What Women Want: Comprehensive Contraceptive Coverage

As stated per the Constitution of the United States of America, citizens of the country are entitled to life, liberty and the pursuit of happiness. Yet, these fundamental beliefs on which this country was based are often disregarded with respect to women in the grand scheme of health policy. When oral contraceptive pills became available, it gave women a novel means by which to take control of their sexual destiny. Today, technology and science have given women more options in terms of reproductive control. However the inconsistency in coverage of contraceptives by health insurance providers in the United States leaves many women without the means to effectively utilize contraceptives and in this way places limits on women in terms of reproductive control.

With the inherent bias of the health care system within the socioeconomic strata regarding access to contraceptives, there come implications of who should and should not be bearing children. For women who receive health insurance through Medicaid coverage includes almost every form of contraceptive. Yet for women in the workforce who receive health insurance through their employer, it is often found that such policies do not cover contraceptives. This disparity leads to an unstated belief that some women are more suited to have children. (King and Meyer, 9) A major factor in the restriction of access to contraceptives is the demographic that is generally believed to utilize them, in particular, teenagers and unmarried women. However, little thought is given to the fact that women in all stages of their life require and are entitled to the freedom of

reproductive control. Studies have found that the reproductive control strategies employed by health care providers vary for women at different socioeconomic levels. (King and Meyer, 10)

Given the history of sterilization abuse in the united states among poor and minority populations, it comes as no surprise that there continue to be questions regarding the methods of reproductive control recommended by health care providers. (King and Meyer, 11) While certain options may be more cost efficient for women who must worry about finances, when health care providers make assumptions or direct their attention towards a certain contraceptive option based on finances alone, these women are immediately restricted by a notion that they are not capable of finding the contraceptive that is right for them due to financial constraints. Whether it be stated directly as with the blatant sterilization movements administered within populations of lower class and minority women, or indirectly with independently funded foundations targeted at population control within the demographic of poor American women, there lies a significant difference in the availability and acceptance of birth control among different classes of women.

A study conducted in Illinois highlighted the dichotomy between contraceptive options and availability among socioeconomic classes. In 1995, Illinois, along with the rest of the country did not have a state mandate requiring employers to cover contraception in their health insurance policy for employees. (King and Meyer, 13) This left the amount of coverage if any up to individual employers. Upon phone interviews of the largest employers in the state, it was found that while a greater percentage of

employers covered permanent methods of birth control such as tubal ligation, few covered any form of non-permanent birth control such as contraceptive pills. (King and Meyer, 13) In contrast, it was found that Medicaid plans had been providing coverage for family planning services even before it became federally mandated that state Medicaid programs include them in their plan. (King and Meyer, 14) Yet, for women who work part-time, employer-based insurance is not an option and they are no longer eligible for Medicaid. Women in this situation often go uninsured and are required to pay out of pocket for contraceptives. In response to this, federally funded programs and government-subsidized clinics began to offer contraceptive options at a much lower cost, with the belief that reproductive control would reduce the number of unwanted births in the lower strata of the socioeconomic ladder. (King and Meyer, 15) Such actions imply an earnest and continuing interest in limiting the birth rate of individuals requiring the assistance of Medicaid. The inconsistency in access to contraceptives between working women and women on Medicaid leaves questions regarding the motive for such different courses of action. It has been thought that in the realm of capitalist society, such measures were taken to alleviate the fear of the rich that the poor would soon overpopulate the country. (King and Meyer, 12)

Furthermore, up until the 1980's there has been evidence of low income and poor patients coming into the hospital for other procedures and leaving the hospital sterilized. (King and Meyer, 11) With such recent evidence of unwanted sterilization due to the decisions of medical professionals with debatable motives, the apprehension of women in this circumstance is understandable. Ultimately, when it comes to

reproductive control the question remains with whom does the authority really lie? In terms of reproductive control, it is clear that the personal is truly political for as long as the health care system relies on the convoluted system of private insurance policies that are free of federal mandates, women will have differential access and treatment when it comes to their reproductive options.

It must be said however that in recent years, steps have been taken to create public policy that provides more coverage for women. As of 2003, 20 of the 50 states had enforced contraceptive coverage for all insurance policies in the state. (Gold, 5) Since then greater efforts have been made by feminist groups and women employees in order to get employers to provide more comprehensive coverage of contraceptives. Yet, this still leaves 30 states in which women continue to be subjected to the unstated bias of who should be having children due to the inconsistent insurance contraceptive coverage within the workforce.

In addition to deepening and reinforcing class lines, when employers cover contraception differentially, the options of women in terms of what works best for their body are restricted. Such lack of comprehensive coverage serves to reduce costs for employers and limits access to newer forms of contraceptives. (Dailard, 2) Contraceptive coverage has been found to be inadequate in nearly all 50 states. (King and Meyer, 12) Employers often work with unions to decide what type of coverage is appropriate for their employees. (King and Meyer, 24) Financial capabilities and requirements vary from company to company, leading to inadequate and patchy coverage of contraceptives among other things. Despite the fact that women represent a significant

portion of most unions, negotiations often affect women negatively as the views and needs of men are accepted as the pervasive norm.

