September 2002

Morning Panel: Recent Trends and Policy Developments at State

Berkeley Journal of Gender Law
Before I begin, I want to apologize on behalf of Sharon Levin. She very much wanted to be here today. But I also want to make clear that while I am going to cover some similar topics and draw your attention to a National Women’s Law Center resource before I start talking about reproductive rights, I am not speaking on behalf of the National Women’s Law Center. Any errors I make or opinions I express are my own.

As you can see from the statistics that we have heard today, there are some very serious disparities not only between women and men in regard to their access to health care, but also among women of different racial or ethnic backgrounds. I just want to direct people’s attention to a resource called the Women’s Health Report Card. It was put out by the National Women’s Law Center. It contains some very comprehensive statistics that break down the state of women’s health among different populations and across different regions. For example, the leading causes of death—and you can see some of the racial disparities—the leading cause of death for white women aged twenty-four to forty-four is accidents, while for Black and Latina women the leading cause of death is HIV. So that’s just one example to highlight how access does affect the status of women’s health in this nation.
I’ll begin by telling you a little bit about how the Report Card was done. The National Women’s Law Center, the Lewin Group, Oregon Health & Science University, and FOCUS on Health and Leadership for Women at the University of Pennsylvania School of Medicine put this study together. They measured the state of women’s health using status indicators such as, for example, how many women in a particular area get routine mammograms and how many women have certain diseases. The study also measured policies by looking at what state governments and the federal government are doing to push forward a positive agenda for women’s health. They asked whether a state requires insurers to cover mammograms and pap smears, for example. They looked at four different categories: access to services, addressing wellness and prevention, key health conditions, and causes of death. They also looked at the extent to which women live in healthy communities. The information in this category included community life expectancy, activity levels, nutrition, exercise, smoking, gun control, domestic violence policies, and so on. All of these things have an impact on women’s health. What the study found overall is that we’re doing pretty poorly as a nation helping women stay healthy. Of course, some states are better than others, and some good news is that California actually is one of the better states. We really have excellent policies as far as domestic violence goes, thanks to Boalt Hall’s own Nancy Lemon. And as Assemblywoman Aroner was talking about, our Healthy Families program is to some extent up and running. If you look at some of the other states, it’s pretty remarkable. We’re almost spoiled here—relatively speaking, of course. We look at what’s going on here and say, “Gosh, we’re really not doing a very good job,” but when you compare California to other places, we really are. There are a lot more women here who have access to an abortion provider. There is better linguistic access to services here compared with other states. So there’s a little bit of good news. The Report Card is really comprehensive, and having so much comparative information in one place can be really helpful for advocates.

I’m going to move on to recent trends in the area of reproductive rights and access to reproductive health care. The first thing I want to talk about is some good news regarding contraceptive coverage. In December of 2000, the E.E.O.C. [Equal Employment Opportunity Commission] ruled that it was in fact a form of sex discrimination for employers who are covered by Title VII not to cover prescription contraceptives in their insurance plans when they cover other prescription drugs. That was really a landmark decision. And this summer, another decision came down in federal court that agreed with the E.E.O.C.’s reasoning. That case was Erickson v. Bartell Drug Company. Jennifer Erickson worked for Bartell, a small drugstore chain in Seattle, Washington. She routinely filled people’s contraceptive prescriptions and was realizing that there
was a lot of variation among different prescription plans in terms of whether and how much they covered these prescriptions. Her own plan did not cover them, so she decided to bring a class action lawsuit. Planned Parenthood represented her, and the National Women’s Law Center was of counsel, as were several other really wonderful groups. This summer, the federal court in Seattle ruled on her case, and it agreed with the E.E.O.C. The court held that it was in fact sex discrimination under the Pregnancy Discrimination Act not to cover prescription contraceptives when other prescription drugs were covered.

At the same time, there has been a push throughout the states to enact legislation that mandates contraceptive coverage. One reason why legislation is necessary in addition to the court rulings is that the effects of litigation victories will be limited to those women who work for employers covered by Title VII. For purposes of the Pregnancy Discrimination Act, employers would need to have at least fifty employees within a seventy-five-mile radius for the law even to apply.

One thing we know is that with fourteen percent of women uninsured, and with the number of women who either work part-time or are covered under other plans, decisions like *Erickson* will not mean universal contraceptive coverage for women. It’s not going to serve people who work in places that have fewer than fifty employees; it’s not going to help people who are self-insured or who are buying into other kinds of coverage. So what a number of states have done—sixteen states right now, according to the most recent figures I have—is to put in place some kind of legislation that mandates contraceptive coverage.

The federal government is also working on this. Senator Olympia Snowe introduced the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC). That bill was actually moving along until just the day before the attacks on the World Trade Center. There was a hearing on EPICC in the Senate, and it looked like we might actually finally be able to get it passed. Unfortunately, it looks like there’s really not going to be any more action in Congress this year; they’re going to be busy with a lot of other things. But I did want to make people aware of that Act.

I’d like to give you just a few statistics about the importance of contraceptive coverage. Most women have the biological potential for pregnancy for more than thirty years of their lives. For most of that time, women are looking to prevent pregnancy. About half of the pregnancies in the United States are unintended. This figure may be higher in minority communities. For example, nearly seventy percent of pregnancies in the African-American community are unintended. I think there’s a real tendency for people to think of reproductive rights as a quintessential white feminist issue. But it’s actually really important to all women and it’s especially important to racial minorities and poor women whose ac-
cess is already impeded and who historically have had their reproductive rights infringed upon egregiously.

