveness. Because the most effective forms of contraception require a prescription for use, the government has limited the access. Some argue that the best solution to the limited access issue is to sell prescription contraception over the counter. This would probably require some sort of health screening to determine that women could safely take the medication.

II. GOVERNMENT RECOGNITION OF THE RIGHT TO CONTRACEPTION

While the Griswold decision recognized the importance of individual freedom in controlling reproduction and limited the states' power to interfere with that decision, it would be a few more years before legislators acted to provide the tools for people of lesser means to make these choices. In 1970, Title X of the Public Health Service Act was signed into law. Title X provides federal funding for voluntary family planning services. In 1982, Congress enacted further

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41 THE WOMEN'S HEALTH DATA BOOK, supra note 9, at 24.
42 Id. at 25.
43 Engender Health, supra note 40.
45 Id. at 3.
46 Id. at 4.
47 381 U.S. 479 (1965).
49 Id. at § 1001(a).
legislation to deal with the specific problems related to teenage pregnancy through Title XX. The early 1980s were also the peak of government spending on family planning services.

Things were relatively quiet on the access-to-contraception front until the development and marketing of the male erectile dysfunction pill, Viagra. Viagra was quickly covered under employer benefit plans that had refused to cover prescription contraceptives. This perceived inequity has led to a push for both state and federal legislation as well as a push in federal court for mandated coverage of prescription contraceptives by health care providers. This section will give a quick overview of Title X, recent state mandate laws, the EEOC decision, and federal district court decisions in their interpretation of existing federal law. While the recent actions for equity in benefits have been the focus of many activists, the original purpose of Title X and the reasons why access to contraception is so important are at risk of being overlooked.

A. Title X Funded Facilities

Title X was signed into law in 1970 because President Nixon felt that "no American woman should be denied access to family planning assistance because of her economic condition." It is estimated that Title X funding has helped to prevent over twenty million unintended pregnancies and nine million abortions since being signed into law.

Through Title X, the federal government supports family planning clinics around the country for people who would not otherwise be able

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53 Id. at 531.
55 The Allan Guttmacher Institute, supra note 51.
to access these services. However, many of these clinics are not covered under employer managed health plans. This means that the facilities must charge individual women an often deeply discounted rate instead of seeking reimbursement from their insurers. In 2005, Title X funded programs received $288 million. While this seems like a substantial amount of funding, the amount of money which is set aside to support such programs is nearly half of what it was twenty-five years ago. When women use these facilities and have third-party health insurance, the Title X facilities often cannot get reimbursement for provision of the contraception, which further reduces their funds and effectiveness. Furthermore, the CDC study shows that these facilities are used by a small number of women for their family planning services compared to other available services. While the reduction in financial support has certainly had an impact on the effectiveness of Title X facilities, the small number of women who seek out their services suggests that an increase in funding for Title X clinics might not increase access to contraception and reduce unintended pregnancies.

B. Recent State Mandates Requiring Coverage of Contraceptives

Over the past decade many state legislatures have taken action to mandate coverage of prescription contraceptives by employer related health plans. Twenty-three states currently have some type of contraceptive equity law on the books. These plans do not regulate em-

58 Id. at 9-10.
60 Dailard, supra note 57, at 9 (noting the amount of money provided under Title X is actually fifty-eight percent less than it was in 1980, including inflation).
61 Id. at 10.
62 CDC REPORT, supra note 3, at 130 (only seven percent of women who had used family planning services used a Title X clinic).
63 See ARIZ. REV. STAT. ANN. §§ 20-1057.08A(1), 20-1402L(1), 20-2329A(1) (2003); ARK. CODE ANN. § 23-79-1103(a) (2005); CAL. INS. CODE § 10123.196 (West 2002); CONN. GEN. STAT. ANN. § 38a-530e (West 2003); DEL. CODE ANN. tit. 18 § 3559 (2000); GA. CODE ANN. § 33-24-59.6 (2005); HAW. REV. STAT. §§ 431:10A-116.6, 432:1-604.5 (2005); 215 ILL. COMP. STAT. ANN. 5/356z.4 (West 2003); IOWA CODE ANN. § 514C.19 (West 2002); ME. REV. STAT. ANN. tit. 24 §§ 2332-J(1), 2847-G(1), 4247(1) (2002); MD. CODE ANN. INS. § 15-826 (LexisNexis 2006); MASS. GEN. LAWS ANN. ch. 175 §§ 47W(a)-(b), 176A §§ 8W(a)-(b), 176B §§ 4W(a)-(b), 176G §§ 4O(a)-(b) (West 2006); MO. ANN. STAT. § 376.1199(1)(4) (West 2002); NEV. REV. STAT. ANN. §§ 698A.0415, 689B.0376 (West 2002); N.H. REV.
employers who pay for health care claims with their own funds. 64 Those privately funded plans are federally regulated by the Employee Retirement Income Security Act (ERISA). 65 Many of the state regulations include a variety of exceptions to the mandates, including the right of employers or insurers to refuse coverage for a religious or, in a few cases, any reason. 66 A few of the states regulate HMOs and small and individual market insurers but most do not. 67 Additionally, some states have mandates requiring coverage of "family planning services" by HMOs but have not interpreted these laws as requiring coverage of contraception. 68 Because state mandates do not regulate individual health care plans, upon which many Americans depend for their health care, they are not the best way to regulate insurers.

