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NOTES

Controversy Aroused: North Carolina Mandates Insurance Coverage of Contraceptives in the Wake of Viagra

The much-heralded entrance of Viagra into the pharmaceutical market has brought with it some unexpected side effects besides headaches and facial flushing. Its treatment in the United States insurance industry has resulted in a surge of legislative attention[1] reviving a long-dormant concern: gender-based inequity in insurance coverage.[2] American women continue to voice outrage at the

1. David A. Fahrenthold, *Woman Sues for Contraceptive Coverage*, WASH. POST, July 22, 2000, at A3 ("The issue [of state and federal mandates for insurance plans to provide contraceptive coverage] gained national attention in the mid- to late-1990s, when health insurance companies began to provide coverage for the prescription drug Viagra for men."); Ellen Goodman, *Other Views: Class Action Lawsuit Tests Insurance Rules on the Pill*, OLYMPIAN (Olympia, Wash.), July 30, 2000, http://news.theolympian.com/stories/20000730/Opinion/99336.shtml (on file with the North Carolina Law Review) ("But a few years ago, when insurance plans began picking up the tab for Viagra, the light bulb went on over the medicine cabinet. How come employee health care plans covered pro and not contra-ception?"); Phil Galewitz, *HMO to Cover Birth Control*, *at* http://abcnews.go.com/sections/living/DailyNews/hmo_contracteptives 981016.html [sic] (Oct. 16, 1998) (on file with the North Carolina Law Review) (citing the demand for Viagra as part of the impetus behind new health insurance plans for federal employees that will cover prescription contraceptives if they cover other prescriptions drugs); Nat'l Conference of State Legislatures, *Women's Health: Health Insurance Coverage for Contraceptives*, *at* http://www.ncsl.org/programs/health/contrace.htm (last modified July 27, 2000) (on file with the North Carolina Law Review) [hereinafter NCSL, *Women's Health*] ("The momentum to support coverage of contraceptives increased when the male impotence drug, Viagra, entered the market and insurers covered its costs."); *Women's Groups Urge Coverage of Contraceptives*, *at* http://www.insure.com/health/zzbcontrol699.html (last updated June 11, 1999) (on file with the North Carolina Law Review) ("The issue [of pushing through legislation to ensure contraceptive coverage for women] gained steam when the male impotence drug Viagra came onto the market.").

Viagra was introduced into the public market in April 1998. Kim H. Finley, Comment, *Life, Liberty, and the Pursuit of Viagra? Demand for "Lifestyle" Drugs Raises Legal and Public Policy Issues*, 28 CAP. L. REV. 837, 837 (2000); Marlene Cimons, *FDA Approves First Pill for Impotence*, NEWS & OBSERVER (Raleigh, N.C.), Mar. 28, 1998, at 4A; Food & Drug Admin., *Consumer Information About Viagra*, *at* http://www.fda.gov/cder/consumerinfo/viagra/viagra_consumer.htm (on file with the North Carolina Law Review). The first broad state mandate requiring insurance companies to cover contraceptives was also passed in April 1998. Act of April 28, 1998, ch. 117, 1998 Md. Laws 1194 (codified at MD. CODE. ANN., INS. § 15-826 (Supp. 2000)); Jena Heath, *State Senate Votes to Require Contraceptive Coverage*, NEWS & OBSERVER (Raleigh, N.C.), Mar. 5, 1999, at 1A.

2. Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't*

astonishing speed with which access to Viagra has been provided in the United States, given the distinctly less favorable treatment accorded reversible contraceptive methods[3] by the insurance industry.[4]

Want You to Do Those Nasty Things, 13 WIS. WOMEN'S L.J. 119, 120–21 (1998); Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 172, 195 (1999); Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 363–64 (1998); Finley, *supra* note 1, at 840; *see also* Debra Baker, *Viagra Spawns Birth Control Issue*, A.B.A. J., Aug. 1998, at 36, 36 (1998) (quoting Kathryn Kolbert, the reproductive rights lawyer who argued *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and co-founded the Center for Reproductive Law and Policy: "This is a problem that is so obvious it got hidden. Because women were denied coverage for so long, no one ever questioned it. Viagra demonstrates the inequities."); Rehka Basu, *Birth Control: 'Claim Denied,'* REG. (Des Moines, Iowa), Mar. 7, 1999, 1999 WL 7197347 (observing that Viagra demonstrates the extent to which women's health needs have been marginalized through discriminatory insurance coverage); Michelle Brutlag, *Bill Tells Insures to Level the Viagra Playing Field*, CHI. TRIB., Feb. 21, 1999, § 4, at 3 (pointing to the "injustice" found by Rep. Mary Flowers, the proponent of Illinois' now-defeated version of the "pill bill," that the same insurers who cover Viagra refuse coverage for birth control); Carey Goldberg, *Insurance for Viagra Spurs Coverage for Birth Control*, N.Y. TIMES, June 30, 1999, at A1 (observing the belief held by sponsors of several successful contraceptive coverage mandate bills that birth control's parallel to Viagra has been a strong argument against opposition); Sharon Lerner, *Uncovered Sex*, VILLAGE VOICE, June 15, 1999, at 56 (stating that for women, "exclusion of birth control [from insurance coverage] has come to feel like just another unfair fact of life" and referencing one prominent pill historian's puzzlement that the oral contraceptive, one of the few points of consensus between pro-life and pro-choice factions, has nevertheless historically been blacklisted by insurance companies); Virginia Postrel, *Sex Mandates*, FORBES, May 31, 1999, at 121, 121 (discussing the "lifestyle" versus "medically necessary" treatment distinction raised by both Viagra and contraceptive coverage); Paul Rauber, *It's a Man's World*, SIERRA, Sept.-Oct. 1998, at 20, 20 (noting that only a few months after Viagra's introduction into the market, half of all prescriptions were covered by insurers, whereas almost forty years after the introduction of the pill, only fifteen percent of traditional indemnity insurance plans and less than forty percent of health maintenance organizations covered all five of the most common reversible contraceptives); Darlene Superville, *Insurance Coverage of Contraceptives Likely for Federal Work Force*, DAILY REC. (Baltimore, Md.), Sept. 17, 1998, at 10B, 1998 WL 9509102 ("As health insurers jockeyed to cover the pill that promised to spice up men's dormant sex lives, angry women's groups began criticizing the reluctance of many of the same companies to pay for prescription contraceptives for women.").

3. "Reversible" is the term generally used by commentators and health experts to refer to contraceptive methods less permanent than sterilization. *See, e.g.*, Law, *supra* note 2, at 369 (comparing sterilization, which is, "as a practical matter, irreversible," with other more temporary types of birth control).

4. Brutlag, *supra* note 2 (noting Illinois Representative Mary Flowers' view that it is an " 'injustice that some of those same insurers pay for Viagra yet won't always cover an old standby such as birth control pills"); Goldberg, *supra* note 2 (commenting on the "Viagra effect" of uproar from women's groups regarding inequity in contraceptive coverage). Many consumers, however, are unaware that their insurance plans omit contraceptives from coverage. Brutlag, *supra* note 2 (quoting Representative Mary Flowers: "Here in America, you don't know [if oral contraceptives can be obtained through insurance] until you actually try to apply for it or get it."). At least one

As the proposed federal Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC)[5] languishes in congressional committee, and as several state legislatures implement broad contraceptive coverage mandates of their own,[6] the "little blue pill" has demonstrated a remarkable ability to arouse not only ardor in eager consumers, but also heated debate in all levels of American government.[7] This debate includes issues regarding insurance costs, "quality of life" versus "medically necessary" treatments, and the forces of the free market versus legislatively-authored insurance contracts.[8] Although Viagra and contraceptives are not medicinally parallel in nature or function, both provide a degree of control over an individual's sexuality that would otherwise be absent. The acceptance of Viagra as a medication generally covered by insurance has raised numerous issues regarding the coverage of contraceptives and insurance equity.

North Carolina recently followed seven other states[9] and passed section 58-3-178 of the North Carolina General Statutes,[10] a broad[11]

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commentator has remarked on the inability of U.S. employers and employees to obtain concrete information about what is and is not covered under a given health insurance plan, despite a legal entitlement to know. Law, *supra* note 2, at 386; *see also* Sharon Lerner, *Bitter Pill*, WORKING WOMAN, Nov. 1999, at 22, 22 (noting many lawmakers' ignorance of the fact that insurance companies typically exempt contraceptive coverage from policies that otherwise cover most forms of prescriptions).

5. S. 104, 107th Cong. (2001); S. 1200, 106th Cong. (1999); H.R. 2120, 106th Cong. (1999).

6. For a comprehensive summary of contraception-related state law, see NCSL, *Women's Health*, *supra* note 1; *NARAL Resources: Insurance Coverage for Contraception*, *at* http://naral.org/mediaresources/publications/2000/charts_insurance.html (last visited Nov. 5, 2000) [hereinafter *NARAL Resources*] (on file with the North Carolina Law Review).

7. *See* NCSL, *Women's Health*, *supra* note 1 (noting the momentum in state legislatures); *infra* note 91 (discussing action at the federal level).

8. *See infra* notes 98–127 and accompanying text.

9. *See* CAL. HEALTH & SAFETY CODE § 1367.25(a) (West 2000); 1999 Conn. Acts 99-79 §§ 1(a), 2(a) (Reg. Sess.); GA. CODE ANN. § 33-24-59.6(b)(1) (Supp. 2000); ME. REV. STAT. ANN. tit. 24, § 2332-J (West 2000); ME. REV. STAT. ANN. tit. 24-A, §§ 2756, 2847-G, 4247 (West 2000); MD. CODE. ANN., INS. § 15-826 (Supp. 2000); NEV. REV. STAT. ANN. §§ 689A.0415, 689A.0417, 689B.0377 (Michie Supp. 1999); N.H. REV. STAT. ANN. §§ 415:18-i, 420-A:17-c, 420-B:8-gg (Supp. 1999); VT. STAT. ANN. tit. 8, § 4099c (Supp. 2000).

10. Act of June 30, 1999, No. 231, 1999 N.C. Sess Laws 555.

11. "Broad" in this context indicates a state mandate that requires all insurers, without qualification, to provide coverage for a range of medically approved contraceptives if they offer prescription drug coverage. *See* NCSL, *Women's Health*, *supra* note 1. Other states limit their mandates to certain types of plans or require only that contraceptive coverage not be automatically absent from an employer's list of options. *See id.*

contraceptive coverage mandate.[12] The purpose of this Note is to trace the contours of the current legal landscape regarding mandated contraceptive coverage, with some specific attention paid to the North Carolina statute. This Note initially discusses the legal and policy considerations both in favor of and against a contraceptive coverage mandate[13]—considerations that certainly played a role in the passage of the North Carolina law.[14] The Note demonstrates that considerations supporting mandated contraceptive coverage are fairly compelling[15] and include a favorable cost-benefit analysis,[16] the potential applicability of Title VII to the gender-based impact resulting from a lack of contraceptive coverage,[17] and the areas of non-preemption left open to the states by the Employee Retirement Income Security Act of 1974 (ERISA).[18] The Note likewise reveals that considerations disfavoring mandated contraceptive coverage, including the categorical distinction between "medically necessary" and "quality-of-life" treatments[19] and the concept of moral hazard,[20]

12. N.C. GEN. STAT. § 58-3-178 (1999). Although twenty-three states' laws address contraceptive coverage to some degree, only eight states, including North Carolina, have truly broad mandates. NCSL, *Women's Health*, *supra* note 1. For example, Hawaii and Virginia, two states taking a narrower but nonetheless significant approach, have passed laws prohibiting insurers from excluding coverage of FDA-approved contraceptive drugs and devices as an employer option. HAW. REV. STAT. § 432:1-604.5 (1999); VA. CODE ANN. § 38.2-3407.5:1 (Michie 1999); NCSL, *Women's Health*, *supra* note 1. These provisions do not mandate coverage. HAW. REV. STAT. § 432:1-604.5; VA. CODE ANN. § 38.2-3407.5:1 (Michie 1999); NCSL, *Women's Health*, *supra* note 1. Part of Texas's administrative code prohibits insurers from excluding coverage for oral contraceptives if other prescription drugs are covered. 28 TEX. ADMIN. CODE § 21.404(3) (West 2000); NCSL, *Women's Health*, *supra* note 1. The Texas law mandates coverage of the birth control pill alone, though it is only one of several contraceptive methods that are available solely by prescription. 28 TEX. ADMIN. CODE § 21.404(3) ("No insurer may exclude from prescription drug benefits oral contraceptives when all other prescription drugs are covered."). For a general overview of FDA-approved contraceptive options, see Tamar Nordenberg, *Protecting Against Unintended Pregnancy: A Guide to Contraceptive Choices*, *at* http://www.fda.gov/fdac/features/1997/397_baby.html (June 2000) (on file with the North Carolina Law Review).

