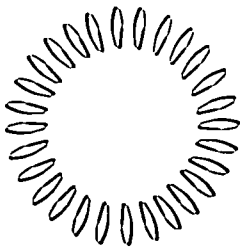
Improving Access to Contraception  A Plan for Action

Nicole/Jen -
FYI
Elena

File: Women's Issues - Contraception

Dear Friend:

Are you tired of constantly defending your reproductive rights — never getting the opportunity to promote a forward-thinking agenda to improve women's health? Well times have changed! And we need your help.

The Center for Reproductive Law and Policy, the nation's only public interest legal organization committed solely to protecting women's reproductive rights and health, believes that universal access to safe, effective, and appropriate contraception is a cornerstone of a reproductive rights agenda for the next century. Like many other women's health care services, however, not all contraceptive options are available to all women.

In the United States, nearly half of large-group health plans do not routinely cover any contraceptive method. Of the 97 percent that cover prescription drugs and devices, only 33 percent cover oral contraceptives. Government workers and members of the military are also not given comprehensive coverage for contraception. Many women who are uninsured or underinsured must turn to family planning clinics that face ever-shrinking funding. For low-income women who rely on Medicaid, one of the most comprehensive federal health programs, the guarantee of access to family planning services is being undermined by lack of adequate information and the transition to managed care. At a time when women around the world, especially in Southern nations, have few contraceptive options and little access to other reproductive health care services, relentless pressure from anti-choice forces has dramatically curtailed funding for international population assistance.

Access to safe, effective, and appropriate contraception remains an urgent — but generally unrecognized — public health need.

CRLP believes that now is the time to address this problem. And we have developed a simple, six-step plan to improve access to contraception. These recommendations range from ensuring that contraceptives are included in private insurance to the extension of coverage for contraception in federal and state health programs to increasing public funding for family planning efforts.

We recognize that attacks on reproductive rights and health, particularly on the right to choose abortion, will persist. And we will continue to counter them aggressively. But we cannot wait for those assaults to end before turning to the critical task of providing women with the ability to choose from the full range of reproductive health services. Improving access to contraception will be a significant step toward that goal. We hope we can count on you to be a part of this effort.

Very Truly Yours,

Janet Benshoof
President

Janet Crepps
Staff Attorney
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Brenda Romney
Staff Attorney
Federal Program

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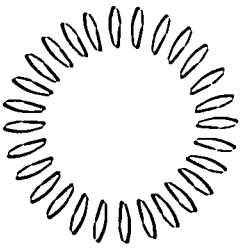

Contraception
An Urgent Public Health Need

When it upheld a woman's right to choose abortion in *Planned Parenthood v. Casey*, the U.S. Supreme Court recognized that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[1] Unwanted or mistimed childbearing can curtail a woman's educational and work opportunities, constrict her social role, and exclude her from full participation in the "marketplace and the world of ideas."[2] Unintended pregnancies, which result in part from lack of access to contraceptive care, also exact tragic tolls on the health and well-being of women and their families and place a burden on society as a whole. For these reasons, access to appropriate and affordable contraception plays an indispensable role in promoting women's health and advancing women's equality.

Like many women's health care services, however, not all contraceptive drugs, devices, and medical services are available to all women. Each year, an estimated 31 million women are at risk for unintended pregnancy.[3] Those who rely on private insurance may find that their health benefit plans do not include prescription contraceptive drugs, devices, or related medical services, or that the coverage they do receive is limited. Government employees at the federal, state, and local levels, and their dependents, face similar restrictions on coverage for birth control. Members of the uniformed services and their families are also denied the full range of contraceptive care. Women who are uninsured or underinsured, and those who otherwise have difficulty paying for medical care, often rely on family planning clinic providers that cannot meet the growing demand for their services — a direct result of shrinking public funding.