As there are no federal mandates that require contraceptive coverage by private insurance companies, employers tend to view contraceptive coverage as an unnecessary extra that will only raise costs. (Dailard, 12) Cost being the primary factor in determining the amount of coverage, even when employers cover contraceptives, not all methods are included. (Rodriguez, 14) This inherently limits the options of female employees and forces them to choose a method of contraception that the company deems fit which might very well differ from the what the woman might have chosen if she had all the options available on the market today. (Rodriguez, 14) Companies have argued that contraceptive methods fringe on volatile issues such as abortion and so are unfavorable to be addressed. (White, 275) With the public image and the company's interests on the forefront of every move, employers look past the benefits that may be provided for their workers. Particularly, women are placed at a disadvantage as their needs are overlooked for the advancement of the company as a whole. Yet, these same moral objections are not held when it comes to the lower rungs of the socioeconomic ladder as Medicaid provides comprehensive coverage for contraceptives. So where the government has no moral objection to providing such services to those utilizing Medicaid, employers take issue with the moral implications of giving contraceptive coverage to their employees.

Studies as recent as 2003 show that with comprehensive contraceptive coverage there is actually no increase in insurance premiums and over time, employers actually end up saving money, as there are fewer unintended pregnancies. (Gold, 6) In fact, the cost

of insurance coverage without contraceptive coverage was found to be on average 15-17% higher. (Dailard, 13) With such undeniable evidence of the benefits of contraceptive coverage, money can no longer be used as an avenue by which women are restricted in their contraceptive choices. What once was a private matter must come into the public arena in order to provide women with the choices they are entitled to.

In addition to class lines, the gap in gender equality is apparent through the universal coverage of erectile dysfunction medication for men under employer-based insurance and the inconsistent coverage for contraceptives for women. Such disparity suggests a need for change in terms of mandated policy for contraceptive coverage by health insurance providers. (White, 301) Within weeks of the appearance of Viagra on pharmacy shelves, men had began to file lawsuits against insurance companies that did not cover the erectile dysfunction pill under their plan. In contrast, while oral contraceptive pills have been on shelves since 1964, the first lawsuit against an insurance company on the basis of inadequate coverage was not filed until 2000, nearly 50 years after its initial introduction. (White, 273)

Further, due to inadequate coverage, women are often required to pay out-of-pocket for contraceptives. This leads to a very distinct disparity in health care expenses for men and women. It has been found that women pay 68% more in out-of-pocket costs on average than men. (White, 278) While great efforts are made by employers to reduce their own costs, these costs are then directly transferred to individual women.

The fact of the matter is that the necessity of contraceptives has been downplayed and ignored for so long that mainstream society has come to believe that contraceptives

for women reflect a lifestyle choice that has no place in the realm of health insurance. Yet the same argument can be applied to other prescriptions that are given simply to alleviate symptoms and not provide a real cure. Often times, employers dismiss contraceptives as an extra cost claiming that they are not "medically necessary". (White, 279) Yet, there seems to be a very thin line that separates what is "medically necessary" from what is convenient. There are many instances in which contraceptives are prescribed as a medical necessity. Such situations include the prevention of pregnancies that are known to be complicated, and the regulation of hormonal imbalances and as a preventative measure against ovarian cancer. (White, 280) Yet, in this patriarchal society, male-dominance extends into the realm of women's rights, limiting the control that a woman has on her own reproductive rights. It is truly unfortunate that in today's society, women continue to be subjected to sexism when it comes to decisions regarding their own bodies. Women must be viewed by society as individuals that have the ability to make competent and rational decisions when it comes to their reproductive health, unhindered by limitations set forth by employers and insurance companies looking to save money.

It is true that the outlook for women in terms of getting the coverage they need in the near future is positive. In the last few years, public policies have been set forth that attempt to integrate the needs of women in employer-based insurance plans. Specifically, in recent years, the United States Equal Opportunity Commission has deemed it to be sexually discriminatory for an employer to not include contraceptives in their prescription plan for health insurance. (Dailard, 13) However, more changes need to be made on a

federal level such that there need not be a disparity in access to or cost of contraceptives among gender, or class lines. This requires action on every level, starting with the women who are affected by these decisions every time they visit their health care professional.

Since the advent of reproductive control methods, women have struggled to find a balance between what they need and what they can get. Inadequate insurance coverage of contraceptives not only limits women in their reproductive options, but it also allows society to construct barriers along class and gender lines. Given the vast demographic of women that are affected by contraceptive limitations, it is surprising that the issue did not enter the public realm earlier. While moral objections and religious beliefs have effectively swept the issues surrounding contraceptive use and distribution, such views must be separated from the political sphere in order to reinstate women with the power and freedom that they are entitled to. It took years of personal turmoil for women of all ages and various socioeconomic levels before a statement was made regarding the inadequacy and disparity evident in the health insurance system in terms of contraceptive coverage. This is the unfortunate reality of living in a patriarchal society where money talks more loudly then most other types of action. Yet, this cannot stop women at all levels of society from making their voices heard and their opinions count. Given the advances made by society in terms of civil liberties and women's rights, it seems that it is just a matter of time before contraceptive freedom and personal control is given the attention it deserves on the stage of change. Nevertheless, immediate steps must be taken by individuals and interest groups alike to create these tides of change.

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