13. *Infra* notes 26–127 and accompanying text.

14. Heath, *supra* note 1 (noting the bill sponsor's view that its passage was required for insurance equity for women and noting that the bill's primary opponent was the National Federation of Independent Businesses); Wade Rawlins, *Birth Control Coverage Advances*, NEWS & OBSERVER (Raleigh, N.C.), June 16, 1999, at 1A (noting one mandate supporter's view that the legislative measure was necessary as a matter of insurance equity and one mandate opponent's view that the statute would harm small businesses).

15. *See* Heath, *supra* note 1; Rawlins, *supra* note 14.

16. *See infra* notes 26–58 and accompanying text.

17. *See infra* notes 59–77 and accompanying text.

18. *See infra* notes 78–93 and accompanying text.

19. *See infra* notes 101–10 and accompanying text.

20. *See infra* notes 98, 111–18 and accompanying text.

are more problematic in their nature and application. The Note, however, then indicates that anti-mandate concerns such as increased insurance cost and the inflexibility inherent in government-dictated benefit plans are harder to discount.[21] Having taken notice of these legal and policy considerations, the Note then discusses section 58-3-178 of the North Carolina General Statutes and compares it to similar provisions in other states.[22] A close analysis of certain aspects of North Carolina's broad mandate and comparable mandates from other states reveals some narrow restrictions hidden in their purported breadth.[23] Finally, the Note discusses certain construction-based loopholes that may be available to avoid some of the effects of narrow interpretations,[24] at least until more comprehensive mandates are available through either preemptive federal legislation or a more expansive judicial interpretation of the federal Pregnancy Discrimination Act (PDA).[25]

Favorable public opinion and the results of a cost benefit analysis provide a compelling argument for a contraceptive coverage mandate. One poll conducted by the Kaiser Family Foundation found that eight in ten Americans, both male and female, would support insurance coverage of contraceptives up to a hypothetical cost increase of five dollars per month.[26] Despite this indication of public support, the question of cost-benefit balance is far from settled in the controversy over mandated insurance benefits. Indeed, dollar-related concerns[27] preoccupied the minds of opponents of section 58-

21. *See infra* notes 119–24 and accompanying text.
22. *See infra* notes 128–44 and accompanying text.
23. *See infra* notes 145–67 and accompanying text.
24. *See infra* notes 168–73 and accompanying text.
25. *See infra* notes 184–85 and accompanying text.
26. Andrew Herrmann, *Paying Up Front or Paying Later*, CHI. SUN-TIMES, Apr. 7, 1999, at 33, 1999 WL 6533369. Herrmann emphasizes that the five dollar increase is purely hypothetical and that these willing eight out of ten Americans would in fact have to pay far less. *Id.* (referring to the 1998 finding of the Alan Guttmacher Institute that covering contraception would cost employers about $1.43 more per month and cost employees only about thirty-six cents more per month); *see also* Hayden, *supra* note 2, at 195 ("A Kaiser Family Foundation poll indicated that seventy-five percent of all Americans support insurance coverage for contraceptives while only fifty percent advocated coverage of Viagra.").
27. The projected annual cost of North Carolina's "pill bill" is seventeen dollars per employer and four dollars per employee. Rawlins, *supra* note 14. These annual figures reflect the monthly cost estimated by the Alan Guttmacher Institute study conducted in June, 1998. Jacqueline E. Darroch, *Cost to Employer Health Plans of Covering Contraceptives: Summary, Methodology and Background*, at nn.21 & 23, *at* http://www.agi-usa.org/pubs/kaiser_0698.html (June 1998) (on file with the North Carolina Law Review) (listing study findings regarding employer cost per contraceptive type); *see also* Heath, *supra* note 1 (listing the monthly cost estimated by the Alan Guttmacher

3-178 of the North Carolina General Statutes.[28]

At least one notable and often cited study[29] found that the prevention of pregnancy and pregnancy-related costs through the use of contraceptives resulted in "substantial economic savings and social benefits."[30] These economic savings especially benefited third parties in insurance plans who would otherwise have borne the brunt of pregnancy-associated expenses.[31] Central to the analysis of the study was the assumption that, if contraceptives were covered by insurance, individuals who do not use birth control because of its expense would begin practicing a covered contraceptive method.[32] Thus far, however, no studies have been conducted exploring the validity of this basic assumption upon which much of the cost-benefit analysis in

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Institute study conducted in June 1998); Herrmann, *supra* note 26 (same). As one commentator deftly remarked, "[a]lthough this figure [reflecting the cost of contraceptive coverage] may appear expensive to some, . . . [compare it] with the $100.00 cost per month per male for Viagra." Hayden, *supra* note 2, at 186.

28. *See* Rawlins, *supra* note 14. North Carolina state representative Charlotte Gardner, a Republican and one of only two women to vote against the House version of the bill, maintained that the cost incurred would pose too great a burden on small businesses. *Id.* Similar business concerns have been voiced in other states considering this kind of legislation. *See* A. Jay Higgins, *King Threatens to Veto Contraceptive Pill Bill*, DAILY NEWS (Bangor, Me.), May 18, 1999, 1999 WL 3296388 (noting Governor King's concern that raising the overall cost of insurance would negatively affect Maine's ability to attract job applicants and businesses); *Viagra and Birth Control*, N.Y. POST, July 3, 1999, at 16, 1999 WL 20998030 (discussing how raises in across-the-board coverage costs lead to a choice between either laying off part of the work force or radically raising the amount of money employees must contribute to health care). *See generally* Beh, *supra* note 2, at 138 (stating that critics of state insurance coverage mandates typically argue that the mandates "raise premiums, reduce consumer choice, disproportionately concentrate health care resources on particular health problems, and eventually increase the number of uninsured individuals").

29. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 494 (1995), *cited in, e.g.*, Beh, *supra* note 2, at 120–21, nn.8–9; Law, *supra* note 2, at 366, n.13; Darroch, *supra* note 27.

30. Trussell et al., *supra* note 29, at 502.

31. *Id.* at 500. Third-party payers cover most of the bills for these pregnancy and pregnancy-related expenses—births, newborn hospitalizations, ectopic pregnancies, and spontaneous abortions. *Id.* In addition, most private plans include coverage for induced abortion. *Id.* As the Trussell study concludes, "any technology that reduces the incidence of these events provides considerable savings to payers." *Id.*

32. If coverage of contraceptives simply leads to the financing of birth control for users who would otherwise have paid out-of-pocket, then the third-party payers' overall costs are likely to increase. *Id.* Only a corresponding decrease in pregnancy will partially or completely absorb the additional cost of contraceptive coverage. If, however, only fifteen percent of women previously not using any method of birth control were to begin using one as a result of insurance coverage, savings in pregnancy care costs alone would cover any money spent on oral contraceptive pills for all other users in a given plan. Philip R. Lee & Felicia H. Stewart, *Editorial: Failing to Prevent Unintended Pregnancy is Costly*. 85 AM. J. PUB. HEALTH 479, 479 (1995).

favor of contraceptive coverage hinges.[33]

If coverage of contraceptives did result in an overall reduction of pregnancy, available statistics suggest that the recouped financial costs would be considerable.[34] Unintended pregnancies account for almost sixty percent of the 6.3 million pregnancies in the United States each year.[35] This figure is higher than that of any other developed country except France.[36] Of those unintended pregnancies, more than half occur among the ten percent of American women who report that they use no birth control method.[37] A vaginal birth with no complications costs approximately five to six thousand dollars.[38] Assuming insurance coverage of contraceptives annually costs an employer twenty dollars per female employee,[39] the

33. *See* Trussell et al., *supra* note 29, at 500 ("[I]f broader coverage leads to improved access and substantially more effective contraceptive use, our models suggest that payers may save resources by avoiding the costs of unintended pregnancies. Clearly, additional studies will be necessary to address this issue."). Studies done concerning the impact of contraceptive price changes on the level of demand for those contraceptives generally have focused on developing countries. *See* Barbara Janowitz & John H. Bratt, *What Do We Really Know About the Impact of Price Changes on Contraceptive Use?*, INT'L FAM. PLAN. PERSP., Mar.–Apr. 1996, at 38, 38–40; United Nations Population Info. Network, *Summary of Discussions (Session Three: Cost-Benefit Analysis of Family Planning)*, *at* http://www.undp.org/popin/unfpa/pubs/econmeet/sect4.html (last visited Feb. 23, 2001) (on file with the North Carolina Law Review).

34. *See generally* Darroch, *supra* note 27 (providing a summary of estimated cost of contraceptive coverage by Buck Consultants for the Alan Guttmacher Institute). In Darroch's words, "[c]omparisons of use of highly effective methods with those that are more difficult to use successfully or with nonuse ... clearly show that effective contraceptive use when couples are sexually active and do not want to have a child leads to better health and to lower health care costs." *Id.*

35. Law, *supra* note 2, at 364 (citing INST. OF MED., THE BEST INTENTION: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 1 (Sarah S. Brown & Leon Eisenberg eds., 1995)).

36. *Id.* (citing Elise F. Jones et al., *Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries*, 20 FAM. PLAN. PERSP. 53, 55 (1998)).

37. *Id.* (citing Alan Guttmacher Institute, *Contraception Counts: State-by-State Information*, May 1997, at 1). The Trussell study found that the absence of any birth control method over the course of five years resulted in 4.25 unintended pregnancies at a cost to the insurance carrier of roughly $14,500 in a managed care plan and $6,500 in a traditional indemnity plan. Trussell et al., *supra* note 29, at 497. Dr. Trussell's costs of unintended pregnancy "included costs incurred from time of conception until pregnancy termination, including costs associated with ectopic pregnancy, spontaneous abortion, induced abortion, and term delivery." *Id.* at 496. The costs of term delivery consisted of prenatal care, delivery, and newborn hospitalization. *Id.* For a table illustrating a breakdown of the pregnancy costs according to these various outcomes, see *id.* at 497 tbl.4.

38. Kathleen O'Connor, Editorial, *Birth Control Coverage: Productivity vs. Reproductivity*, SAN FRANCISCO BUS. TIMES, Mar. 26, 1999, http://sanfrancisco.bcentral.com/sanfrancisco/stories/1999/03/29/editorial5.html (on file with the North Carolina Law Review).

39. *Id.*

cost of the coverage for one normal vaginal delivery resulting from an unintended and preventable pregnancy would cover the costs of contraceptive coverage for three hundred women.[40] Moreover, apart from the expenses associated with the pregnancy itself, children of unintended pregnancies are more likely to bring with them increased costs associated with prolonged post-natal medical care.[41] As a preventive measure, in other words, contraceptive coverage more than pays for itself. Pregnancy-related costs and the costs of prolonged post-natal care are avoided by preventing pregnancy altogether.

The perceived inequity in insurance coverage for women stems from the fact that their out-of-pocket health care costs coincide directly with a lack of coverage for contraception-related care. Most women experience approximately 20.5 childbearing years during which, if they are sexually active and not pregnant or seeking to become pregnant, they require contraception.[42] During this potentially reproductive time period, three-quarters of American women fund their medical care expenses through traditional indemnity insurance plans,[43] two-thirds of which exclude coverage for contraceptive pills.[44] As Professor Sylvia Law notes, "only fifteen percent of traditional indemnity plans provide coverage for all of the

40. *Id.*; *see also* Rawlins, *supra* note 14 (noting the observation of a small-business owner and North Carolina State Representative, Cherie Berry, that she thought the additional cost of contraceptive coverage for employees of small businesses was dwarfed by the cost and disruption of an unwanted pregnancy).