Women with medical conditions that require the avoidance of pregnancy or that preclude the use of one or more contraceptive methods have a particularly urgent need for increased availability of comprehensive contraceptive care. Yet the significant financial burdens associated with contraceptive services and some forms of birth control may steer women away from the most appropriate and effective family planning options. In 1993, for example, the total cost of Norplant insertion was approximately $700, the total cost of an IUD insertion was approximately $400, and a year's supply of oral contraceptives and the associated physical exam cost approximately $300.[16]

Thanks in large part to efforts to educate the public on the prevention of HIV, it is well known that some forms of contraception can prevent sexually transmitted infections (STIs). But it may be less commonly recognized that the availability of contraceptive services also provides a route toward education, screening, and treatment related to STIs. Detection of STIs is essential to stemming the epidemic of such infections, which affect nearly 12 million women and men in this country annually.[17] Early treatment can reduce the chance that a woman will experience pelvic inflammatory disease or an ectopic pregnancy.[18]

Women and their families suffer economically and socially from lack of access to affordable contraception

On average, women of childbearing age (15 to 44) pay more for their health care than their male counterparts. According to one study, these women spend 68 percent more in out-of-pocket medical costs.[19] In addition, women make up 69 percent of those in this age category who are forced to spend 10 percent or more of their income on out-of-pocket health expenses, a figure that includes almost five million women who are privately insured.[20]

Women and their families also face economic and social disadvantages when a lack of access to contraception results in unintended pregnancy. The unplanned addition of a child to a family may stretch already limited resources, particularly for single mothers, who are more likely to have lower incomes than two-parent families. The same is true for adolescents, who experience unintended pregnancy and resulting births at a greater rate than other groups of women. Studies indicate that there is a strong association between a young age at first birth and both poverty and the receipt of public assistance.[21] In addition, studies indicate that teenagers who become mothers are more likely to drop out of high school, leaving them less able to compete in the job market.[22]

Failure to ensure access to comprehensive contraceptive care is expensive

According to one estimate, a sexually active woman who does not use contraception over the course of five years will experience 4.25 unintended pregnancies, costing upwards of $14,500 for a private insurer and nearly $6,500 for public health systems.[23] These expenses are significantly greater than the costs associated with any form of contraception.[24] At the same time, early detection and treatment of STIs can reduce serious and potentially costly health problems associated with these diseases, such as pelvic inflammatory disease, infertility, premature delivery, and infection in the newborn.[25]

Public expenditures for contraceptive services have also proven cost-effective. One study recently concluded that every tax dollar spent on contraceptive care saves an average of three dollars in Medicaid funds alone that would have been spent providing care to pregnant women and newborns.[26] In 1987, had there been no public-sector expenditures for contraceptive services, expenses associated with unintended births and pregnancy terminations would have cost federal and state governments an additional $1.2 billion in Medicaid funds.[27]

services.[40] If not prevented, 533,800 of these would result in unintended births and 632,300 would be terminated by abortion.[41]

Despite the proven health benefits and cost-effectiveness of these programs, they have been repeatedly targeted for cuts – and even elimination – by legislators and the executive branch at the federal and state levels. When inflation is taken into account, overall spending by federal and state governments to provide contraceptive care fell by 27 percent between 1980 and 1994.[42]

Appropriations for Title X, the only federal program whose sole goal is to fund family planning services, suffered a particularly significant reduction during this period — a decline of 65 percent in constant dollars.[43] Due to this decrease, Title X-supported clinics cannot provide services to the degree that they have in the past. In order to cover their costs, these facilities may cut back on the number of patients they serve, eliminate some services, or require fees.[44]

A call to action

Access to affordable and appropriate contraceptive options is a cornerstone of women's health, equality, and reproductive rights. Yet many women continue to be left without the ability to choose from the full range of contraceptive drugs, devices, and medical services. Private health care plans exclude contraceptive coverage, government insurance programs deny comprehensive contraceptive care, and public funding for family planning services is insufficient to meet the needs of low-income women and the uninsured.

As a result, the health and well-being of women and families in this country continue to suffer due to preventable unintended pregnancies, poor birth outcomes, decreased educational and work opportunities, and inconsistent or inappropriate medical care. We can and must act now to address the failure of our health care system to provide for women's most basic medical needs.