For the states that do have some type of legislation requiring coverage of contraception, there is no consistency in those mandates. The most comprehensive mandates prohibit the exclusion or restriction of benefits for FDA-approved contraceptive drugs, or outpatient services providing contraception services, if that plan covers other prescription medicines and outpatient services. 69 These laws prohibit plans from charging a higher deductible or co-payment for family planning and birth control services than they charge for other services. 70 The most comprehensive laws do not offer any exceptions to these requirements. 71 Some states allow the insured to file a complaint directly with the state instead of contacting the employer first if there is an issue with the insurance policy. 72


64 NWLC, supra note 54, at II.
67 Id.
68 According to the National Women's Law Center, these states include Michigan, Montana, New Jersey, North Dakota, Ohio, Oklahoma and Wyoming. NAT'L WOMEN'S LAW CTR., CONTRACEPTIVE EQUITY IN YOUR STATE: KNOW YOUR RIGHTS - USE YOUR RIGHTS 3 (2005).
70 Id. § 514.C19(3).
71 Id.
On the other end of the spectrum, the less comprehensive mandates only restrict a limited group of insurers and allow refusal to provide such services. Many of these laws include “conscience clauses,” which allow employers to refuse providing insurance for contraceptives if they are morally opposed to doing so. While these “conscience clauses” generally only apply to religious employers, one state allows any employer or insurer to exclude contraceptives from a health plan if contraception is contrary to the “moral, ethical or religious” tenets of that person or entity. This exception essentially makes the law ineffective if the employer gives written notice that it will not provide contraception coverage for any of the above reasons.

All of the state mandates are also limited by the ERISA, which supersedes “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” The Supreme Court has limited the scope of what industries ERISA supersedes in relation to state laws, and generally allows state regulation of the insurance industry. The line is less clear with self-funded insurance plans, which fall under the ERISA exemption, and generally employers who provide their own benefits packages are not considered to be regulated by state law because the state cannot regulate employer health plans.

Even with the limited reach of these state mandates through the conscience clauses and ERISA, there is a much higher rate of coverage in these states than elsewhere. This shows that advocates for contraceptive equity have been effective in getting more health plans to cover prescription contraceptives. However, as discussed infra, the higher rate of coverage for contraception does not seem to have had a significant impact on the rate of unintended pregnancy.

C. The 2000 EEOC Decision

In 2000, the Equal Employment Opportunity Commission (EEOC) found that an employer’s failure to cover prescription contra-
ceptives when it covered other “preventative drugs, devices and services” was a violation of Title VII and the Pregnancy Discrimination Act (PDA).\textsuperscript{79} The EEOC made note of the various benefits that prescription contraceptives provide and that the employer’s health plans excluded coverage of contraceptives “regardless of intended use.”\textsuperscript{80} The commission determined that it was the intent of Congress that the PDA cover contraception because it had not specifically included exclusionary language as it had for abortion and that contraception would be included based on the stated purpose that the law prohibits discrimination “based on the whole range of matters concerning the childbearing process.”\textsuperscript{81} The EEOC was not swayed by the employer’s defense, which included arguments that provision of contraceptives was cost prohibitive and that prescription contraceptives were denied to both sexes, and, thus, there was no discrimination.\textsuperscript{82}

While this decision has some effect on Title VII employers, it is limited to those employers that fall under Section 701(b) of the act (those having fifteen or more employees).\textsuperscript{83} Also, Title VII only regulates health plans that are provided directly from the employer; this does not include plans that are purchased through insurance agencies.\textsuperscript{84} While the EEOC did find that coverage of preventative medicines must include coverage for contraceptives, many policies do not have an absolute exclusion of contraceptives, as was the case here, and often will cover contraceptives if they are prescribed for another purpose besides birth control.\textsuperscript{85} The EEOC might come to a different decision for an employer offering this type of coverage. Furthermore, the argument that denying contraceptives coverage is \textit{per se} discrimination based on sex is debatable. Spouses are often dependent upon their partners’ health insurance, and it could also be argued that, for married people at least, pregnancy has a major effect on both sexes.\textsuperscript{86}

\textsuperscript{80} Id.
\textsuperscript{81} Id.
\textsuperscript{82} Id.
\textsuperscript{83} 42 U.S.C. § 2000e(b) (2001).
\textsuperscript{84} Sharona Hoffman, AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes’ Applicability to Health Insurance, 23
\textit{CARD}OZO L. REV. 1315, 1348 (2002).
\textsuperscript{86} See Hoffman, supra note 84, at 1351 (citing Krauel v. Iowa Medthodist Med. Ctr., 95 F.d 674 (8th Cir. 1996)).
Besides the limited jurisdiction of the EEOC decision and the unique facts involved in that case, an administrative decision is not the most desirable way to protect individuals' fundamental rights. Administrative decisions are not always long term and a new decision could be made with a change in administration; in fact, none of the current commissioners of the EEOC were on the commission at the time of this decision. Also, administrative decisions, though often deferred to by courts, have no actual authority over the judiciary. Legislation, though also subject to change, is a much more reliable means to protect individual rights.