41. Hayden, *supra* note 2, at 187 ("The estimated expense of childbirth and follow-up care rises dramatically to an average of between $14,000 and $30,000 per year for the first year of life for infants born with a low birth-weight."); Law, *supra* note 2, at 366 ("Reducing unintended pregnancy is the single most effective means of reducing the number of distressed, low birth weight babies [and the resulting costs of their care]." (citing INST. OF MED., THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 1 (Sarah S. Brown & Leon Eisenberg eds., 1995))); Patricia H. Shiono & Richard E. Behrman, *Low Birth Weight: Analysis and Recommendations*, FUTURE OF CHILDREN, Spring 1995, at 5, *available at* http://www.futureofchildren.org/LBW/02LBWANA.htm (on file with the North Carolina Law Review) ("[O]f the $11 billion spent on health care for infants today, approximately 35% ($4 billion) of these dollars are spent on the incremental costs of low birth weight infants . . . ."). *Contra* Shiono & Behrman, *supra*, at 43 ("It is unclear whether or not the observed decreased rates of low birth weight among women who receive prenatal care are due to the effectiveness of prenatal care in preventing low birth weight or are due to other differences between women who receive prenatal care and those who do not."). These differences include more advanced education levels and other socioeconomic advantages that may lead to better health. *Id.*

42. Beh, *supra* note 2, at 165. Of course, contraceptives are unnecessary if a woman chooses abstinence.

43. Darroch, *supra* note 27.

44. Law, *supra* note 2, at 369–70.

most commonly used reversible prescription contraceptives, and forty-nine percent of plans cover none of these methods."[45] HMOs, in contrast, tend to provide somewhat more equitable coverage; eighty-four percent cover birth control pills;[46] however, only about half of HMOs cover diaphragms, IUDs, or Depo-Provera injections.[47] Surprisingly, in 1995, the greatest number of American contraceptive users—approximately thirty-nine percent—relied upon sterilization as their chosen preventative method.[48] This state of affairs is explainable in part because sterilization is the form of contraception most commonly covered by private insurance benefits.[49] Largely because all reversible prescription contraceptive methods are currently available only for female use,[50] and because insurance coverage for such methods is limited, if provided at all, women spend approximately sixty-eight percent more in out-of-pocket health care costs than men.[51] The general consensus is that reproductive health

45. *Id.* at 372.

46. Darroch, *supra* note 27. For cost- and policy-related reasons why some insurance companies chooose to limit coverage, see *infra* notes 98–127 and accompanying text.

47. Darroch, *supra* note 27.

48. Linda J. Piccinino & William D. Mosher, *Trends in Contraceptive Use in the United States: 1982–1995*, FAM. PLAN. PERSP., Jan.–Feb. 1998, at 4, 5; *see also* Lauran Neergaard, *Birth Control by the Byte?*, *at* http://abcnews.go.com/sections/living/DailyNews/contraceptives990405.html (Apr. 5, 1999) (on file with the North Carolina Law Review) ("[S]terilization is the leading American birth control.").

49. Law, *supra* note 2, at 369.

50. Kathleen A. Bergin, *Contraceptive Coverage Under Student Health Insurance Plans: Title IX as a Remedy for Sex Discrimination*, 54 U. MIAMI L. REV. 157, 175 (2000); Law, *supra* note 2, at 370. This fact is unlikely to change in the near future. According to Dr. David Grimes of the University of North Carolina Medical School, American scientific advances in the area of contraceptives are becoming a rarity. Heather Maher, *Pregnant Pauses: Small Steps Forward on the Birth Control Front*, *at* http://abcnews.go.com/sections/living/DailyNews/birthcontrol990927.html (Sept. 28, 1999) (on file with the North Carolina Law Review) (quoting Dr. Grimes: "Contraceptive research and development is really drying up in the U.S. Fifteen or twenty years ago, we were the undisputed leader in the field, and now we're very much in the backwaters."). Reasons behind this sudden drop in scientific development include the recent political apathy surrounding family planning issues and the enormous price tag of products liability suits. *Id.* Reversible forms of prescription contraception include the birth control pill, IUDs, and Norplant. Law, *supra* note 2, at 369–70; *see also* Planned Parenthood, *Your Contraceptive Choices*, *at* http://www.plannedparenthood.org/birth-control/contrachoices.htm (Mar. 1998) (on file with the North Carolina Law Review) (discussing the effectiveness and side effects of all types of birth control currently available in the United States).

51. Law, *supra* note 2, at 374. This particular statistic is frequently cited in support of mandated insurance coverage for contraception. *See, e.g.*, GA. CODE ANN. § 33-24-59.6 (1999) (giving findings of the Georgia General Assembly); S. 1200, 106th Cong. § 2(10) (1999) (listing congressional findings in the as-yet-unenacted Equity in Prescription Insurance and Contraceptive Coverage Act of 1999). Professor Law notes a 1994 study indicating that twice as many women as men had out-of-pocket expenditures for medical

care costs account for much of this sixty-eight percent figure.[52]

In contrast to their coverage of contraception, most health plans routinely cover pregnancy and certain pregnancy-related costs.[53] A 1993 survey of private insurance plans revealed that ninety-seven to ninety-eight percent of traditional indemnity plans covering one hundred or more employees typically provided coverage for childbirth, as did the same percentage of HMOs.[54] Sixty-six percent of traditional indemnity plans of the same size also routinely covered abortion, whereas seventy percent of HMOs did so.[55] Ninety percent of HMOs and similarly-sized traditional indemnity plans paid for abortion at least under certain circumstances.[56] If increased contraceptive coverage would decrease the number of pregnancies and abortions, thereby reducing the money spent on these covered pregnancy-related benefits,[57] and if such savings would be passed on to consumers in the insurance market, then the refusal of the insurance industry to provide such coverage is economically irrational and contrary to the results of a considered cost benefit analysis.[58]

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services exceeding ten percent of their income. Law, *supra* note 2, at 374–75 (citing WOMEN'S RESEARCH & EDUC. INST., WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES 6 (1994)).

52. Law, *supra* note 2, at 375 ("The costs of prescription contraceptives, excluded from general insurance coverage, account for the largest portion of this disparity." (citing WOMEN'S RESEARCH & EDUC. INST., WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES 10–11 (1994))); ACLU Reproductive Freedom Project, *Promoting Access to Contraception and Opposing Threats to its Availability at Home and Abroad, at* http://www.aclu.org/issues/reproduct/contaccess.html (on file with the North Carolina Law Review) (1998) ("Largely because of the insurance industry's failure to cover contraceptive supplies and services, women of reproductive age spend approximately 68% more than men in out-of-pocket health care costs.").

53. Beh, *supra* note 2, at 161; Darroch, *supra* note 27. Prior to the enactment of the Pregnancy Discrimination Act of 1978 (PDA), Pub. L. No. 95-555, 92 Stat. 2076 (codified at 42 US.C. § 2000e(k) (1994)), insurers typically did not cover pregnancy because of the view that pregnancy was a voluntary condition rather than a disease requiring medically necessary treatment. Beh, *supra* note 2, at 160–61. The PDA shifted attitudes regarding pregnancy, making widespread coverage available, even in plans not governed by federal law. *Id.* at 161.

54. Darroch, *supra* note 27.

55. *Id.*

56. *Id.*

57. This point is the central and as yet unvalidated assumption of the pro-mandate cost benefit argument. *See supra* note 33 and accompanying text.

58. Beh, *supra* note 2, at 159 ("As a general rule, insurers do not favor preventative medicine. When it comes to sexual and reproductive health, the preference for [sterilization] surgery and [sexually-transmitted] disease treatment ignores the cost-savings and health benefits associated with preventative medicine."); Hayden, *supra* note 2, at 188 ("From a purely economic perspective, providing access to contraceptive coverage for women is fiscally beneficial for insurance companies. The cost of preventative care is minimal in comparison to the expense of treatment after the fact, especially in the context

The potential applicability of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act (PDA), also supports mandated contraceptive coverage.[59] The PDA prohibits discrimination based on a woman's intention or potential to become pregnant.[60] Such discrimination is necessarily sex discrimination because the capacity to bear children is uniquely female.[61] Professor

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of birth control and pregnancy."). *But see* Beh, *supra* note 2, at 138 (summarizing cost-related arguments typically presented by insurance companies and consumers alike against mandated insurance coverage).

59. 42 U.S.C. § 2000e(k) (1994) (including pregnancy-related discrimination in the category of prohibited sex discrimination under Title VII); Law, *supra* note 2, at 376–83. Title VII applies only to employers who have fifteen or more employees for a statutorily-prescribed period of time. 42 U.S.C. § 2000e(b). The sweep of its protections is accordingly limited to the employees of these "qualified employers." Hayden, *supra* note 2, at 194. Title VII, like many of the broad state contraceptive coverage mandates, also has a religious exemption for bona fide religious organizations who choose to discriminate for religious purposes. 42 U.S.C. § 2000e-1(a) (1994); *see also infra* notes 164–73 and accompanying text (discussion religious exemptions in existing state statutes mandating contraceptive coverage).

The Supreme Court has held that the PDA's protection against discrimination based on "pregnancy, childbirth, or related medical conditions" extends not only to an insured under an employer benefit plan, but also to that insured's covered dependents. Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 683–84 (1983) (interpreting 42 U.S.C. § 2000e(k) (1994)). Thus, if inequitable coverage violates the PDA, employers will have to provide equitable coverage not only to insureds, but also to their dependents.

60. *See* 42 U.S.C. § 2000e(k).

61. Law, *supra* note 2 at 378. *Contra* Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 146–47 (1976) (holding that exclusion of pregnancy-related benefits from an insurance plan did not constitute gender discrimination), *congressionally overruled by* Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076. The *Gilbert* Court rationalized this result by explaining that the insurance company was not invidiously discriminating on the basis of gender, but rather was simply excluding one physical condition from the list of disabilities that would be compensated. *Gilbert*, 429 U.S. at 134 ("The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition, pregnancy, from the list of compensable disabilities."); *see also* Law, *supra* note 2, at 375 (discussing *Gilbert*).

Interestingly, language in the more recent Supreme Court case of *Bragdon v. Abbott*, 524 U.S. 624 (1998), might open the door to requiring contraceptive coverage by employee insurance under the Americans with Disabilities Act of 1990 (ADA), Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–12213 (1994) and in scattered sections of 47 U.S.C.). *See Bragdon*, 524 U.S. at 638 ("Reproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself."); Finley, *supra* note 1, at 866–67 (arguing that the "sexual dynamics surrounding it" language would seem to allow infertility and impotency to be classified as disabilities, with birth control discrimination following shortly behind). Whereas birth control impedes reproduction, *Bragdon* was concerned with HIV status, a physical condition that the plaintiff argued restricted her ability to reproduce and bear children. *Bragdon*, 524 U.S. at 637. Thus, the analogy is not perfect.

At least in terms of the ADA, then, this difference between impeding and enhancing reproduction might prove crucial to the distinction between Viagra and birth

Law argues that because discrimination based on a woman's desire to avoid the personal physical experience of pregnancy is likewise gender-specific, the PDA's provisions also should extend to issues such as inequitable contraceptive coverage in the insurance industry.[62] In other words, women alone suffer the physical consequences of pregnancy, and so are disproportionately saddled not only with the risks of pregnancy, but also with the costs associated with avoiding those risks—the costs of most types of reversible contraception.[63] According to Professor Law, courts should hold that such a disproportionate, gender-based burden violates the PDA.[64]

Professor Law is not alone in this belief. In June 1999, sixty women's groups requested that the Equal Employment Opportunity Commission (EEOC) instruct employers that excluding contraceptives from health plan coverage constitutes sex discrimination.[65] Although the EEOC's "policy guidance" on this

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control. Viagra would be covered because male impotency is a disability inhibiting reproduction, but birth control would not, because its function seeks to inhibit pregnancy. Significantly, however, male impotency frequently results from physical conditions related to aging and the deterioration in health that goes with it. *Causes and Treatment for Male Impotence*, *at* http://www.andrology.com/main01.htm (last updated Nov. 2000) (on file with the North Carolina Law Review) (listing causes of "secondary impotence," which sets in after years of normal sex, as including diabetes mellitus, hypertension, atherosclerosis, kidney failure, heart disease, stroke, and Parkinson's disease). Most men using Viagra therefore are not typically in their prime reproductive years. Bob Dole and Hugh Hefner, for example, probably are not enthusiastic users and proponents of the drug because they want to hear the pitter-patter of little feet. *See* Finley, *supra* note 1, at 838 n.6 (noting Hefner's statement that Viagra was "the greatest *recreational* drug ever" (emphasis added)). If Viagra is not being taken for procreative purposes, it should not constitute a required accommodation for a disability under the *Bragdon* decision.

62. Law, *supra* note 2, at 382–83 ("The current state of technology permits prescription contraceptives only for women. Thus, when an employer covers all prescription drugs except for contraception, the discrimination against women is explicit."); *see also* Bergin, *supra* note 50, at 175 ("[A]ll medically prescribed reversible contraceptive methods are used solely by women. Thus, women alone shoulder both the responsibility and the risks associated with obtaining and utilizing reversible contraception."); Hayden, *supra* note 2, at 182 ("By virtue of being female, women alone are faced with the risk of pregnancy every time they engage in sexual intercourse without effective contraception."); Fahrenthold, *supra* note 1 (quoting Gloria Feldt, President of Planned Parenthood Federation of America: "Singling women out for less than complete health coverage forces them to use their own money or face getting pregnant—and that's a woman-only issue."). Professor Law also notes that the EEOC interprets the PDA to prohibit discrimination against women who have had abortions. Law, *supra* note 2, at 381 (citing 29 C.F.R. pt. 1604 app. (1997)).