Endnotes

1. *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992).
2. *Stanton v. Stanton*, 421 U.S. 7, 14-15 (1975).
3. Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 28 (Sarah S. Brown and Leon Eisenberg, eds., National Academy Press 1995) (hereinafter referred to as *The Best Intentions*).
4. Elise F. Jones et al., *Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries*, 20:2 Fam. Plan. Persp. 53, 54-55 (March/April 1988).
5. Committee on Contraceptive Research and Development, Institute of Medicine, National Academy of Sciences, *Contraceptive Research and Development: Looking to the Future* S-3 (Polly F. Harrison and Alan Rosenfield, eds., National Academy Press 1996) (hereinafter referred to as *Contraceptive Research and Development*).
6. *The Best Intentions*, at 92 (citing W.D. Mosher, *Contraceptive Practice in the U.S., 1982-1988*, 22:5 Fam. Plan. Persp. 198 (Sept./Oct. 1990).
7. *Id.* at 99.
8. Jacqueline D. Forrest, *Epidemiology of Unintended Pregnancy and Contraceptive Use*, 170 Am. J. Obstet. Gynec. 1485-88 (1994).
9. *The Best Intentions*, at 70-72.
10. Children's Defense Fund, *The State of America's Children Yearbook* 28 (1995).
11. *The Best Intentions*, at 66-72.
12. The National Commission to Prevent Infant Mortality, *Troubling Trends: The Health of America's Next Generation* 38 (Feb. 1990) (hereinafter referred to as *Troubling Trends*).
13. Kenneth J. Meier & Deborah R. McFarlane, *State Family Planning and Abortion Expenditures: Their Effect on Public Health*, 84:9 Am. J. of Pub. Health 1468, 1470 (Sept. 1994).
14. *Troubling Trends*, at 38.
15. *Contraceptive Research and Development*, at 1-2 (citation omitted).
16. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85:4 Am. J. of Pub. Health 494, 495-96 (April 1995) (hereinafter referred to as *The Economic Value of Contraception*).
17. David J. Landry & Jacqueline D. Forrest, *Public Health Departments Providing Sexually Transmitted Disease Services*, 28:6 Fam. Plan. Persp. 261 (Nov./Dec. 1996).
18. *See, e.g.*, Susan D. Hillis et al., *The Impact of a Comprehensive Chlamydia Prevention Program in Wisconsin*, 27:3 Fam. Plan. Persp. 108 (May/June 1995).
19. Women's Research and Education Institute, *Women's Health Insurance Costs and Experiences* 2 (1994).
20. *Id.*
21. For example, approximately half of the adolescents who give birth before the age of eighteen receive welfare within five years of giving birth. *The Best Intentions*, at 56-58.
22. *Id.* at 55.
23. *The Economic Value of Contraception*, at 497.
24. *Id.* at 499.
25. The Alan Guttmacher Institute, *Issues in Brief: Sexually Transmitted Diseases in the U.S.: Risks, Consequences and Costs* 4 (April 1994); *The Best Intentions*, at 120.
26. Jacqueline D. Forrest & Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, 28:5 Fam. Plan. Persp. 188, 193 (Sept./Oct. 1996) (hereinafter referred to as *Impact of Publicly Funded Contraceptive Services*).
27. *Id.*
28. The Alan Guttmacher Institute, *Uneven and Unequal, Insurance Coverage and Reproductive Health Services* 12 (1995). This study indicates that "conventional indemnity plans" are the largest source of insurance coverage, affecting 58 percent of "insured employees" compared to the 20 percent covered by "preferred provider organizations," 19 percent by "health maintenance organizations," and 3 percent enrolled in "point-of-service networks." *Id.* at 5.
29. *Id.* at 17.
30. *Id.* at 12.
31. Excluding insurance coverage for medically appropriate prescriptions and devices needed exclusively by women while covering all medically appropriate prescriptions and devices needed by men is an impermissible gender-based classification. Although the U.S. Supreme Court has permitted pregnancy/gender-based classifications that purportedly equalize the sexes, *see e.g., Geduldig v. Aiello*, 417 U.S. 484 (1974), and *Michael M. v. Superior Court of Sonoma County*, 450 U.S. 464 (1981), it has never sanctioned the imposition of burdens on women alone because of their unique procreative abilities. *See, e.g, International Union, UAW v. Johnson Controls*, 499 U.S. 187 (1991).
32. *See, e.g, Newport News Shipbuilding and Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669 (1983) (health insurance plan that provided less extensive pregnancy benefits for spouses of male employees than for female employees unlawfully discriminated on the basis of sex and thus was an unlawful employment practice under Title VII); *E.E.O.C. v. South Dakota Wheat Growers Ass'n.*, 683 F. Supp. 1302 (D.S.D. 1988) (exclusion of pregnancy-related costs from conversion health benefit plan constituted unlawful sex discrimination under Title VII).
33. 5 U.S.C. §§ 8901, *et seq.* The Office of Personnel Management ("OPM") reviews applications and enters into annual federal procurement contracts with commercial insurance carriers and other organizations that wish to sponsor health plans for federal employees. OPM has final authority over all benefits, exclusions, and limitations in FEHBA plans and is authorized to contract for such benefits, limitations, and exclusion as it "considers necessary or desirable." *Id.* § 8902(d).
34. 10 U.S.C. §§ 1071, *et seq.*
35. *See* 32 C.F.R. §199.4(e)(3).
36. *Impact of Publicly Funded Contraceptive Services*, at 189.
37. 42 U.S.C. §§ 300, *et seq.*
38. 42 U.S.C. §§ 1396, *et seq.*
39. Terry Solom, et al., *Public Funding for Contraceptive, Sterilization And Abortion Services, 1994*, 28:4 Fam. Plan. Persp. 166, 167 (July/Aug. 1996) (hereinafter referred to as *Public Funding*).
40. *Impact of Publicly Funded Contraceptive Services*, at 192-93.
41. *Id.* at 193.
42. *Public Funding*, at 170.
43. *Id.*
44. The Alan Guttmacher Institute, *Issues in Brief: Title X and the U.S. Family Planning Effort* 6 (Feb. 1997).