D. Does Federal Law Already Require Coverage Under Title VII and the PDA?

Several federal district courts have recently come down with decisions supporting the position that Title VII and the PDA do require an employer to provide coverage of prescription contraceptives for an otherwise comprehensive plan. While these decisions have certainly been victories in the battle for prescription equity, they have a limited effect, and some of the legal reasoning is questionable.


The first and most cited case involving the coverage of mandated prescription contraceptive coverage has been the case of Jennifer Erickson, who sued her employer, a pharmaceutical company, for failing to provide contraceptives under a health plan that provided coverage of other preventative prescription medicines. Ms. Erickson

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87 The EEOC decision was only binding upon the parties to that particular case and does not provide legal precedent. See Korland, supra note 52, at 543-44.


89 See Marbury v. Madison, 5 U.S. 137, 177 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is.").


91 141 F. Supp. 2d 1266.

was awarded summary judgment on the issue of whether her employer's exclusion of prescription contraceptives from an otherwise comprehensive plan was discrimination under Title VII as amended by the PDA. The employer, Bartell Drug Company, argued unsuccessfully that contraceptives were voluntary and do not treat or prevent illness, that fertility control is not covered by the PDA, that employers must be able to control costs through scope of benefits, that the plan excluded all "family planning" drugs and was facially neutral, and that the issue was one for the legislature.

The court's decision was based in large part on its interpretation of the Supreme Court's decisions in *Newport News Shipbuilding & Dry Dock Co. v. EEOC* and *International Union et al., v. Johnson Controls, Inc.* These decisions lay out the Supreme Court's interpretation on the application of both Title VII and the PDA. *Newport News* determined that a benefit policy that provided hospitalization benefits for female employees but not for male employees' spouses was discriminatory against male employees and a violation of Title VII and the PDA. In *Johnson Controls*, a policy that excluded female employees who were fertile from working near lead while allowing male employees to do so was found to be a clear violation of Title VII, and the PDA only bolstered this conclusion. Using this precedent, the *Erickson* court created a test that determines if the benefit plan is 1) "comprehensive" and 2) provides equal coverage.

Some view the *Erickson* decision as over-extending the scope of Title VII and the PDA because "contraception" is distinguishable from the terms "pregnancy" and "childbirth" used in the law. This argument is supported by the holdings of another district court decision which found that infertility treatment did not fall under the protections of "related to childbirth" in the PDA. This difference in interpretation limits the power of the *Erickson* decision.

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93 *Erickson*, 141 F. Supp. 2d at 1277.
94 *Id.* at 1272.
97 *Newport News*, 462 U.S. at 684.
98 *Johnson Controls*, 499 U.S at 211.
99 *Erickson*, 141 F. Supp. 2d at 1272.
101 *Id.* at 446-47 (citing Krauel v Iowa Methodist Medical Center, 95 F.3d 674 (8th Cir. 1996)).
2. Disparate Impact Versus Disparate Treatment

In her influential paper, Sylvia A. Law made the argument that, while failure to cover prescription contraceptives was clearly a case of disparate treatment of women because only a woman can become pregnant, there was a strong argument for disparate impact. The Erickson court declined to follow the disparate impact argument. This also has a limiting effect on the power of the decision. Under the disparate treatment argument, if a prescription contraceptive is designed for men, employers could exclude both men and women without breaking the law. Because no court has found that failure to cover prescription contraception disparately impacts women, this argument is merely an academic argument with no real authority over health care providers.

3. Title VII and the PDA

In 1978, Congress amended Title VII by adding the Pregnancy Discrimination Act (PDA) to prohibit discrimination based on "pregnancy, childbirth, or related medical conditions." The prohibition of discrimination requires affected persons get the same "receipt of benefits under fringe benefit programs." Some have advocated that Title VII and the PDA are, in effect, a federal mandate that employers provide coverage for prescription contraceptives. There are some gaps in this argument. First, Title VII only applies to certain employers. Second, Title VII only regulates benefits that are provided by an employer, not those purchased from an insurance company. Third, because the purpose of contraception is to prevent pregnancy, coverage might not fall under the "related medical conditions" of pregnancy covered by the statute. Finally, in order to show a violation of

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102 See generally Sylvia A. Law, Sex Discrimination and Insurance for Contraception, 73 WASH. L. REV. 363 (1998) (this paper was cited in both the EEOC decision and the Erickson decision).