63. *See, e.g.*, Bergin, *supra* note 50, at 175.

64. Law, *supra* note 2, at 381–83.

65. Laura Meckler, *Women's Groups Ask EEOC to Force Coverage of Birth Control*, CHI. TRIB., July 7, 1999, § 8, at 8; *Washington in Brief*, WASH. POST, June 11, 1999, at A5.

subject is not legally binding on employers,[66] it likely will influence employers, as well as bolster the merits of any lawsuit brought under such a claim.[67] The EEOC in fact recently issued a Commission Decision[68] finding that a certain employer health plan violated the PDA when it excluded prescription contraceptive drugs from coverage while covering a number of comparable preventive drugs and services, as well as Viagra.[69] The EEOC based its decision at least in part on the idea that this kind of insurance coverage exclusion necessarily constitutes sex discrimination because only women are affected—prescription contraceptives are currently available only for female use.[70] Although the EEOC emphasized that an employer is not required to make contraceptives available to employees through insurance, it noted that the employer could not choose to provide coverage for comparable treatments and medications but exclude contraceptives from coverage.[71]

The first lawsuit addressing whether employers can exclude contraceptives from coverage was filed on July 19, 2000, by a group of female employees in Seattle.[72] Pharmacist Jennifer Erickson[73] heads

66. Meckler, *supra* note 65.

67. Professor Law speculated in her 1998 article that no one had brought a Title VII challenge to inequitable insurance provisions for several reasons including the difficulty of getting specific coverage information from providers, the limited number of attorneys who would be willing to take on the financial risk that would accompany such a claim, and the insignificance of recovered expenditures when compared to the time and expense of a legal battle. Law, *supra* note 2, at 388–89. Since the publication of Law's article, however, a class action lawsuit involving a Title VII challenge to inequitable insurance provisions has been filed in Seattle. *Class Action Filed Against Employer Excluding Contraceptives from Benefits*, ANDREWS EMPL. LIT. REP., Aug. 22, 2000, at 6, 6, WL 14 No. 19 ANEMPLR 6 [hereinafter *Class Action Filed*]; *infra* notes 71–80.

68. This type of EEOC decision is "a formal Commission determination as to whether there is reasonable cause to believe that unlawful discrimination has occurred with respect to a specific charge or charges." U.S. Equal Employment Opportunity Comm'n, *EEOC Issues Decision on Two Charges Challenging the Denial of Health Insurance Coverage for Prescription Contraceptives*, *at* http://www.eeoc.gov/press/12-13-00.html (Dec. 13, 2000) (on file with the North Carolina Law Review).

69. *Id.*

70. U.S. Equal Employment Opportunity Comm'n, *Questions and Answers: Commission Decision on Coverage of Contraception*, *at* http://www.eeoc.gov/docs/qanda-decision-contraception.html (last modified Dec. 14, 2000) (on file with the North Carolina Law Review) ("Because prescription contraceptives are available only for women, 100 percent of those affected by the exclusion are women. This, by definition, constitutes sex-discrimination.").

71. *Id.*

72. *Class Action Filed*, *supra* note 67.

73. Erickson has been called an ideal "poster plaintiff" for this issue because she is married, has yet to have children, and is even a pharmacist. Goodman, *supra* note 1. She spends three hundred dollars of her own money each year to purchase contraceptives. *Id.*; Fahrenthold, *supra* note 1. The Bartell Drug Company plan that excludes Ms. Erickson's

this class action against her employer, Bartell Drug Company, under the theory that its exclusion of contraceptives from two self-insured[74] health plans violates Title VII.[75] Ms. Erickson and the other plaintiffs allege that their company's failure to provide coverage for contraceptives has a disparate impact on female employees.[76] They further allege that no business necessity justifies this coverage exclusion.[77]

Because the two plans in the Erickson lawsuit are self-insured, ordinary state mandates requiring contraceptive coverage cannot reach them.[78] Self-insured plans are instead regulated by ERISA,[79] a comprehensive federal act that preempts state law to the extent it relates to employee benefit plans.[80] A finding by the Seattle district

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birth control pills from coverage also excludes Viagra, infertility drugs, weight loss drugs, and immunization agents. Bernard McGhee, *Paying for the Pill, at* http://abcnews.go.com/sections/living/DailyNews/birthcontrol_coverage0719.html (July 19, 2000) (on file with the North Carolina Law Review). Despite these exclusions, the plan apparently covers a number of other preventive medical services and prescriptions, including birth control pills prescribed for medical conditions unrelated to contraception. *Class Action Filed*, *supra* note 67; McGhee, *supra*. For Erickson's story in her own words, see Jennifer Erickson, *I'm Tired of Paying Big Bucks for Birth Control*, SELF, Oct. 2000, at 142, 142).

74. Self-insured plans are those plans funded directly by employers. Beh, *supra* note 2, at 139–40. As opposed to group plans purchased by employers from independent insurance companies, under self-insured plans, companies pay claims from a reserve of company money. *Id.*; Fahrenthold, *supra* note 1. Because self-insuring employers are not considered to be engaged in the insurance industry under ERISA, ERISA rather than state law governs their plans. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(B) (1994).

75. *Class Action Filed*, *supra* note 67, at 6; Fahrenthold, *supra* note 1; Goodman, *supra* note 1; McGhee, *supra* note 73. Ms. Erickson and others have the support of Planned Parenthood. Fahrenthold, *supra* note 1.

76. *Class Action Filed*, *supra* note 67, at 6.

77. *Id.* (noting the plaintiffs' position that the exclusion of contraceptives from coverage is unjustifiable because it was not "job-related [or] . . . consistent with business necessity); *see also* Hayden, *supra* note 2, at 185 ("[A]n employer's insurance policy may not adversely impact women disproportionately compared to men unless the employer demonstrates a 'business necessity' . . . .").

78. Fahrenthold, *supra* note 1 ("Under a 1974 federal statute, self-insured companies . . . are exempt from state insurance laws."); *supra* note 74 and accompanying text (discussing ERISA's preemption of state law with respect to self-insured plans); *infra* note 85 and accompanying text (same). The state of Washington has yet to pass a law addressing contraceptive coverage. NCSL, *Women's Health*, *supra* note 1.

79. 29 U.S.C. § 1001–1461 (1994).

80. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1985) ("Section 514(a) of ERISA broadly pre-empts state laws that relate to an employee-benefit plan . . . ."); Beh, *supra* note 2, at 138 ("ERISA contains a preemption clause which dilutes the ability of states to mandate specific insurance coverage insured under some ERISA plans."). The majority of Americans have ERISA-qualified health insurance. Beh, *supra* note 2, at 138 & n.118 (citing figures from the Health Insurance Association of America, which reveal that "32% of small employers . . . [and] 85% of large employers (25 employees or more)

court that the self-insured plans' provisions violate the PDA, however, might allow state agents to enforce compliance with Title VII.[81] Forcing self-insured plans to comply with Title VII by eliminating insurance coverage inequity would create the same result via federal law that would have been reached had a state mandate been applicable.

In *Metropolitan Life Insurance Co. v. Massachusetts*,[82] the United States Supreme Court held that state mandates regarding health care benefits in non-self-funded insurance policies are not preempted by ERISA.[83] The Court's decision relied in large part on the plain language of ERISA's "insurance savings clause," which states that "law[s] of any State which regulate[] insurance, banking, or securities"[84] are exempted from ERISA's larger blanket of preemption.[85] The Court was influenced further by the fact that state regulation of the substantive provisions of insurance plans—mandated benefit laws being just one of the more recent examples—predated ERISA legislation; mandated benefits, therefore, could not be easily dismissed as non-traditional insurance laws that ERISA should preempt.[86] Furthermore, the Court noted that the state law at

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offer health benefits, and 77% of employees work in firms making health benefits available."); Bergin, *supra* note 50, at 163 ("While twenty-five million people obtain medical coverage through independent private policies, the vast majority—just over 165 million—finance health care costs by participating in employer-sponsored group health plans."). ERISA, however, does not expressly protect employees from discriminatory health care plans. Finley, *supra* note 1, at 869. ERISA's protections are only triggered when an employer retaliates against a health plan participant for exercising her rights under that plan, when an employer interferes with a health plan participant's use of the plan, or when the health plan participant is wrongfully denied benefits under her plan. 29 U.S.C. § 1132 (1994); Finley, *supra* note 1, at 869.

81. Law, *supra* note 2, at 397–98 (interpreting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), as a case in which the U.S. Supreme Court held that ERISA could not prevent Title VII from being enforced by state authorities).

82. 471 U.S. 724 (1985).

83. *Id.* at 744.

84. 29 U.S.C. § 1144(b)(2)(A) (1994).

85. "Self-insured" plans themselves are excepted from this general exception under the "deemer clause." *Id.* Because the "deemer clause" provides that no employee-benefit plan, with certain exceptions, shall be considered to be an insurance company or to be engaged in the insurance business, *see id.*, the "insurance savings clause" allowing state law regulation of the insurance and banking industry does not apply to employers who insure themselves. Beh, *supra* note 2, at 139–40. ERISA, therefore, still preempts state law with regard to self-insured plans, and state mandated benefits thus do not apply to them. 29 U.S.C. § 1144(b)(2)(A); *cf.* Beh, *supra* note 2, at 139 ("Thus, the more onerous state mandates become, the more attractive self-insuring health plans become to employers who are able to self-insure.").

86. *See Metro. Life*, 471 U.S. at 742. This factor is important because states historically have enjoyed broad regulatory powers concerning the substantive terms of

issue displaced no specific provision of ERISA because ERISA did not "regulate the substantive content of welfare-benefit plans."[87]

Because the ERISA exception that allows state regulation of insurance, banking, and securities does not reach self-insured employers,[88] employees with self-insured plans can only hope for mandated coverage through favorable judicial construction of the PDA[89] or from federal law mandating such benefits.[90] The Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC),[91] a proposed amendment to ERISA, is an example of this kind of federal legislation. Introduced and rejected in both 1997 and 1999,[92] the bill was recently reintroduced in the Senate and now sits in committee with little prospect of success.[93]

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insurance contracts. *Id.* at 728–29. The Court rejected the argument that because state mandated benefit statutes were a recent phenomenon, they should be preempted by ERISA's "insurance savings clause." *See id.* at 742 ("[I]t is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws. As we have indicated, state laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70's, when Congress considered ERISA.").

87. *Id.* at 732 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983)).

88. *See supra* notes 74, 84.

89. *Supra* notes 59–77 and accompanying text.

90. Beh, *supra* note 2, at 139–40 (stating that federal mandates will be necessary to reach self-insured employee benefit plans); Hayden, *supra* note 2, at 192 (advocating federal intervention to achieve contraceptive coverage for all women).

91. S. 104, 107th Cong. (2001). EPICC would amend ERISA by adding a provision setting standards relating to benefits for contraceptives. *See id.* Although state contraceptive coverage mandates meet the *Metropolitan Life* requirement of falling into the non-preemption area of insurance regulation, EPICC, because of its substantively regulatory content, could preempt such mandates. One of the factors the *Metropolitan Life* Court considered in making its decision was the fact that ERISA did not substantively regulate the content of insurance plans. *See Metro. Life*, 471 U.S. at 742. If passed, EPICC would. EPICC therefore might replace any state benefit mandates in existence at the time of its enactment. Unfortunately, EPICC's enactment is unlikely. *Infra* note 92 and accompanying text.

92. The Senate bill was first introduced on May 14, 1997 by United States Senator Olympia Snowe. S. 743, 105th Cong. (1997). United States Representative James Greenwood introduced a similar bill into the House of Representatives on July 16, 1997. H.R. 2174, 105th Cong. (1997); *see also Cost of Adding Contraceptive Coverage to Health Plans Minimal*, WOMEN'S HEALTH WKLY., Sept. 28, 1998, at 9, 9–10 (noting the respective dates on which EPICC was introduced into the Senate and the House of Representatives). For identical bills introduced in subsequent Congresses, see S. 104, 107th Cong. (2001); S. 1200, 106th Cong. (1999); H.R. 2120, 106th Cong. (1999).