The Facts About Contraceptive Coverage in Private and Government Insurance

Private insurance plans unfairly exclude contraceptive coverage

Forty-nine percent of large-group insurance plans do not routinely cover any contraceptive method.[1]

Although 97 percent of large-group plans provide prescription drug coverage, only 33 percent cover oral contraceptives.[2] Two-thirds of the plans covering prescription drugs fail to cover oral contraceptives.

Ninety-two percent of typical large-group insurance plans routinely cover medical devices in general, but only 15 percent include coverage for diaphragms, 18 percent cover IUDs, and 24 percent cover Norplant.[3]

Federal employees are not guaranteed comprehensive coverage

At the federal level, non-military employees are eligible to receive health insurance under the Federal Employees Health Benefits Act ("FEHBA"),[4] the single largest insurance program in the country.

Because the federal government contracts with private insurance companies, some of the health plans offered to federal workers and their dependents do not include coverage for all FDA-approved prescription contraceptive drugs and devices or medical services related to contraception.

State and municipal employees may not have coverage for the full range of contraception

In many states, plan administrators select the benefits offered to government workers and do not always provide comprehensive contraceptive care. For some state and municipal employees, benefits are determined by statutes or regulations or though collective bargaining agreements, all of which may limit or exclude contraception.

Members of the military are denied certain contraceptives

Members of the uniformed services and their dependents, including those stationed at overseas military bases, are eligible to receive health insurance through the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS").[5]

Regulations governing CHAMPUS do not cover all FDA-approved prescription contraceptive drugs and devices or medical services related to contraception. For example, Norplant insertion and removal, cervical caps,

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The Facts About Public Funding of Family Planning

Increasing access to contraception is good medicine and good public policy

Public funding to increase access to contraception, including sterilization and FDA-approved prescription contraceptive drugs and devices,[1] helps:

- prevent many unintended pregnancies;
- provide an avenue for prevention, detection, and treatment of sexually transmitted infections,[2] and
- reduce rates of infant mortality and low-birth weight infants.[3]

Each year, approximately 60 percent of the 6.3 million pregnancies that occur in the United States (roughly 3.5 million pregnancies) are unintended.[4] A little more than half of all unintended pregnancies results in abortion.[5]

Nearly 12 million women and men in this country are affected by sexually transmitted infections (STIs) annually.[6] Detection and early treatment of STIs are essential to stemming the epidemic of such infections and reducing related medical complications.