103 Erickson, 141 F. Supp. 2d at 1277.

104 Korland, supra note 52, at 553 (stating that "[t]he Erickson decision would be more insulated from future rollback if the court had found for the employees based on a disparate impact theory rather than on a disparate treatment theory").

105 Backmeyer, supra note 92, at 444-45.


107 Id.

108 See generally Law, supra note 102.

109 42 U.S.C. § 2000e(b) (2000) (the act only covers employers who are in an "industry affecting commerce" with fifteen or more employees).

110 Hoffman, supra note 84, at 1348.

the PDA, the Supreme Court has required that a plaintiff show in a
direct comparison that coverage for one sex is unequal to another.\textsuperscript{112}
This is theoretically difficult in the area of prescription contraceptives
since there are no prescription contraceptives currently available for
men.\textsuperscript{113}

The inconsistent interpretation of whether government entities are
required to cover prescription contraception is easily seen by comparing
memoranda prepared by two different state attorneys general. Peggy A. Lautenschlager, the Wisconsin Attorney General, found that
excepting contraceptives from otherwise comprehensive prescription
plans would be a violation of the Wisconsin version of Title VII.\textsuperscript{114}
The Arkansas Attorney General was of the opposite opinion and
found that exclusion of contraceptives from an education-sponsored
health coverage program certainly did not violate the Arkansas Con-
stitution and "probably" would not violate the U.S. Constitution.\textsuperscript{115}

The fact that two important state officials came to opposite con-
clusions on whether an employer's failure to provide prescription
medicines under an otherwise comprehensive prescription health plan
violates Title VII and the Constitution shows the need for clarification
from the federal government. Congress could fix inconsistencies of
opinion such as these by amending the PDA.

For all of the above reasons, Title VII and the PDA do not clearly
provide an adequate mandate for coverage of prescription contracep-
tives. State mandates and the EEOC tribunal are also lacking in their
authority and power to bring about change in the process of providing
contraception coverage as a health benefit. This has led to the push for
the implementation of a federal mandate for contraception coverage.

III. PROPOSED FEDERAL LEGISLATION: EQUITY IN
PRESCRIPTION INSURANCE AND CONTRACEPTIVE
COVERAGE ACT (EPICC)

The federal government has offered comprehensive coverage of
contraception to its employees since 1998.\textsuperscript{116} However, the legislation
that the federal government has passed protecting the rights of citizens

\begin{footnotes}
\item[112] Hoffman, \textit{supra} note 84, at 1350-51.
\item[113] \textit{Id.} at 1351.
\item[116] \textit{See} U.S. \textit{OFFICE OF PERS. MGMT., FEDERAL EMPLOYEES HEALTH BENEFITS
PROGRAM: HANDBOOK} (2005), \textit{available} at
\end{footnotes}
not employed by the government is unclear, inadequate, and under-funded.

In Senate Resolution 162, the Senate expressed the importance of the decision in *Griswold v. Connecticut* and resolved that "Congress should take further steps to ensure that all women have universal access to affordable contraception." In the resolution, the Senate noted that nearly seventeen million women rely on publicly supported health care. To help ensure access to contraceptives, Senator Snowe reintroduced the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC).

EPICC was first introduced in the Senate and House of Representatives in 1997 and has been reintroduced in 1999, 2001, 2003, and again in 2005. The act has not yet passed in Congress. The bill would be an amendment to ERISA and require all group health plan providers and group health plan insurance issuers to cover prescription contraceptives or their generic equivalent if the plan provides coverage for other prescription medicines and devices. The bill also proposes to make the same amendment to the Public Health Service Act (PHSA) (which included the creation of Title X).

The effect of such legislation would be to fill many of the remaining gaps in coverage of prescription contraceptives. However, there would still be significant groups of women who would remain unaffected. This section will take a look at some of the reasons why EPICC has not been able to pass and why it may require serious effort from advocates to be made into law. These efforts would be more effective in a battle against unintended pregnancy, not equity in coverage.

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117 381 U.S. 479 (1965).
119 Id. at S. 6171.
124 S. 1396 § 714(a)(1).
A. What Is Stopping Congress from Enacting EPICC?