93. *See* Baker, *supra* note 2, at 37 ("[T]he proposed federal Equity in Prescription Insurance and Contraceptive Coverage Act was introduced more than a year ago and has yet to get a committee hearing. Few expect one anytime soon."); Christine Ianzito, *Get Your Pills Paid For*, SELF, Oct. 2000, at 145, 145 ("Urge your senators and representatives to support the federal Equity in Prescription Insurance and Contraceptive Coverage Act, which has been floating around in legislative never-never land for years."). Despite the

Thus, three fundamental arguments buttress state-mandated contraceptive coverage. First, a cost-benefit analysis supports state mandates insofar as its basic assumption of a decrease in unintended pregnancies and a corresponding absorption of increased contraceptive coverage costs is correct.[94] Second, should courts hold that the PDA encompasses inequities in contraceptive coverage, state mandates will aid in meeting the states' responsibility to enforce Title VII.[95] Third, except as to self-insured plans, ERISA does not preempt the states' power to mandate benefits.[96] Until Congress passes a federal mandate such as EPICC, states may require contraceptive coverage in non-self-funded plans without running into conflict with a federal provision.[97]

Not only the insurance industry, but also consumer laypersons—who obviously want their rights protected—have raised multi-faceted objections to and arguments against mandated insurance benefits. Among the most prominent arguments are the "medically necessary"/"quality-of-life" treatment distinction, the related issue of "moral hazard,"[98] and the relative rigidity of having insurance contracts written by legislative bodies rather than by market forces.[99] The contention that overall initial cost increases in insurance plans leave more people uninsured is also not to be ignored.[100]

The advent of Viagra brought the "medically necessary"/"quality-of-life" treatment distinction into the spotlight. The insurance industry traditionally has denied coverage for procedures or medications viewed as elective or cosmetic and not

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difficulty in getting this broader act passed, Congress did pass a law ensuring contraceptive coverage for federal employees. Omnibus Consolidated & Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, 112 Stat. 2681; Stephanie Barr, *Birth Control, Not Money, Was Key in One Budget Battle*, WASH. POST, Oct. 19, 1998, at A19. Given the "anti-abortion sentiment that runs through the Republican-controlled Congress," supporters of mandated contraceptive coverage viewed this congressional action as a significant step. Superville, *supra* note 2.

94. *See supra* notes 26–58 and accompanying text.

95. *See supra* note 59–77, 81 and accompanying text.

96. *See supra* notes 78–90 and accompanying text.

97. *See supra* notes 83–92 and accompanying text.

98. "Moral hazard" is defined as "the possibility of loss to an insurance company arising from the character, habits, or circumstances of the insured." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1469 (Philip Babcock Gove ed., 1993). Coverage of lung cancer treatment, for example, arguably leads to the "moral hazard" of increased smoking among insureds. *See, e.g.*, Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 237 (1996) ("What moral hazard means is that, if you cushion the consequences of bad behavior, then you encourage that bad behavior.").

99. *See infra* notes 119–24 and accompanying text.

100. *See supra* note 28.

medically required—so-called "quality-of-life" treatments.[101] Based on this distinction, Kaiser Permanente and Aetna U.S. Healthcare refused to provide coverage for Viagra under their policies because of their view that Viagra was more of a "quality of life" or "recreational" drug rather than one prescribed for a bona fide physical problem.[102] Kaiser maintained that its coverage for the evaluation and treatment of sexual dysfunction would remain unaffected.[103] When some insurance companies began to cover

101. Health insurance companies have been denying coverage for the birth control pill since its invention almost forty years ago because they classify it as a "lifestyle drug," not a "medical necessity." Hayden, *supra* note 2, at 182 ("For years, insurance companies have excluded some if not all forms of contraceptives based on the determination that prescription birth control is not a "medical necessity."); Finley, *supra* note 1, at 840 ("Most private insurers have denied coverage for the birth control pill since its inception almost forty years ago. Insurers call the only prescription contraceptive in pill form, which is only for women, a 'lifestyle drug.' "); Goodman, *supra* note 1 ("Many [employers faced with questions of insurance] have described [birth control] pills and diaphragms as a 'lifestyle choice' on par with Retin-A or cosmetic surgery or—as one California legislator put it—'hairspray.' "). Courts divide on the question of whether or not infertility treatments are "medically necessary" as that term is used in the insurance industry. Finley, *supra* note 1, at 851–52 (noting that this conflict might have been resolved by the Supreme Court decision of *Bragdon v. Abbott*, 524 U.S. 624 (1998), a case which could be construed as classifying infertility as a "disability" that must be accommodated by employer-provided insurance under the ADA). At least two courts have found that bone marrow transplants are not medically necessary. Farley v. Benefit Trust Life Ins. Co., 979 F.2d 653, 661 (8th Cir. 1992); Grethe v. Trustmark Ins. Co., 881 F. Supp. 1160, 1166–67 (N.D. Ill. 1995); *see also* Finley, *supra* note 1, at 850–52 (discussing *Farley* and *Grethe*). Several treatments that appear to straddle the border between "quality of life" and "medical necessity" are covered by the majority of insurance policies—e.g., blood pressure medications, allergy prescriptions, and immunizations. Hayden, *supra* note 2, at 184.

102. Beh, *supra* note 2, at 119–20. Viagra in fact does nothing to "cure" either impotency or erectile dysfunction. LARRY KATZENSTEIN, VIAGRA: THE POTENCY PROMISE 7, 71 (1998); Hayden, *supra* note 2, at 181; Finley, *supra* note 1, at 844. Viagra only alleviates the symptoms of impotency or erectile dysfunction by allowing sexual function to resume temporarily. KATZENSTEIN, *supra*, at 7, 71; Finley, *supra* note 1, at 844–45; Hayden, *supra* note 2, at 181.

103. Beh, *supra* note 2, at 144. This seemingly illogical line-drawing appears to stem from the fear that Viagra would be used not just to correct impotency, but to recapture the sexual vigor of youth in men unaffected by clinical impotency. *See* Postrel, *supra* note 2, at 121 ("Viagra may have been created to treat specific, disease-related conditions, such as the effects of prostate cancer or diabetes. But to some men, a truly 'healthy' condition is what's normal for a 17-year-old. They want Viagra to restore their youth."); *see also* Discovery Health, *Anti-Impotence Pill Raises Specter of Abuse*, *at* http://www.discoveryhealth.com/DH/ihtIH/WSDSC000/9105/8316/184523.html?d=dmtContent (last updated May 4, 1998) (on file with the North Carolina Law Review) ("Reports of . . . men queu[ing] up to fill 40,000 prescriptions a day of the anti-impotence pill Viagra . . . raise concerns that not all these men may be suffering from erectile dysfunction . . . [but] [r]ather . . . merely may be seeking to improve their sexual prowess."). Faced with a price tag of roughly ten dollars for each Viagra pill, *see Insurers Accused of Gender Bias Over Coverage of Viagra*, STAR TRIB. (Minneapolis-St. Paul, Minn.), May 13, 1998, at 11A, 1998 WL 6352946, Kaiser and others balked at the potential cost of "recreational"

Viagra, various women's groups and medical associations raised the fairly compelling, if imperfect, parallel of Viagra to contraceptives.[104] The insurance companies covering Viagra also responded with the "medically necessary"/"quality of life" distinction, this time characterizing Viagra as medically necessary and contraceptives as life-enhancing.[105]

The fact that both the insurers that provided coverage for Viagra and those that did not used the same treatment-distinguishing

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overuse. These concerns are not unfounded; after Viagra was introduced in April 1998, doctors were writing more than 300,000 prescriptions a week by mid-May. Finley, *supra* note 1, at 837. In contrast, birth control pills cost eighty-two cents per pill. Ianzito, *supra* note 93, at 145.

104. *See* Goldberg, *supra* note 2 ("Viagra, which counteracts impotence, is not an exact logical parallel to pills or devices that counteract conception. But it was close enough to be used that way by lawmakers who saw their moment and jumped at it . . . ."); Hayden, *supra* note 2, at 181 (arguing that, like Viagra, contraceptives do not cure any condition but allow individuals to enjoy and control their sexuality in a relatively unencumbered fashion); *id.* at 183 (pointing to an assertion by the American College of Obstetricians and Gynecologists that reasonable access to effective contraception improves health of both mothers and infants). Intuitively, birth control seems more "medically necessary" than Viagra because contraception eliminates not only an individual's potential physical burden of pregnancy, but the potential burden on society of an unwanted child as well. Finley, *supra* note 1, at 867–68 (comparing the medical "need" for an erection with the medical "need" to avoid pregnancy).

105. *See* Postrel, *supra* note 2, at 121 (noting Reverend Joseph E. Looney's remarks before the Connecticut legislature considering mandating contraceptive coverage that contraception was "disgusting and demoralizing," whereas Viagra "enhance[d] a natural function"); *see also, e.g.*, Brutlag, *supra* note 2 (quoting Chris Hamrick, spokesman for the Illinois Association of HMOs, an organization representing twenty-six HMOs in that state: "Viagra treats a medical condition, whereas contraception is more of a therapeutic prescription"); *cf.* Stacey Burns, *Legislature 1999: Bill Requires Coverage for Contraceptives*, NEWS TRIB. (Tacoma, Wash.), Mar. 10, 1999, at B1 (quoting Senator Georgia Gardner as saying of the contraceptive mandate proposal, "[t]his bill isn't about sex. What it's about is medical coverage for medical conditions.").

Although Medicaid does not cover "quality of life" medications such as weight loss drugs, Finley, *supra* note 1, at 870–71, the federal government regards both contraceptives and Viagra as "medical necessities," at least in terms of Medicaid coverage. Since a 1972 amendment to the Medicaid statute, the federal government mandates that states cover all medically approved contraceptive devices, supplies, and related care under Medicaid. 42 U.S.C. § 1396d(a)(4)(C) (1994); Bergin, *supra* note 50, at 168; Hayden, *supra* note 2, at 196. Medicaid likewise covers Viagra. Finley, *supra* note 1, at 839 ("Even Medicaid, the government's medical insurance program for the poor, jumped on the bandwagon and mandated states pay for the [Viagra] prescription pill because it did not fall within the exceptions to deny coverage."); AFI Health Comm. Reports, *Medicaid Coverage of Viagra, available at* http://www.ncsl.org/statefed/rprt0798.htm (July 1998) (on file with the North Carolina Law Review) ("The HCFA [Health Care Financing Administration] letter indicates that states are required to provide coverage for Viagra under the provisions of the Medicaid drug rebate program established in the Omnibus Budget Reconciliation Act of 1990 . . . ."). In fact, the Department of Defense recently received fifty million dollars for Viagra use by male military personnel and veterans. Finley, *supra* note 1, at 847.

categories to reach completely opposite conclusions illustrates how nebulous the term "quality of life" is.[106] The argument could be made that impotence is a "natural" result of the progression into old age, just as bearing children is a "natural" result of the progression into womanhood.[107] Under this view, both Viagra and contraceptives are only quality-of-life "enhancers" that avoid natural bodily consequences. They are not, under this view, drugs that combat abnormal medical conditions.[108] If both are quality of life "enhancers" rather than "medical necessities," neither should be covered. If, however, sexual function is a component of health, both Viagra and contraceptives should be covered. As medical advances increase lifespans and as newfound health care innovations are geared more toward the "quality" of these longer lives, the quality-of-life distinction will become more tenuous.[109] Such distinctions are likely to become more arbitrary and more susceptible to being informed by political and moral judgments rather than by objective medical justifications.[110] Insurance companies thus should abandon such distinctions.

As a corollary to this troublesome distinction, the insurance industry also hesitates to cover what it considers "recreational" or "life enhancing" treatments because of the possible moral hazard of

106. Although blood pressure medication, allergy prescriptions, and immunization shots do not cure physical ailments, they are nonetheless covered by most insurance policies. Hayden, *supra* note 2, at 184.

107. KATZENSTEIN, *supra* note 102, at 13 ("Impotence ... becomes increasingly prevalent with age); Beh, *supra* note 2, at 165 (noting that once a woman reaches reproductive age, assuming sexual activity and ordinary levels of fertility, she must spend an average of 20.5 years of her life trying to avoid pregnancy through some method of contraception).

108. *See* Postrel, *supra* note 2, at 121.

109. *See* Finley, *supra* note 1, at 844 (quoting one bioethicist: "[I]t is important that we protect our access to drugs and treatments that improve our health by protecting normal functions. The key will be determining what counts as normal ... [and] Viagra represents only the beginning of ... difficult decisions about who pays for the promising treatments of the future."); *id.* at 871 ("The future holds a number of new drugs that will not be easily classified into the neat categories of medically necessary vs. lifestyle or even experimental drugs."); Postrel, *supra* note 2, at 121 (" 'Enhancement,' which goes beyond merely curing disease, is the next great medical frontier [and presents a] slippery issue[] illustrated well by Viagra.").