The United States has alarmingly high infant mortality and low-birthweight rates,[7] both of which are associated with unintended pregnancy.[8]

The rate of "infant mortality could be reduced by an estimated 10 percent" if "all pregnancies were planned."[9] Elimination of unplanned pregnancy could also reduce the number of low-birthweight infants by 12 percent.[10]

Public funding for contraceptive care is cost-effective

A 1996 study concluded that every tax dollar spent for contraceptive services saves an average of $3.00 in Medicaid funds alone that would have been spent providing care to pregnant women and newborns.[11]

In 1987, had there been no public-sector expenditures for contraceptive services, expenses associated with unintended births and abortions would have cost the federal and state governments an additional $1.2 billion in Medicaid funds.[12]

Public funding for family planning services is insufficient to meet the needs of low-income women and the uninsured

Almost one in four of the 21 million women in the United States who use some form of reversible contraception rely on public funds for their contraceptive care.[13]

Each year, publicly funded family planning helps 1.3 million women avoid unintended pregnancy.[14] If not prevented, 533,800 of these pregnancies would result in unintended births and 632,300 would be terminated by abortion.[15]

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The Facts About U.S. Funding for International Family Planning

Funding for international family planning benefits families

U.S. funding for international family planning programs enables women and men to exercise a basic human right: the right to choose the number and spacing of their children.

For over 30 years, the U.S. has been essential to international family planning efforts, providing services to families in 60 countries.[1]

When women lack reproductive health services, children and their mothers die:

- Seven million infants die annually because their mothers were not physiologically ready for childbirth or lacked obstetric care.[2] One in five infant deaths could be averted by birthspacing alone.[3]
- Approximately 585,000 women die each year from causes related to pregnancy and childbirth, rendering at least one million children motherless each year. An additional 18 million women suffer from serious maternity-related disabilities.[4]

Funding for international family planning is good health policy

The U.S. population assistance program supports:

- maternal and child health;
- breastfeeding initiatives;
- the provision of basic health information and services for youth;
- the prevention of sexually transmitted infections, including HIV/AIDS;
- the reduction of female genital mutilation;
- improvement of women's status; and
- environmental health.[5]

Modern contraceptive use in low-income countries has risen from under 10 percent in the 1960s to 35 percent today, helping to reduce high-risk pregnancies and abortions and saving the lives of hundreds of thousands of women.[6]

In countries as diverse as the Central Asian Republic, Colombia, Mexico, and Russia, studies have documented that increased contraceptive use reduces abortions.[7] According to the World Health Organization, 50 million women have abortions each year, half of them illegal. Seventy-five thousand women die annually from self-induced or unsafe abortions.[8]

Funding for international family planning is sound foreign policy

International family planning programs promote the health and well-being of families, which is related to a number of essential foreign policy goals, including:

- worldwide recognition of basic human rights, including the right to achieve the highest standard of health; and

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financial support from the U.S. is crucial if UNFPA is to continue to provide much-needed reproductive health services in underserved regions of the world.

- UNFPA is being targeted because it has provided limited support to family planning programs in the People's Republic of China. There is no evidence of complicity by UNFPA in China's coercive population practices. The international agency's global programs should not be held hostage to the conduct of the Chinese government.