Despite the fact that eight out of ten people in the country support health insurance coverage of prescription contraceptives, Congress has not been able to pass EPICC.\(^{126}\)

1. Conscience Clause?

One reason that Congress might be hesitant to pass EPICC is that it does not contain a "conscience clause," as many state laws do.\(^{127}\) Currently, prescription contraceptives are getting a large amount of attention in the media because of pharmacists' refusal to distribute contraceptives because they are morally opposed to contraception.\(^{128}\) EPICC might be interpreted to require that religious employers who provide or purchase health plans for their employees cover prescription contraceptives if the plans provide any prescriptions.\(^{129}\) While many view this as one of the strengths of the bill, it certainly could create some political upheaval.\(^{130}\)

However, it is not clear if EPICC actually would require religious employers to cover contraception. EPICC would amend ERISA, which does not cover "church plans."\(^{131}\) To fall under the category of church plan, the employer or benefit provider must simply qualify as such under the IRS standards.\(^{132}\) Tax-exempt status covers a broad range of charitable organizations, but any employer who makes a profit is not exempt.\(^{133}\) Yet, given the current debates over conscience clauses and pharmacists, it seems unlikely that these broad exemptions could circumvent the debate.


\(^{127}\) Sixteen of the twenty-three states with mandates have some sort of conscience clause. See Guttmacher Institute, supra note 66.

\(^{128}\) See, e.g., Ellen Goodman, Dispensing Morality, WASH. POST, Apr. 9, 2005, at A23.

\(^{129}\) There are already examples of this political upheaval at the state level. See, e.g., Catholic Charities of Sacramento, Inc. v. Superior Court, 10 Cal. Rptr. 3d 283 (Cal. 2004) (requiring a religious employer to provide contraceptive coverage under a state act).

\(^{130}\) See generally Lowell, supra note 122.


\(^{132}\) Id.; see also I.R.C. § 501(c)(3) (2004).

2. The First Step Towards Greater Federal Control over the Health Insurance Industry?

Traditionally, the regulation of the insurance industry has been viewed to fall under the power of the states.\textsuperscript{134} A federal mandate that essentially micro-manages insurance plans by requiring the coverage of a specific prescription could be viewed as the beginning of a slippery slope towards federally managed health care. While many people would welcome such regulation,\textsuperscript{135} the issue of prescription contraception seems like an unlikely place for a revolution in health care to begin. Furthermore, employers could seek refuge from such regulation under the McCarran-Ferguson Act, which protects state regulations from federal pre-emption.\textsuperscript{136} Even though the actual limitations of that act have been interpreted narrowly by the Supreme Court,\textsuperscript{137} EPICC is a regulation of employee health benefit plans, and the McCarran-Ferguson protection would probably not apply.\textsuperscript{138}

B. Potential Results If EPICC Does Pass

If EPICC were to pass, it could lead to several undesirable results. Employers and health care providers could stop including prescription medicines in their group plans.\textsuperscript{139} Even though the EEOC did not find much weight in the argument that coverage of contraception is cost prohibitive,\textsuperscript{140} and proponents of mandated coverage have cited it as cost effective,\textsuperscript{141} the rising costs of prescription medicines could provide an excuse for health care providers to move away from providing the service.\textsuperscript{142} Furthermore, as discussed infra, passing EPICC could lead to a greater gap between the rich and poor and the educated and uneducated. The better educated and wealthier may become disinterested in the fight against unintended pregnancy when the issue of ac-

\textsuperscript{134} See Hoffman, supra note 84, at 1319-22.
\textsuperscript{135} See generally Sharona Hoffman, Unmanaged Care: Towards Moral Fairness in Health Care Coverage, 78 Ind. L. J. 659, 660 (2003) (arguing that consumers of insurance demand moral fairness, rather than the traditional actuarial fairness, and federal mandates regarding covered services meet that goal).
\textsuperscript{136} See Hoffman, supra note 84, at 1319 (quoting the McCarran-Ferguson Act, 15 U.S.C. § 1012(b)).
\textsuperscript{138} Id.
\textsuperscript{139} See Hoffman, supra note 84.
\textsuperscript{140} EEOC Decision, supra note 79.
\textsuperscript{141} Gold, supra note 29, at 6 (finding that coverage of all available forms of contraception would only cost an employer $0.36 a month).
\textsuperscript{142} Backmeyer, supra note 92, at 439.
cess to contraception is not a perceived inequity directly impacting their lives.

IV. EPICC WOULD NOT HELP THOSE IN GREATEST NEED OF PRESCRIPTION CONTRACEPTION

While EPICC would certainly help many women gain equity in their health care costs, it would not help those who are in most need of the benefits that contraception access and proper use provide. The recently released report from the CDC and NCHS on the Reproductive Health of Women in the United States (CDC report) reveals that women who are most at risk for unintended pregnancies are the least likely to gain any advantage from the proposed EPICC act. In fact, these studies show that for there to be real progress in battling the problem of unintended pregnancies, society must start thinking seriously about how important real equality in our society is and imaginatively about how to cure the inequities.

EPICC is designed to amend ERISA's regulation of employee benefits. While this would certainly fill in many of the gaps in coverage currently left by the various state mandates, the only people that would be affected by this are those who can afford to purchase private health insurance on their own or work for a company that offers a benefits plan. EPICC would have the least amount of impact on women who are most likely to have an unintended pregnancy and who are the least likely to have such benefits.