I also was going to go through some of the erosion of reproductive rights that’s been occurring under the new administration. It seems like an odd time to be attacking the President, but eventually things should calm down, and we’re all going to need to remember where we’re at in terms of rolling back reproductive freedoms. To give you a little time-line, by the end of December 2000, we had two really crucial nominations that were anti-choice. John Ashcroft was appointed as the Attorney General and Tommy Thompson—an opponent of abortion, though not always of family planning—was appointed as the Secretary of Health and Human Services. Before the President was even inaugurated, there were threats to the recent F.D.A. approval of mifepristone for use as a non-surgical abortifacient. The administration wanted to review that approval, which was twelve years in the making, and in essence cause delay in getting the drug to the public, if not prevent its distribution altogether. As I’m sure most people know, on the President’s second day in office he reinstated the global gag rule. There was actually an amendment offered in the House to repeal the gag rule, but it didn’t pass.

In April, the President proposed to end contraceptive coverage for Federal employees. The Federal Employees Health Benefits Program has had a contraceptive coverage provision since 1997 and when the President was putting together his budget this year, one of the things he wanted to do was to remove the funding from that program. We did achieve a small victory with that this summer which was really great. Unfortunately, there is still a ban on abortion coverage for federal employees. As she does every year, Representative Rosa DeLauro tried to introduce an amendment to the Federal Employee Health Benefits Program to repeal the ban, but it failed once again.

The Bush administration also did not increase funding for Title X Family Planning this year, so actually if you take into account inflation it looks like a decrease in funding. Up until now, we’ve been seeing a steady increase in funding to those clinics, but that’s not happening now and it seems unlikely that it’s going to happen in the future.

Towards the end of April, the House passed the Unborn Victims of Violence Act. I don’t know if people are familiar with this bill. It’s one of those things where anti-choice legislators like to make it look like it’s going really well for women. In this case, the bill would increase the penalties for an assault on a woman who is pregnant. So conservative legislators were really touting this as a victory for domestic violence advocates, as though it would combat violence against women. But the crux of the Act was really that its protections were directed at the fetus. By creating stiffer penalties for violence directed at a fetus, this bill was going to be basically another way to sneak into law the idea that life begins immedi-
ately after conception, rather than at the point of viability, which is an important aspect of the Supreme Court’s decision in *Roe v. Wade*. Fortunately, the bill did not get through the Senate, so we don’t have an Unborn Victims of Violence Act just yet.

I want to add a couple of other things. I don’t want to hit everything because I feel like I want to talk about something good toward the end. One other thing that I want to point out relates to my own experience. This summer was really the first time that I had the opportunity to gain any knowledge of exactly how the Federal Government really works as far as what gets done administratively and what gets done legislatively. So I don’t know if this policymaking procedure is unique to this administration when it comes to implementing unpopular initiatives, but I observed a real push to use administrative regulations to again try to sneak in the idea that life begins immediately after conception. Toward the end of the Clinton administration, the President had revamped a rule about the protection of human research subjects. The rule dealt with pregnant women who were subjects in clinical research funded by the federal government, and he had made some pretty positive policy revisions.

Let me back up; any administrative rule that is proposed will not be enacted for sixty or ninety days—I don’t recall exactly—after it has finished the official rulemaking process. So anything that was pending at the end of Clinton’s administration, which is basically everything that Clinton rushed to get through, Bush put on hold and basically said, “We’re going to review all of these things.” And one of the things they reviewed was this rule about the protection of human research subjects. The Secretary of Health and Human Services wanted to do things like reintroduce a paternal consent requirement for a woman to participate in research if she was pregnant. He also proposed that if indeed research was going to have an impact on the fetus that it could only be done if the overall point of that research was to make sure the fetus was carried to term. I’m not entirely sure where that rule stands right now. I know that there was a period of notice and comment over the summer.

Another administrative issue that’s been a problem for women’s access to services goes back to what Assemblywoman Aroner mentioned regarding waivers. It’s very hard to get waivers right now, as Georgia discovered when it applied. One kind of waiver that states can get in the Medicaid process is a waiver for family planning that allows states to increase the budget they have for family planning for low income women whose incomes are above the federal minimum. In July, the Department of Health and Human Services denied Georgia’s application for one of these Medicaid waivers to expand family planning, and then the Department basically stated that it wasn’t going to be approving family planning waivers anymore, period. I haven’t heard anything else since that point, but that’s where things stood at the end of the summer.
So that's a little timeline of what's been going on with reproductive rights at the federal government level. If people have questions, I was involved in doing some advocacy on thePatients’ Bill of Rights and some other managed care reforms so I would be happy to talk about that a little bit as well. I will say, personally, that one thing I noticed at press conferences on the Patients’ Bill of Rights this summer, was that there wasn't a real presence there among women's groups. I don't think it was really clear the extent to which legislation like that matters to women. It is really important, first of all, for continuity of care, and secondly because there were provisions in the legislation not only to ensure continuity of care, but also to ensure that women have access to OB-GYNs as primary care providers. What happens a lot in managed care is you’ll have to jump through hoops or you’ll have to see an internist first and then get a referral to go see an OB-GYN. It really shows the lack of recognition on the part of the managed care plans that many women use their OB-GYN as their primary health care provider. There was some good language in the Patients’ Bill of Rights to that end. Again, if people have questions, I'm happy to talk about that afterwards, but I think in the interest of time, I want to let Susan [Berke Fogel] go.

**Relevant Sources**


Civil Rights Act of 1964 (Title VII), 42 U.S.C. § 2000 e(k), § 701 (k).