Endnotes

1. U.S. Agency For International Development, *The Impact of Delaying USAID Population Funding from March to July 1997* 5 (Jan. 1997) (hereinafter referred to as *The Impact of Delaying*).
2. The Rockefeller Foundation, *High Stakes: The United States, Global Population and Our Common Future* 8 (1997) (citing World Bank, *Population and Development: Implications for the World Bank* (1994)) (hereinafter referred to as *High Stakes*).
3. The Alan Guttmacher Institute, *Issues in Brief, A Response to Concerns about Population Assistance* 4 (1997) (hereinafter referred to as *A Response to Concerns*).
4. *High Stakes*, at 8 (citing UNICEF, *The Progress of Nations 1996* (1996)); The Alan Guttmacher Institute, *Issues in Brief, Endangered: U.S. Aid for Family Planning Overseas* 2 (1996) (hereinafter referred to as *Endangered*).
5. *A Response to Concerns*, at 1; *The Impact of Delaying*, at 4.
6. *The Impact of Delaying*, at 6 ("developing" countries reviewed excludes China); High Stakes, at 5 (citing 50 percent contraceptive prevalence in "developing" countries, including China).
7. *The Impact of Delaying*, at 6.
8. *High Stakes*, at 8.
9. *Id.* at 4.
10. *A Response to Concerns*, at 6.
11. *The Impact of Delaying*, at 6.
12. *A Response to Concerns*, at 2.
13. 22 U.S.C. § 2151b (b) & (f) (1994). This provision of the Foreign Assistance Act prohibits the use of funds "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions." *Id.* at § 2151b(f)(1). The provision also prohibits the use of funds "for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations." *Id.* at 2151b(f)(1). In addition, a U.S. Agency for International Development Policy Determination was codified as a regulation barring funding for, *inter alia*, "information, training, or communication programs that seek to promote abortion as a method of family planning." 48 C.F.R. 752.7016(b) (1996).
14. 22 U.S.C. § 2151b(b) & (f).
15. Letter from Mark O. Hatfield, U.S. Senator, to The Hon. Christopher H. Smith, U.S. Representative (Sept. 24, 1996) (on file with The Center for Reproductive Law and Policy).
16. *High Stakes*, at 24-25.
17. *Endangered*, at 2.
18. Population Crisis Committee, *Impact of the Mexico City Policy on Family Planning Programs and Reproductive Health Care in Developing Countries, Major Findings* 4-5 (1988).
19. *The Impact of Delaying*, at 8-9.
20. Cynthia P. Green, *Profiles of UN Organizations Working in Population* 20 (Population Action International, 1996).
21. *Id.* at 20-21.

F.U: Women's Issues-Contraceptive Sec / Nicole —
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Elena

C · R · L · P

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MEMORANDUM

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TO: Elena Kagan, *Deputy Assitant to the President – Domestic Policy*

FROM: Kathryn Kolbert and Julie Kay

DATE: May 28, 1997

RE: ***Title VII Challenge to Denial of Contraceptive Coverage***

I. Introduction

Despite nearly universal prescription drug coverage, employer-sponsored group health insurance policies deny women the full range of contraceptive coverage. According to the Alan Guttmacher Institute, "67% of women of reproductive age rely on private, employment-related [health insurance] coverage, obtained through either their own employer or a family member's employer." Alan Guttmacher Institute, UNEVEN & UNEQUAL at 4. Of typical large-group plans, 97% offer prescription drug coverage. Among these plans, however, 49% do not routinely cover any contraceptive method, and only 15% cover all five reversible contraceptive methods (IUD insertion, diaphragm fitting, Norplant insertion, Depo-Provera injection and oral contraception). *Id.* at 12. Many policies specifically

exclude coverage for contraceptives even if they are prescribed for a medical condition other than birth control. [1]

In contrast, employer-sponsored plans offer full coverage for drugs and devices needed only by men. For example, most insurance policies provide coverage for drugs to treat prostatic, penile, testicular or urogenital diseases. Insurance policies routinely cover medication for male impotence, including urethral creams, interpenile suppositories, oral medication to enable a sustained erection, injection therapy, and vacuum or other medical devices. This coverage, the cost of which exceeds the cost of contraceptive coverage, is provided whether or not a male patient seeks treatment for fertility related purposes.