The CDC report shows that there is a relationship between unintended pregnancies and women's economic status and education level, as well as with their age. Certainly, women who have a higher income or education level are more likely to have a health insurance plan. This raises serious doubts as to the effectiveness that EPICC will have in providing access to contraceptives to women who really need it.

A. EPICC Will Not Help Poor Women

Women who are in a lower income bracket are much more likely to have unintended pregnancies than wealthier women. Women of lesser financial means will also benefit less by EPICC than wealthier women, even though they are in more need of help. The CDC study shows a significant difference in the rates at which women with an

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144 CDC REPORT, supra note 3, at 56. (finding 81.3 percent of wealthy women's pregnancies were intended, while only 55.4 percent of poor women's were intended).
income of one hundred and fifty percent or less of the poverty level (poor women) use private doctors/HMOs compared to women with income of three hundred percent (wealthy women) or more of the poverty level. In 2002, nearly eighty percent of wealthy women and seventy percent of poor women received at least one medical service. Of the women who did receive medical services, wealthy women were nearly twice as likely to use a private doctor/HMO as poor women, while poor women were three times more likely to use clinics. Furthermore, wealthy women were twice as likely to use health care providers for family planning services. About the same number of women in each income level paid for their family planning services out of their own pocket. Four-fifths of wealthy women paid for their family planning services with some help from their insurance, while about one-third of poor women relied on any help from their insurance. These statistics clearly indicate that poor women are much less likely to use the private insurance/HMO health providers to gain access to contraceptives and other family planning services.

Women of a lower income level are also more likely to suffer from chronic diseases. These chronic diseases are at risk of being exacerbated by pregnancy and can lead to an increased rate of complications at pregnancy. This leads to higher public costs resulting from unintended pregnancies. Even though EPICC would also amend the PHSA and require more comprehensive coverage by Medicaid

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146 CDC REPORT, supra note 3, at 130 (medical services included a Pap smear, pelvic exam, prenatal or postpartum care, counseling, abortion, pregnancy test, and test or treatment for STDs.)

147 Id. (finding that 41.8 percent of poor women, in comparison to 72.7 percent of wealthy women, used private doctors/HMOs and that 30.1 percent of poor women, in comparison to 9.4 percent of wealthy women, used clinics).

148 Id. at 133 (finding that of the women who sought family planning services, 46.5 percent were wealthy, while only 26.5 percent were poor; family planning services include sterilization, birth control counseling, check ups, and emergency contraception services).

149 Id. at 134 (12.1 percent of women at 0-149 percent of the poverty level paid out of their own income alone, while 14.4 percent of women at 150-299 percent and 13.1 percent of women above 300 percent did.).

150 Id. (79.5 percent of wealthy women who used family planning services paid through private insurance/HMOs, while only 35.3 percent of poor women did).

151 THE WOMEN’S HEALTH DATA BOOK, supra note 9, at 31.

152 Id.
through Title X, the low rate of women using these facilities indicates that this would probably not be effective. Furthermore, these facilities already provide coverage of contraceptives to the poor, yet this group continues to have a high rate of unintended pregnancy. This indicates that something more than providing access is necessary to deal with the problem of unintended pregnancy.

It is a logical step to recognize that women who are wealthier are much more likely to be able to afford private health insurance or have jobs that include some type of health insurance. Because women in the higher income bracket are much less likely to have unintended pregnancies, it also seems logical that they are already accessing contraceptives as a way to control reproduction, even if their health insurance does not cover it. So while the cost of prescription contraceptives may be inconvenient and even discriminatory for women with higher income, it is not prohibitively so. While EPICC would remove the burden of excess cost for prescription contraceptives for women who have health insurance, it would not help the women in lower income brackets who have no existing health insurance and are in more need of help.

B. EPICC Would Offer Little Help to Uneducated Women

Of women who have been pregnant, over sixty percent of those with no high school diploma said their pregnancy had been unintended, while less than twenty percent of women with a bachelor’s degree said their pregnancies were unintended. In other words, women with at least a bachelor’s degree are less than half as likely to have an unintended pregnancy as all other women.

Uneducated women are also more likely to have larger families. The average woman in the United States wants two children. The CDC study found that over one-third of women who had more than four pregnancies have no high school diploma, while only one-tenth have a bachelor’s degree. Because the average American women wants only two children, larger families among less educated women could indicate that less educated women have more children than they want. Part of the reason for a high rate of unintended pregnancies among uneducated women might be that they misuse contraceptives. One study found that women who had a low educational status were

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153 CDC REPORT, supra note 3, at 130 (only 7 percent of women who use family planning service use Title X).
154 Id. at 55.
156 CDC REPORT, supra note 3, at 36.
more than twice as likely to become pregnant after a birth (postpartum) than others.\textsuperscript{157}