110. The problem is determining what should be used instead to draw the line between compensable treatments and non-compensable ones. One commentator warns that giving only Viagra the insurance-covered status of "medical necessity" could lead to a "fiscal nightmare," especially if the drug is approved for use in women. Finley, *supra* note 1, at 870. If the floodgate of coverage is opened by Viagra or contraceptives, weight loss medications and baldness treatments—"lifestyle" drugs currently exempted from insurance plans—might follow quickly behind. *Id.* at 870–71.

overuse.[111] Where insurance companies consider an activity, such as sexual activity, to be "largely voluntary . . . and controllable,"[112] they generally refuse to provide coverage for the risks generated by such activity out of fear that doing so will cause insureds to engage in that risk-creating activity.[113] Professor Hazel Glenn Beh suggests that anticipation of potential overuse explains why insurance companies frequently balk at covering both contraceptives and Viagra.[114] She nevertheless contends that the looming threat of overuse is somewhat overstated.[115] Demand for these kinds of health care services is kept in check by already present external considerations.[116] Moreover, insurance companies themselves could provide more extensive controls as a matter of treatment-access gate-keeping.[117]

The "moral hazard" concept is a problematic method of setting limits on coverage because insurance companies cover treatments for a large variety of physical conditions that arguably result from "voluntary" activity.[118] Moreover, at least as far as contraceptive coverage is concerned, the "moral hazard" argument seems unavailable to insurance companies that already cover the costs of abortion, pregnancy, and sexually transmitted disease—all of which result from voluntary sexual activity. Like the distinction between treatments that are "medically necessary" and those that only improve the "quality of life," the concept of moral hazard has the

111. Beh, *supra* note 2, at 125–32. For a comprehensive discussion of the subject of "moral hazard," see generally Baker, *supra* note 98.

112. Beh, *supra* note 2, at 126.

113. *Id.* at 128.

114. *Id.* ("Insurers fear that desperate infertile couples might over-utilize assisted reproductive technologies despite low success rates simply because an insurer is paying the cost."); *see also* John Hendren, *Impotence Pill Coverage Eyed: Insurers are Wondering How Much Sex is Enough*, CHI. SUN-TIMES, Apr. 30, 1998, at 3 ("With Viagra becoming the hottest drug on the market, health insurers are demanding proof from doctors that their patients need the impotency pill and are not just looking to spice up their sex lives.").

115. Beh, *supra* note 2, at 128–29.

116. *Id.* at 129. External considerations limiting demand include the physical and sometimes life-altering consequences of a treatment decision, the treatment's physical and psychological toll, and the treating physician's counsel. *Id.*

117. *Id.* As part of her discussion of insurance coverage of Viagra, Professor Hazel Glenn Beh lists some possible external controls that insurance companies could impose to avoid the abuse of over-consumption. *See id.* at 146–47. These controls include definitive diagnosis and documentation, limiting coverage when the cause of the problem is not organic or caused by some "voluntary" activity (such as, in the case of impotence, alcoholism or substance abuse), and limiting the quantity of pills prescribed. *See id.*

118. *See, e.g.*, U.S. Equal Employment Opportunity Comm'n, *supra* note 70 (noting that the insurance plan at issue covered a number of "preventive" medicinal treatments, including vaccinations, blood pressure and cholesterol control treatments, weight loss drugs, and dental care, as well as surgical sterilization and Viagra).

capacity for arbitrary application by the insurance industry and therefore is not as useful a line-drawing mechanism as a cost benefit analysis.

Some proponents of contraceptive coverage, however, contend that legislative action, whether at the state or federal level, is not the best vehicle for reform.[119] Individuals otherwise favoring mandates are concerned about the rigidity of legislation and the over-politicization of certain morally charged issues such as those concerning reproductive rights.[120] Likewise objecting to legislative action, insurance companies maintain that the free market best regulates the content of insurance benefit plans.[121] Both views have enjoyed some success. Despite the general tendency of female legislators faced with the subject of contraceptive coverage to join forces across party lines,[122] passage of state law contraceptive mandates has not been overwhelmingly successful.[123] Although some legislative failure can be explained by the minority presence of women in state legislatures, a contraceptive coverage mandate nevertheless struggled, and was still pending in February, 2000, in the Washington State Legislature with the highest proportion of women in American history.[124] The failure of this kind of legislation perhaps

119. Beh, *supra* note 2, at 121 ("[B]ecause of the moral and political nature of sexuality, legislation is not a particularly appealing method of achieving a better insurance contract. For example, women's health may be compromised by legislative restrictions on reproductive health care choices. Neither insurers nor insureds should want Congress to write our insurance contracts."); Postrel, *supra* note 2, at 121 (contending that legislatures subject insurance contracts to inflexible standards reflecting the personal and political values of the moment).

120. Beh, *supra* note 2, at 121; *see also* Postrel, *supra* note 2, at 121 ("Both the pill and Viagra are about sex, of course, which makes them good for headline-hungry politicians.").

121. Brutlag, *supra* note 2 (referencing UnitedHealthcare Illinois' corporate policy of opposing state law insurance coverage mandates). One company spokeswoman explained the prevailing industry view by stating, "[w]e believe that the marketplace appropriately addresses what should and should not be covered under health plans." *Id.*

122. Goldberg, *supra* note 2. For an excellent discussion of the roles played by female legislators across the country, see Penny M. Miller, *Staking Their Claim: The Impact of Kentucky Women in the Political Process*, 84 KY. L.J. 1163, 1184–86 (1995–96). According to Professor Miller, "[f]emale legislators are reported to be more liberal than men, even when controlling for party membership and female state legislators are more concerned with feminist issues than their male colleagues." *Id.* at 1189.

123. Lerner, *supra* note 4, at 22 (noting that as of the date of her piece, Florida, Idaho, Indiana, Louisiana, Missouri, Montana, Nebraska, New Mexico, Oregon, Utah, and West Virginia had all rejected contraceptive coverage mandate legislation). For more up-to-date information, see *NARAL Resources*, *supra* note 6 (providing a chart listing state contraceptive coverage requirements).

124. Goldberg, *supra* note 2; Wash. State Legislature, *History of SB 5512*, *at* http://www.leg.wa.gov/pub/billinfo/1999-00/senate/5500-5524/5512_history.txt (Feb. 25,

indicates that these women, while concerned with contraceptive related issues, would rather deal with insurance companies on a more private, non-legislative level. Insurance contracts have the perpetual possibility of being renegotiated, whereas changes in laws are not achieved so fluidly.

The primary arguments against contraceptive coverage mandates therefore involve a reduced pool of insureds because of the increased cost of coverage, the coverage-limiting distinction between "medically necessary" and "quality of life," the somewhat inseparable issue of the threat of moral hazard,[125] and the inflexibility and subjective values inherent in the enactment of legislative measures.[126] The first and last of these concerns are the most compelling; unlike the others, they do not involve gray-area concepts that are subject, by virtue of their very malleability, to manipulation by large insurance companies or politicians to suit particular agendas.[127]

Turning to North Carolina's contraceptive coverage mandate, the statute provides that, subject to a specific religious employer exemption,[128] "every insurer providing a health benefit plan that provides coverage for prescription drugs or devices *shall provide coverage for prescription contraceptive drugs or devices.*"[129]

2000) (on file with the North Carolina Law Review). Women comprise forty-eight percent of the Washington Legislature, compared with an average of 22.3% in other state legislatures. Goldberg, *supra* note 2. Boding less well for federal initiatives such as EPICC, however, women make up only 12.1% of the United States Congress, and congressional party lines tend to be harder to cross. *Id.*; *supra* notes 91–93 and accompanying text. A successful non-partisan effort by female representatives is, therefore, even less likely at the congressional level.

125. *See supra* notes 98, 101–18 and accompanying text.

126. *See supra* notes 119–24 and accompanying text.

127. *See supra* notes 106–24 and accompanying text.

128. N.C. GEN. STAT. § 58-3-178(e) (1999). Under the statute, a religious employer meeting certain requirements may request that contraceptives-related coverage not be provided because the coverage conflicts with the employer's religious beliefs. *Id.* The religious objector must (1) be exempt under section 501(c)(3) of the Internal Revenue Code; (2) organized and operated for religious purposes, with a central function of instilling religious values; and (3) mainly employ people of the same religious beliefs. § 58-3-178(e)(1)–(3). If a religious employer requests an insurer not to provide coverage, the insurer must provide written notice to every person who would be affected by this modification under the plan. § 58-3-178(e). The notice must be posted in at least ten point type in the health benefit plan, the plan's application, and the sales brochure. *Id.* If the objectionable drugs or devices are not prescribed for contraceptive purposes, but rather for some other medical reason, coverage for these drugs or devices may not be excluded from a plan, regardless of any applicable religious employer exemption. *Id.* Relatedly, coverage may not be refused under this exemption if prescription contraception is necessary to preserve the life or health of the insured. *Id.*

129. § 58-3-178(a) (emphasis added). The term "health benefit plan" encompasses, to the extent allowable by exceptions to ERISA or by a waiver, "an accident and health

"Insurers" under the statute include insurance companies, service corporations, HMOs, and multiple employer welfare arrangements—all as organized and defined under applicable provisions of North Carolina law.[130] "Prescription contraceptive drugs or devices," with two explicit exceptions, include pregnancy-preventing drugs and devices approved by the FDA and prescribed by an authorized health care provider.[131] The statute allows any insurer to apply the same co-insurance, deductibles, or other limitations to contraceptive drugs or devices that it applies to other prescription drugs or devices under a given plan.[132] Moreover, the statute forbids insurers from providing incentives or penalties to affect either the use of the covered contraceptives by an insured or the contraception-associated services or prescriptions made available by a health care professional.[133]

The North Carolina mandate also requires insurers furnishing health care professional outpatient services under any given plan to provide for any outpatient services associated with contraceptive use.[134] These services include, for example, the trip to a physician to have a diaphragm fitted. Again, as with contraceptive methods and their non-contraceptive counterparts, insurers may apply the same co-insurance, deductibles, or other limitations that they apply to other

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insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization contract; a plan provided by a multiple employer welfare arrangement," or some other kind of benefit arrangement. § 58-3-178(c)(1). Some kinds of insurance are specifically excluded from this definition. *See* § 58-3-178(c)(1)(a)–(m) (excluding various types of more limited policies, including Medicare supplement, worker's compensation, and short-term limited duration policies).

130. § 58-3-178(c)(2).

131. § 58-3-178(c)(4). The FDA-approved contraceptive drugs that are nevertheless excepted from the statute are RU-486 (the so-called "abortion pill") and Preven (the so-called "morning after" pill). § 58-3-178(c)(4)(a)–(b).

The FDA has also approved another version of the "morning after" pill, levonorgestrel. Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception, 60 Fed. Reg. 8610, 8611–12 (Feb. 25, 1997); Maher, *supra* note 50 (discussing development and benefits of this "better tolerated, more effective emergency contraception pill"). Levonorgestrel causes far fewer side effects than Preven, particularly in terms of nausea, dizziness, vomiting, and headaches. Maher, *supra* note 50. This new drug probably would still be excepted from the North Carolina contraceptive mandate as an "equivalent drug product" to Preven. *See* N.C. GEN. STAT. § 58-3-178(c)(4)(b) (1999) (excepting "[t]he prescription drug marketed under the name 'Preven' or any 'equivalent drug product' as defined in G.S. 90-85.27(1)"). Section 58-3-178 contains a parallel exception for any "equivalent drug product" of RU-486 also exists. § 58-3-178(c)(4)(a).

132. § 58-3-178(a).

133. § 58-3-178(d)(4).

134. § 58-3-178(b). Outpatient contraceptive services are defined as "consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy." § 58-3-178(c)(3).

outpatient services to contraception-associated outpatient services.[135] If a plan does not provide outpatient services, but does cover prescription drugs or devices, North Carolina law also requires coverage for any medical examination or procedure associated with the use of the prescribed contraceptive drug or device.[136]

The eight states mandating broad contraceptive coverage[137] differ slightly in their statutory language indicating which insurance plans are affected.[138] For example, Maine and Nevada use separate statutory provisions to address different kinds of plans.[139] California, unlike North Carolina which specifically excludes "disability income"

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135. § 58-3-178(b).

136. § 58-3-178(a).

137. *See supra* note 9 (listing the seven mandates other than North Carolina's).