As a result of this unequal coverage, women pay substantially more than men for their health care. The National Family Planning and Reproductive Health Association estimates that women spend approximately 68% more in out of pocket health care costs than men do, largely attributed to the denial of coverage of oral contraceptives. NFPRHA REPORT (Mar. 28, 1997) at 5. [2]

This memorandum considers the possibility of a challenge, under Title VII of the Civil Rights Act, to employment related health plans that provide full coverage for prescription drugs and devices for men, including drugs and devices needed only by men, while excluding available forms of prescription contraceptives that are needed only by women. A Title VII claim would argue that denial of contraceptive coverage is unlawful sex discrimination. An employer-sponsored plan that denies only women full coverage of prescription drugs and devices, and thus

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[1] For example, one HMO excludes coverage for "[b]irth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control," unless coverage is provided under a rider or attachment to the standard plan. *Welcome to Oxford* (Oxford Health Plans, Norwalk, CT) Jan. 1997, at 15.

[2] Hawaii is the only state with a statutory requirement that any employer-sponsored policy, contract, plan or agreement that provides prescription drug coverage "shall not exclude any FDA-approved prescriptive contraceptive

forces women to pay more for their health care benefits than their male co-workers, treats individual employees "in a manner which but for that person's sex would be different." Because the ability to become pregnant belongs exclusively to women, the discrimination is *per se* sex-based. But even if these policies are not found facially discriminatory, the denial of prescription contraceptive coverage clearly has a disparate impact on women. Indeed, 100% of the impact falls upon women. Moreover, a plan that denies prescriptive contraceptive coverage also would violate the Pregnancy Discrimination Act ("PDA") because the failure to provide prescription contraceptives for the prevention of pregnancy is discrimination based on "pregnancy" or a "pregnancy-related medical condition" as defined by the PDA.

As discussed more fully below, we have found no cases that specifically address these issues. Nevertheless, there is a strong argument that employer-sponsored plans that fail to provide the full range of contraceptive coverage for women, while otherwise covering prescription medications and devices for men, discriminate on the basis of "sex," "pregnancy," and "a pregnancy related condition" in violation of Title VII and the PDA. Not only are these claims supported by the language of Title VII and the PDA, they are consistent with the Acts' overall remedial purpose of eradicating gender-based discrimination.

Further, none of the defenses allowable under Title VII could justify this discrimination. Employer-sponsored health plans that exclude prescription contraceptives cannot be justified by the Equal Pay Act exemptions, by the fact that policies covering contraception are not available from insurers, or by the high cost of providing coverage. Lastly, employers may not raise religious objections to the provision of contraceptive coverage. A religious exemption is available only for those employees who are specifically hired to "carry out the employer's religious activities."

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drug or device, or impose any unusual co-payment, charge, or waiting requirement for such drug or device."

II. Denial of Comprehensive Prescription Contraceptive Coverage is Sex-Based Discrimination Prohibited by Title VII

Title VII makes it unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U.S.C. § 2000e-2(a)(1). This provision applies to the benefits an employer provides its employees, including health insurance coverage, because "[h]ealth insurance and other fringe benefits are 'compensation, terms, conditions, or privileges of employment.'" *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 667, 682 (1983) (quoting 42 U.S.C. § 2000e-2(a)(1)); *see generally Arizona Governing Committee v. Norris*, 463 U.S. 1073 (1983) (there is "no question" that a deferred compensation plan constitutes a condition or privilege of employment, and retirement benefits are compensation under Title VII).

The test of whether a plan discriminates on the basis of gender is whether it treats an employee "in a manner which but for that person's sex would be different." *Newport News*, 462 U.S. at 683 (holding that a pregnancy limitation in employer's health insurance plan discriminates against male employees by providing only limited coverage for their spouses while providing female employees with full coverage); *see also International Union, UAW v. Johnson Controls*, 499 U.S. 187, 200 (1991) (employer's policy of excluding women from certain jobs because of concern for a potential fetus the employee might conceive discriminatorily treats women in a manner which but for the person's sex would be different). As the Court in *Newport News* explained, "a plan that provided complete hospitalization coverage for the spouses of female employees but did not cover spouses of male employees when they had

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Haw.Rev.Stat. § 431:10A-116.6 (1996).