The outlook is not improving for the uneducated either. The Department of Labor has found that people in lower paying jobs are significantly less likely to receive comprehensive benefit packages from their employers.\textsuperscript{158} This is especially important because of the fact that future growth in job opportunities will be fastest in service occupations and professional occupations.\textsuperscript{159} These two groups will account for sixty percent of employment growth over the next ten years, but they occupy opposite ends of the spectrum for education needed and compensation (including benefits) provided.\textsuperscript{160} The practical result is that women who have the least amount of education generally are the least likely to have comprehensive health insurance, while women who are highly educated are more likely to have health insurance. Women with less education are also paid less, and, thus, the costs of prescription contraceptive may be more prohibitive. Unfortunately, the same women who are in the most need of help with access to contraception are going to be the least affected by EPICC because they are the least likely to be covered by a health policy which would fall under the proposed legislation.

C. Teenagers Are Another Group Likely to Be Unaffected by EPICC

Women under the age of twenty had the highest rate of unintended pregnancies among all age groups measured in the CDC study.\textsuperscript{161} The rate of unintended pregnancies in groups over the age of twenty was almost half of the rate among teens.\textsuperscript{162} The high rate of unintended pregnancy among teenagers may be because they fall under the uneducated and poor categories discussed above. However, there are other factors that could certainly have an effect on these numbers.

\textsuperscript{157} I.M. Bennett et al., \textit{Unintended Repeat Pregnancy and Low Educational Status: Any Role for Depression and Contraception Use?}, \textit{72 Contraception} 244, 244 (2005).


\textsuperscript{160} Id.

\textsuperscript{161} \textit{Id.}

\textsuperscript{162} CDC REPORT, \textit{supra} note 3, at 56 (finding over twenty percent of teenage pregnancies were unwanted and over fifty percent mistimed).
As stated above, prescription contraception is the most reliable form of contraception. Yet, while the pill is the second most commonly used form of contraception, only sixty percent of teenagers chose that form of contraception. In fact, sexually active teenagers were less likely to be using the pill as women in their twenties. Teenagers' choice of contraception may be related to their health plans, family and societal stigmas, and lack of education.

This is supported by the fact that, when abortions are included, nearly seventy-eight percent of adolescent pregnancies are unintended. This rate may even be higher because adolescents are more likely to use services outside of their health plans to have an abortion because of confidentiality issues.

Even if teenagers had access to family planning services, they might not use them. Sexually active teenagers consulted any service about family planning at nearly half the rate of other women.

Private doctors and HMOs would fall under state mandates and the proposed EPICC requiring coverage of prescription contraception, while Title X facilities are federally funded to provide inexpensive access to prescription contraceptives. This means that the facilities that are most commonly used by teenagers for family planning services and to access contraceptives are not going to be impacted by EPICC.

The low rate of sexually active teenagers who use family planning services leads to a few conclusions. One is that younger women whose group plans did not cover contraceptives had less financial means than older women. Another is that they were dependants who did not want to use their parents' plans to gain access to contraceptives because they were worried about their parents' reactions. Studies

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163 Prescription hormonal contraceptives are over 99 percent effective, while other reversible methods of contraception can vary from 60-97 percent in effectiveness. Engender Health, supra note 40.

164 CDC REPORT, supra note 3, at 92.

165 Id. at 92, 95 (31.8 percent of women in their twenties were using the pill as opposed to only 16.7 percent of women in their teens; however, for those women who have already had sexual intercourse, 77.9 percent of women in their twenties were using the pill and 61.4 percent of women in their teens were also using the pill).

166 Wilcox et al., supra note 12, at 253.

167 Id. at 254.

168 CDC REPORT, supra note 3, at 130 (finding that around forty percent of teenagers received one family planning service, while the rate was over seventy percent for other age groups).

169 Title X facilities provide family planning services to women for a fee determined on a sliding scale for women with an income between 100 and 250 percent of the federal poverty level, and for free to women below 100 percent of the poverty level. PLANNED PARENTHOOD FED'N OF AM., INC., supra note 56, at 2.
of teenage mothers have found that many would change their contraception method instead of telling their parents they were sexually active. Because teenage women do not want their parents to know they are sexually active, they are lacking in guidance on how to act responsibly.

D. Other Options Must Be Considered

A real risk of EPICC is that, once it is passed, people of influence will no longer view access to contraception, and the resulting unintended pregnancies, as a major issue impacting society. The well-educated and wealthy will no longer share a common battle with poor and uneducated women for equity with men through control of their reproductive cycle. While these women are probably not sharing many of the same concerns right now, there is broad support for women to have more control of their reproductive cycles.

Access to contraceptives is important, but the reason it is important is because it prevents unintended pregnancy. EPICC deals with the inequity that many women face by having to spend sixty-eight percent more than men on health care in order to control their reproductive cycle. What EPICC does not do is deal with the issue of unintended pregnancy. If reducing the rate of unintended pregnancy in the U.S. is the real goal of advocates for equity in coverage, then different approaches should be considered.