138. *See* CAL. HEALTH & SAFETY CODE § 1367.25(a) (West 2000) (mandating that "[e]very group [and individual] health care service plan contract, except for . . . specialized health care service plan contract[s]" that covers "outpatient prescription drug benefits" include FDA-approved contraceptive methods); 1999 Conn. Acts 99-79 §§ 1(a), 2(a) (Reg. Sess.) (requiring "each individual health insurance policy" and "each group health insurance policy" covering outpatient prescription drugs to include coverage for FDA-approved contraceptive methods); GA. CODE ANN. § 33-24-59.6(b)(1) (Supp. 2000) (requiring "any individual or group plan, policy, or contract for health care services" to include coverage for any FDA-approved contraceptives); ME. REV. STAT. ANN. tit. 24, § 2332-J (West 2000) (mandating that all types of general insurance contracts that include coverage for prescription drugs, devices, or outpatient services not exclude FDA-approved contraceptive drugs and devices, or related outpatient services); ME. REV. STAT. ANN. tit. 24-A, §§ 2756, 2847-G, 4247 (West 2000) (same); MD. CODE. ANN., INS. § 15-826 (Supp. 2000) (requiring insurers, nonprofit health service plans, and HMOs covering prescription drugs to cover any contraceptive drug or device approved by the FDA); NEV. REV. STAT. ANN. §§ 689A.0415, 689A.0417, 689B.0377 (Michie Supp. 1999) (requiring that "an insurer that offers or issues a policy of health insurance" providing prescription drug or device coverage or outpatient services not exclude contraceptive drugs, devices, or contraceptive-related outpatient services); N.H. REV. STAT. ANN. §§ 415:18-i, 420-A:17-c, 420-B:8-gg (Supp. 1999) (mandating coverage of outpatient contraceptive services for FDA-approved pregnancy-prevention methods by governing health service corporations, HMOs, and any other insurer "issu[ing] or renew[ing] any group or blanket policy of accident or health insurance providing benefits for medical or hospital expenses"); N.C. GEN. STAT. § 58-3-178(c)(1) (1999) (encompassing an "accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; . . . a multiple employer welfare arrangement [plan]" or a plan resulting from some other kind of benefit arrangement); VT. STAT. ANN. tit. 8, § 4099c (Supp. 2000) (requiring "[a] health insurance plan" providing coverage for other prescription drugs to provide coverage for outpatient contraceptive services).

139. *See* ME. REV. STAT. ANN. tit. 24, § 2332-J (covering nonprofit hospital or medical service organizations); ME. REV. STAT. ANN. tit. 24-A, §§ 2756, 2847-G, 4247 (covering individual health insurance contracts, group and blanket health insurance, and HMOs, respectively); NEV. REV. STAT. ANN. §§ 698A.0415, 689A.0417, 689B.0377 (discussing individual health insurance policies' coverage of FDA-approved prescription contraceptive drugs and devices, individual health insurance coverage of contraceptives-related outpatient care, and group and blanket health insurance coverage of contraceptive-related outpatient care).

as an applicable "health benefit plan,"[140] has a statute explicitly addressing contraceptive coverage in individual and group disability policies.[141] If these individual and group disability policies cover prescription drugs and devices, California requires that they also include coverage of "a variety" of FDA-approved prescription contraceptive methods.[142] California, however, does exclude "specialized health care service plan contract[s]"[143] from its primary mandate statute, in much the same manner that other states seek to limit the application of contraception-related mandates to more general insurance plans.[144]

While the majority of the eight broad state mandates require that "any" or "all" FDA-approved contraceptive drugs or devices be covered where other prescription drugs and devices are covered,[145] the mandates of North Carolina, California, and Connecticut may not be as broad in scope.[146] The vague language of these three statutes

140. N.C. GEN. STAT. § 58-3-178(c)(1)(c).

141. *See* CAL. INS. CODE § 10123.196 (West Supp. 2000). The disability insurance provision, like the more general individual and group health care service plan provision, also has a religious employer exemption. § 10123.196(d); CAL. HEALTH & SAFETY CODE § 1367.25(b) (West 2000).

142. CAL. INS. CODE § 10123.196.

143. CAL. HEALTH & SAFETY CODE § 1367.25(a).

144. *See* 1999 Conn. Acts 99-79 §§ 1(a), 2(a) (Reg. Sess.) (limiting application of the coverage mandate to the more general types of insurance plans as defined under section 38a-469 of the Connecticut General Statutes); GA. CODE ANN. § 33-24-59.6(c) (Supp. 2000) (excluding statutorily-designated "limited benefit policies" from mandate); ME. REV. STAT. ANN. tit. 24-A, §§ 2756, 2847-G (exempting certain more limited individual and group insurance plans from contraception-related mandates); N.C. GEN. STAT. § 58-3-178(c)(1)(a)–(m) (excluding more limited types of insurance plans from mandate); VT. STAT. ANN. tit. 8, § 4099c(b) (Supp. 2000) (excluding "benefit plans providing coverage for specific disease[s] or other limited benefit coverage"). Limiting the mandate's application to more comprehensive plans effectively eliminates a large portion of the population that otherwise would benefit from contraception-related coverage.

145. *See* GA. CODE ANN. § 33-24-59.6(c), (e)(2) ("any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive"); ME. REV. STAT. ANN. tit. 24, § 2332-J(1) (West 2000); *id.* tit. 24-A, §§ 2756(1), 2847-G(1), 4247(1) ("all prescription contraceptives approved by the federal Food and Drug Administration"); MD. CODE. ANN., INS. § 15-826(b)(1) (Supp. 2000) ("any contraceptive drug or device that is approved by the United States Food and Drug Administration"); NEV. REV. STAT. ANN. § 689A.0415(1) (Michie Supp. 1999) ("[a]ny type of drug or device for contraception . . . which has been approved by the Food and Drug Administration"); N.H. REV. STAT. ANN. §§ 415:18-I, 420-A:17-c, 420-B:8-gg (Supp. 1999) ("all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration"); VT. STAT. ANN. tit. 8, § 4099c(a) (Supp. 2000) ("all prescription contraceptives and prescription contraceptive devices approved by the federal Food and Drug Administration").

146. *See* CAL. HEALTH & SAFETY CODE § 1367.25(a)(1) ("shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods"); 1999 Conn. Acts 99-79 §§ 1(a), 2(a) (Reg. Sess.) ("shall not exclude coverage

seemingly allows satisfaction of the mandate through coverage of only some of the FDA-approved contraceptive methods.[147] That is, the California, North Carolina and Connecticut statutes prevent exclusion of contraceptive coverage altogether, but they do not dictate the breadth of options that must be made available.[148] These three states' mandates, then, are less broad than those of other states. In comparison, Georgia's mandate allows the use of closed formularies but requires that at least one kind of each of the five FDA-approved prescription contraceptive methods be covered.[149]

A related issue is whether an insured should have access to all brands in any one FDA-approved category. Even in states with the "any" and "all" language,[150] such mandates would most likely be construed by insurance companies to apply to "any" and "all" FDA-approved categories rather than individual brands.[151] At least with the birth control pill, different brands can have markedly different physiological effects on women.[152] California anticipated this

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for prescription contraceptive methods approved by the federal Food and Drug Administration"); N.C. GEN. STAT. § 58-3-178(c)(4) (1999) ("drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives").

147. *See supra* note 145 and accompanying text.

148. California does provide a fall-back provision, however, where a birth control method that is not covered otherwise must be covered where medically appropriate. *See* CAL. HEALTH & SAFETY CODE § 1367.25(a)(1) (West 2000)

149. GA. CODE ANN. § 33-24-59.6(e)(2); *see also* VA. CODE. ANN. § 38.2-3407.5:1(C)(2) (Michie 1999) (requiring that an optional rider of contraceptive coverage be made available to employers, but stating that such a rider does not preclude the use of closed formularies provided one of each of the five FDA-approved prescription contraceptive categories is included). For a discussion of the effectiveness and possible side effects of all five FDA-approved contraceptive methods—the birth control pill, Norplant, Depo-Provera, the IUD, and the emergency morning-after pill—see Planned Parenthood, *supra* note 50.

150. *See supra* note 145 and accompanying text.

151. Judicial construction of this kind of language is not likely to occur in the near future. In general, the time and cost involved in bringing a lawsuit will effectively deter women from fighting to have their choice of covered contraceptive brands. *See supra* note 67. One ray of hope comes in the form of the recently filed Title VII based lawsuit in Seattle. *See supra* notes 72–77 and accompanying text. Should Erickson and her fellow plaintiffs succeed, Planned Parenthood and other organizations might be moved not only to bring similar Title VII lawsuits in other federal districts, but also to bring suits in the event that broad state mandates are nevertheless too narrowly construed. *See supra* notes 144–50 and accompanying text; *infra* notes 152–54 and accompanying text.

152. For an explanation of some of the distinctions between types of oral contraceptives, see Sharon Snider, *The Pill: 30 Years of Safety Concerns*, *at* http://www.fda.gov/bbs/topics/CONSUMER/CON00027.html (Dec. 1990) (on file with the North Carolina Law Review). The varying levels of estrogen and progestin often produce different effects in different users. *See id.* For an example of state legislation addressing this concern, see HAW. REV. STAT. ANN. § 432:1-604.5(c) (Michie Supp. 1999) (requiring

problem with a fall-back provision;[153] however, residents of other states with mandated coverage seemingly will either have to be content with the covered brands available or pay out of pocket for a preferred, non-covered brand. In North Carolina and Connecticut, where coverage for all five FDA-approved contraceptive methods is not explicitly required,[154] the range of covered choices has the potential to be even narrower.

For example, the North Carolina mandate explicitly excludes Preven, the so-called "morning after" pill, and RU-486, the so-called "abortion pill," despite the fact that both drugs are FDA-approved.[155] Georgia and Maine, in a similar statutory maneuver, explicitly prevent any construction that pregnancy termination coverage is mandated.[156] A strong argument against coverage of RU-486 under the New Hampshire statute is grounded in the language of a provision that speaks of coverage for "contraceptive methods *to prevent pregnancy*."[157] Exclusions of these drugs in other states would depend upon judicial construction of the general concept of "contraceptive"

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that an optional rider of contraceptive coverage be made available to employers, but stating that such a rider must include at least one brand of contraceptives from the "monophasic, multiphasic, and the progestin-only categories"). Under this statute, an insured may receive coverage for a brand of oral contraceptive not encompassed by her plan if her use of covered brands has resulted in an adverse drug reaction or if her physician considers her prone to an adverse reaction to the covered brands. *See id.*

153. *See* CAL. HEALTH & SAFETY CODE § 1367.25(a)(1) (West 2000) (requiring that plans provide coverage for an FDA-approved prescription contraceptive method not already covered if the treating health care provider deems none of the covered methods appropriate considering the insured's medical or personal history); CAL. INS. CODE § 10123.196(a)(1) (West Supp. 2000) (parallel provision requiring same). Again, the California statutes speak only of "methods" and not "brands." The concept of consumer choice of brands within a particular method still may not be statutorily required.

154. *See supra* notes 145–49 and accompanying text. Insurance companies in those states might choose to provide coverage for only some of the FDA-approved methods, based on narrow interpretations of those states' statutes. *Id.*

155. N.C. GEN. STAT. § 58-3-178(c)(4)(a)–(b) (1999). For a discussion of Preven, its use and effects, see Nordenberg, *supra* note 12. For FDA approval of RU-486, see *Food and Drug Administration Approves Abortion Pill*, *at* http://www.cnn.com/2000/HEALTH/women/09/28/abortion.pill.02/index.html (on file with the North Carolina Law Review) (Sept. 29, 2000).

156. *See* GA. CODE ANN. § 33-24-59.6(c) (Supp. 2000) ("[N]othing contained in this Code section shall be construed to require any insurance company to provide coverage for abortion."); ME. REV. STAT. ANN. tit. 24, § 2332-J(1) (West 2000) ("This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy."); *id.* tit. 24-A, §§ 2756(1), 2847-G(1), 4247(1) (same). These statutes do not address the issue of Preven coverage specifically. Differing views on whether Preven's prevention of egg implantation could be considered abortive—and therefore whether Preven could be interpreted as within these provisions—is discussed *infra* note 161.

157. N.H. REV. STAT. ANN. §§ 415:18-I, 420-A:17-c, 420-B:8-gg (Supp. 1999) (emphasis added).

or "contraception."[158] Although RU-486 clearly terminates an already-existing pregnancy,[159] Preven, a drug which prevents implantation of any fertilized egg,[160] occupies one of the grayer areas in the reproductive rights controversy. While religious conservatives view Preven as another permutation of abortion inducement,[161] health care professionals often have espoused the view that Preven is a contraceptive, not an abortifacient.[162] Insureds in all states mandating coverage, therefore, most likely will find RU-486 excluded—either explicitly or because of its fairly clear categorization as an abortifacient rather than a contraceptive. Insureds may also encounter difficulty in seeking coverage for Preven, depending on how the applicable state statute is construed. North Carolina avoids this issue of construction altogether by providing clear language against the coverage of Preven.[163]

These more controversial methods of birth control, as well as birth control coverage in general, led to the adoption of religion-related exemption clauses in most statutes mandating coverage.[164]

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158. *Cf. supra* note 145–48 and accompanying text.

159. *Mifepristone for Termination of Early Pregnancy*, FDA CONSUMER, Nov. 2000, at 7, 7.

160. *See Information About the Preven Emergency Contraception Kit, at* http://www.preven.com/product/02-01-01.html (1998) (on file with the North Carolina Law Review) ("The only definitive evidence indicates that [Preven works] by delaying or preventing ovulation.").

161. *See, e.g.*, Paul Carrier, *Diocese Fights Bill on Birth Control*, PORTLAND PRESS HERALD (Me.), Mar. 30, 1999, at A1, 1999 WL 4470049 (reporting that "[t]he Catholic Church also opposes the [Maine coverage mandate] because it would require coverage for the so-called 'morning after' pill"). Preven is functionally equivalent to an IUD, a device clearly classified as a contraceptive, because both prevent a fertilized egg from attaching to the lining of the uterus. *See* Planned Parenthood, *supra* note 50. From a strictly anti-abortion viewpoint—disregarding the view taken by some religions that any interference with conception is immoral—religious opposition to coverage for contraceptives that do not interfere with the implantation of a fertilized egg is hard to understand. A report by the Alan Guttmacher Institute found that use of contraceptives reduced the probability that a woman would have an abortion by eighty-five percent. Susan A. Cohen, *The Role of Contraception in Reducing Abortion, at* http://www.agi-usa.org/pubs/ib19.html (1997) (on file with the North Carolina Law Review).

162. *See, e.g., ARHP Urges N.C. State Senate to Reconsider Amendment to Contraceptive Equity Bill*, U.S. NEWSWIRE, Apr. 2, 1999, 1999 WL 4636297 (noting the view of Dr. James Trussell, board member of the Association of Reproductive Health Professionals, that emergency contraception is just that—contraception—and not to be confused with abortion-inducers such as RU-486).

163. *See supra* note 155 and accompanying text.

164. *See* CAL. HEALTH & SAFETY CODE § 1367.25(b) (West 1999) ("Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for federal Food and Drug Administration approved contraceptive methods that are contrary to the religious employer's religious tenets."); 1999 Conn. Acts 99-79 §§ 1(b), 2(b) (Reg. Sess.) ("Notwithstanding any other provision of

Such exemptions vary in their definitions of exempted religious entities.[165] For example, Nevada's statute exempts religiously-affiliated insurers from providing the mandated coverage. A more typical exemption, however, is for the employer who refuses on

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this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer ... [a] health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets."); ME. REV. STAT. ANN. tit. 24, § 2332-J(2) (West 2000) ("A religious employer may request and a nonprofit hospital or medical service organization or nonprofit health care service organization shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices."); *id.* tit. 24-A, §§ 2756(2), 2847-G(2), 4247(2) (extending the religious employers exclusion to insurers and HMOs); MD. CODE ANN., INS. § 15-826(c) (Supp. 2000) ("A religious organization may request and an entity subject to this section shall grant the request for an exclusion from coverage under the policy, plan, or contract for the coverage ... if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices."); NEV. REV. STAT. ANN. § 689A.0417(5) (Michie Supp. 1999) ("An insurer which offers or issues such a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds."); *id.* §§ 689A.0415(5), 689B.0377(5) (applying the religious employer exemption to group health insurance policies and policies covering prescription drugs or devices); N.C. GEN. STAT. § 58-3-178(e) (1999) ("A religious employer may request an insurer providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets."). *But see* GA. CODE ANN. § 33-24-59.6 (Supp. 2000) (no exemption); N.H. REV. STAT. ANN. §§ 415:18-I, 420-A:17-c, 420-B:8-gg (Supp. 1999) (same); VT. STAT. ANN. tit. 8, § 4099c (1999) (same).

165. *See* CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (specifying four conditions for the religious employer exemption: 1) the entity's purpose is to inculcate certain religious values, 2) the employees of the entity primarily share the entity's religious values, 3) people served by the entity primarily share the entity's religious values, and 4) the entity is a non-profit organization as defined by the Internal Revenue Code); 1999 Conn. Acts 99-79, §§ 1(f), 2(f) (Reg. Sess.) ("As used in this section, 'religious employer' means an employer that is a 'qualified church-controlled organization' as defined in 26 USC 3121 or a church-affiliated organization."); ME. REV. STAT. ANN. tit. 24, § 2332-J(2)(West 2000); *id.* tit. 24-A, §§ 2756(2), 2847-G(2); 4247(2) (" '[R]eligious employer' means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches" as defined in 26 U.S.C. § 3121(w)(3)(A) (1994) and that qualifies as tax-exempt under 26 U.S.C. § 501(c)(3) (1994)); MD. CODE ANN., INS. § 15-826(c) (Supp. 2000) (no qualifying definition of "religious organization," but inference that religious organization is an employer because it must give notice of its exemption to affected employees under (c)(2)); NEV. REV. STAT. ANN. §§ 689A.0415(5), 689A.0417(5), 689B.0377(5) (Michie Supp. 1999) (providing an exemption for insurers affiliated with a religious organization, but providing no definition of a religious organization); N.C. GEN. STAT. § 58-3-178(e) (1999) ("religious employer" may be exempt where three conditions are met: 1) the entity's organization and operation has religious purpose and the entity is tax exempt under 26 U.S.C. § 501(c)(3); 2) one of the primary purposes of the entity is the inculcation of religious values; and 3) employees of the entity primarily share the entity's religious values).

religious grounds to purchase a plan that covers contraception.[166] Connecticut is the only state to allow an individual employee to refuse the mandated coverage because of conflicts with his or her religious belief system.[167] In all state mandates with religious exemptions, an insured must be notified of any exemption which affects him or her under a given plan,[168] and states other than Maryland and Nevada[169] require that, despite any relevant religious exemption, coverage for contraceptives prescribed for certain medical reasons may not be excluded.[170] The medical reasons that come under these exceptions to religious exemptions are either non-contraceptive in nature or contraception necessary to preserve the life or health of the insured.[171]

These exceptions to the religious employer—and, in Nevada's case, to the religious insurer—exemptions have the potential to swallow the exemptions altogether, at least in terms of the oral

166. *Compare* NEV. REV. STAT. ANN. §§ 689A.0415(5), 689A.0417(5), 689B.0377(5) (exempting qualifying insurers), *with* CAL. HEALTH & SAFETY CODE § 1367.25(b)(1) (exempting religious employers), *and* 1999 Conn. Acts 99-79 §§ 1(b)(2), 2(b)(2) (Reg. Sess.) (exempting religious employers); *id.* §§ 1(f), 2(f) (same); ME. REV. STAT. ANN. tit. 24, § 2332-J(2) (same), *and id.* tit. 24-A, §§ 2756(2), 2847-G(2), 4247(2) (same), *and* N.C. GEN. STAT. § 58-3-178(e) (same).

167. 1999 Conn. Acts 99-79 §§ 1(b)(2), 2(b)(2) (Reg. Sess.). Identical language in the Connecticut provisions allows insurers to issue a policy or rider that excludes coverage for prescription contraceptive methods "upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs."

168. *See* CAL. HEALTH & SAFETY CODE § 1367.25(b)(2) (written notice); 1999 Conn. Acts 99-79 §§ 1(c), 2(c) (Reg. Sess.) (written notice in no less than ten point type that must appear in the policy, application and sales brochure for the policy); ME. REV. STAT. ANN. tit. 24, § 2332-J(2) (written notice); *id.* tit. 24-A, §§ 2756(2), 2847-G(2), 4247(2) (written notice); MD. CODE ANN., INS. § 15-826(c)(2) ("reasonable and timely notice"); NEV. REV. STAT. ANN. §§ 689A.0415(5), 689A.0417(5), 689B.0377(5) (written notice); N.C. GEN. STAT. § 58-3-178(e) (written notice in no less than ten point type that must appear in the policy, application, and sales brochure for the health benefit plan).

169. *See* MD. CODE ANN., INS. § 15-826; NEV. REV. STAT. ANN. §§ 689A.0415, 689A.0417, 689B.0377.

170. *See* CAL. HEALTH & SAFETY CODE § 1367.25(c) (listing as possible reasons for prescription other than contraception "decreasing the risk of ovarian cancer or eliminating symptoms of menopause," or any other use "necessary to preserve the life or health" of an insured); 1999 Conn. Acts 99-79 §§ 1(d), 2(d) (Reg. Sess.) ("Nothing in this section shall be construed as authorizing . . . [the exclusion of] coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes."); ME. REV. STAT. ANN. tit. 24 § 2332-J(2) ("This section may not be construed as authorizing . . . [the exclusion of] coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person."); *id.* tit. 24-A, §§ 2756(2), 2847-G(2), 4247(2) (same); N.C. GEN. STAT. § 58-3-178(e) (containing language substantially similar to that of the Maine provisions).

171. *See supra* note 170.

contraceptive pill. Because the pill is known to reduce the incidence of ovarian and endometrial cancers, benign cysts of the breasts and ovaries, pelvic inflammatory disease, and heavy, irregular menstruation, significant, non-contraceptive medical reasons exist to prescribe its use—even when the insured also intends to benefit from the drug's primary function as a contraceptive.[172] Indeed, health care professionals could prescribe the pill and cite non-contraceptive health benefits as a justification, even where the factual reality is that an employee of a religious employer needs coverage for contraception.[173]

In sum, North Carolina's legislature, having weighed the relevant policy considerations, has opted to join those states requiring broad coverage for contraceptives. Referencing the perceived gender-based inequity in the insurance industry, one state representative supportive of North Carolina's mandate said wryly, "It's simply a matter of fairness among other things. I'm not going to ask for a show of hands about how many [of the North Carolina representatives] use Viagra and cover them with their insurance."[174] Certain features of the North Carolina statute, however, limit its effective breadth. Although the statute encompasses most comprehensive insurance plans, it specifically excludes certain types of more limited plans.[175] The North Carolina law also does not state explicitly that "any" or "all" FDA-approved contraceptive methods must be covered.[176] Satisfaction of the mandate arguably could be achieved through provision of coverage for only some of the available and approved contraceptive methods.[177] Women would be left to pay out of pocket for the use of non-covered methods.[178] Moreover, where different brands of birth control are substantively different, such as in the varying estrogen to progestin ratios in different brands of the pill, the North Carolina law provides neither coverage of all brands within a particular method

172. *See* Snider, *supra* note 152; Nordenberg, *supra* note 12.

173. For certain women, however, the pill can pose certain health risks. These women, such as those who are over thirty-five and smoke and those who have certain medical conditions such as a history of blood clots, would have a harder time arguing that the pill was being prescribed for health benefits. *See* Nordenberg, *supra* note 12.

174. Associated Press, *Birth Control Coverage Approved*, NEWS & REC. (Greensboro, N.C.), June 17, 1999, at B1 (quoting representaive Alma Adams (D.-Guilford)).

175. *See* N.C. GEN. STAT. § 58-3-178(c)(1)(a)–(m) (1999).

176. *See supra* notes 145–49 and accompanying text.

177. *See supra* notes 145–49 and accompanying text.

178. Putting women in this position is not much different from having no mandate at all, given that most plans provide coverage for some form of contraception, if only sterilization. *See supra* notes 43–56 and accompanying text.

nor a fall-back provision for coverage where medically appropriate.[179] Fortunately, the statute affords some flexibility in terms of the religious employer exemption and exceptions to that exemption.[180] In particular, the ability of North Carolina health care providers to prescribe contraceptives for health-related reasons even where a religious employer objects may effectively eliminate the religious exemption, at least regarding the birth control pill.[181]

Criticism of legislative control over the content of insurance plans remains strident, especially in the provocative area of control over reproductive rights.[182] More than forty years since the revolutionary contraceptive innovation of the birth control pill, however, free market forces have not worked to produce equitable coverage in the insurance industry, and women, given the time and expense of possible lawsuits, have been hesitant in the past to resort to litigation to enforce their rights to equal coverage.[183] Unless Ms. Erickson and her co-plaintiffs begin a trend of successful Title VII litigation,[184] legislation, although not ideal, appears to be the only viable vehicle for equitable insurance reform. Moreover, if the Equity in Prescription Insurance and Contraception Coverage Act continues to lie dormant in congressional committee,[185] state mandates alone must provide legislative relief. Ultimately, even the more limited state mandates have symbolic value, representing as they do the recognition that responsibility for family planning should not rest on women's shoulders—and pocketbooks—alone. Through section 58-3-178, North Carolina takes a notable step in that direction.

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179. *See supra* notes 145–54 and accompanying text.
180. *See supra* notes 128, 168–73 and accompanying text.
181. *See supra* notes 172–73 and accompanying text.
182. *See supra* note 119 and accompanying text.
183. *See supra* note 67.
184. *See supra* notes 72–81 and accompanying text.
185. *See supra* notes 88–93 and accompanying text.