As shown above, the solution is not merely found through more funding for Title X or other existing government funded programs. While these programs certainly play a crucial role in providing family planning services to the poor and are available in most of the country, women still have to go to the facilities.

170 See Rachel K. Jones & Heather Boonstra, Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement for Contraception, 36 PERSP. SEX & REPROD. HEALTH, 182, 186 (2004) (concluding that research indicates requiring minors to inform their parents before accessing contraception would result in a reduction in teenage use of reliable contraception methods, not their sexual activity).


172 See Sonfield et al., supra note 33.

173 Title X funds pay for contraceptive services in nearly 75 percent of U.S. counties and "[n]early two-thirds of Title X clients have incomes below 100 percent of the poverty level . . . ." Office of Population Affairs, supra note 59.
1. Education May Play a Substantial Role

More than half of women in the U.S. do not have any type of college degree. Providing opportunities for further educational achievement through grants or inexpensive loans would certainly be a step in the right direction. The significant difference in the rates of unintended pregnancy between women with college degrees and without indicates that this might be the most effective way to reduce the high rate of unintended pregnancy in the U.S.

2. Parents, the Anti-unintended Pregnancy?

Open discussions in the family unit would certainly help. The government spends millions of dollars a year on anti-drug commercials. A current advertisement campaign suggests that parents are the anti-drug in an attempt to promote discussion with children about what they are doing in their social lives. If there were the same sort of strategy in the war on unintended teen pregnancy, young women might be more willing and capable of making responsible decisions about sexuality and contraceptive use. This is especially important considering the fact that most adolescents’ primary sources of information are their friends, not their family.

While there is certainly no easy solution for dealing with the relationship of poverty to unintended pregnancy, increasing the availability of education and reducing teen unintended pregnancy might have the effect of reducing the high rate of poverty among women.

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174 U.S. DEP’T OF HEALTH & HUMAN SERVS., MATERNAL & CHILD HEALTH BUREAU, WOMEN’S HEALTH USA 2002 14 (2002) (according to the 2000 U.S. Census Bureau, of women over the age of 25, 16 percent have an eleventh grade education or less and 34.3 percent are high school graduates, meaning that a total of 50.3 percent of women over 25 have no college degree).


177 But see Abbey B. Berenson et al., The Relationship Between Source of Sexual Information and Sexual Behavior Among Female Adolescents, 73 CONTRACEPTION 274, 276-77 (2006) (stating that young women who had been exposed to information about condoms from family members were more likely to use condoms themselves).

178 U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 174, at 6 (eleven percent of women live below the federal poverty level, with poverty more likely to be present among women with young children).
V. CONCLUSION: EQUITY IN COVERAGE WILL NOT HELP CREATE EQUITY IN SOCIETY

It is well recognized that access to contraceptives is fundamental not only for providing women with equal opportunities for personal advancement but also for strengthening society as a whole. The current movement to federally mandate insurance coverage of prescription contraceptives through a modification of ERISA would certainly help relieve many women from the financial burden that is a factor in women’s high costs of out-of-pocket health expenses. However, does this act really provide relief for those who need it? It is impossible to determine how many women who are currently members of a group-health insurance plan are not using prescription contraceptives because they find it cost prohibitive. People who are members of health plans are usually employed or in some way financially capable of affording contraception. The people who are at greatest risk of unintended pregnancies are poor, uneducated, and young women; these women are also the least likely to have jobs that will offer comprehensive benefits like health plans that cover prescription medicines. Some advocates argue that the rate of poverty among women, may make the cost of prescription contraceptives prohibitive. However, women who have a low income have the option of using government-funded Title X facilities to access inexpensive contraception.

While EPICC would relieve financial burdens, it does not deal with the reluctance of those who are most at risk of unintended pregnancy to try and access contraception. There is a real concern that while passing EPICC could provide equity in benefits for upper and middle class women, it will leave lower class women out and further isolate those most at risk for unintended pregnancies. When these women have children who are unwanted or mistimed, their opportunities to obtain higher education and, through that, higher paying jobs that would include benefit plans and the chance to move up the economic ladder are reduced.

These unintended pregnancies cost not only the women they affect but also society as a whole. Poor women, who have a high rate of unintended pregnancy, often have to use government-funded facilities for their pregnancy-related health care needs. This costs the taxpayer.

179 See Sonfield, supra note 33, at 76.
181 Office of Population Affairs, supra note 59.
Despite the failure to really address the issue of unintended pregnancy, EPICC has many merits. Clearly, the excess cost for women who have health insurance to access contraception is an inconvenience that makes women's benefits unequal to men's. Furthermore, requiring coverage of contraceptives could go a long way towards destroying societal prejudices about contraception that play a significant role in the high rate of unintended pregnancy. In the end, the real strength of any movement to make contraception more accessible to women is that it sparks conversation about family planning and can lead to better decisions about the core unit of society.