broken bones would violate Title VII by discriminating against male employees." *Newport News*, 462 U.S. at 683.[3]

In *City of Los Angeles, Dept. Of Water v. Manhart*, 435 U.S. 702, 711 (1978), the Supreme Court held that an employer "had violated Title VII by requiring its female employees to make larger contributions to a pension fund than male employees in order to obtain the same monthly benefits upon retirement." *Norris*, 463 U.S. at 1080 (summarizing its holding in *Manhart*, 435 U.S. 702). The *Manhart* Court rejected the employer's argument that its policy of exacting different pension fund contributions from men and women was based on a longevity factor, rather than on sex. *Id.* The Court found no evidence that the defendant had considered any factor other than sex in calculating an increased charge of over 14% for women, and stated that:

> One cannot say that an actuarial distinction based entirely on sex is based on any other factor other than sex. Sex is exactly what it is based on.

Id. at 1080-81 (quoting *Manhart*, 435 U.S. at 712-13 (quotations omitted)).

Similarly, in *Norris*, the Supreme Court ruled that the state's voluntary pension plan discriminated against women by providing benefits (structured by several outside companies) that paid lower monthly retirement benefits to women than to men who had made identical contributions. *Id.* at 1081. The Court found that the companies participating in the plan had used sex-based mortality tables to calculate monthly retirement benefits, based on the fact that women on average live longer than men, but had not incorporated any other factors correlating with longevity. *Id.* at 1077. The Court found that this distinction was discriminatory:

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[3] At issue in *Newport News* was whether an employer's plan that limited pregnancy-related benefits for male employees' wives, while providing full coverage for all other medical conditions requiring hospitalization, discriminated against male employees by giving their dependents less coverage than that provided to the dependents of female employees. The Court found that the defendant employer's plan was unlawful because it provided "limited pregnancy-related benefits for employees' wives, and afford[ed] more extensive coverage for employees' spouses for all other medical conditions requiring hospitalization." 462 U.S. at 673. Although *Newport News*

> We have no hesitation in holding . . . that the classification of employees on the basis of sex is no more permissible at the payout stage of a retirement plan than at the pay-in stage.

Id. at 1081. The Court concluded that "it is just as much discrimination 'because of . . . sex' to pay a woman lower benefits when she has made the same contributions as a man as it is to make her pay larger contributions to obtain the same benefits." *Id.* at 1086.

In addition to prohibiting *per se* gender-based qualifications, Title VII prohibits employment practices that have a disparate impact on one gender. To establish a prima facie case of disparate impact, a plaintiff must show that the challenged employment practices " in fact fall more harshly on one group than another without justification." *Krauel v. Iowa Methodist Medical Center*, 95 F.3d 674, 681 (8th Cir. 1996) (quotations omitted). The plaintiff must offer "statistical evidence of a kind and degree sufficient to show that the practice in question has caused the exclusion of benefits because the beneficiaries would be women." *Id.* (quotations omitted); *see also Lorance v. AT & T Technologies, Inc.*, 490 U.S. 900, 913 (1989) (If adopted with an unlawful discriminatory motive, a facially neutral seniority system may be challenged at the time it is adopted); *see also Connecticut v. Teal*, 457 U.S. 440, 453 (1982) (employer liable for discrimination unless it can demonstrate that the employment examination measured job-related skills and was not just an arbitrary, artificial barrier to exclude minority candidates).

Because only women are deprived of prescription contraceptive coverage, and thus these policies facially discriminate against women, it should not be necessary to demonstrate that the policy has a disparate effect on women. Nevertheless, given that only women use prescription contraceptives, and that they pay significantly more out-of-pocket health care costs than men, the disparate effect would not be difficult to prove.

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concerned coverage provided to employees' spouses, the Court held that discriminatory coverage constituted discrimination against the employees themselves.

Health care plans that deny coverage for oral contraceptives for female employees, while providing coverage for all other pharmaceuticals, essentially provide male employees with a full range of prescription medications and devices while female employees' coverage is limited. This constitutes unlawful employment discrimination. As the Supreme Court has recognized:

> In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.

County of Washington v. Gunther, 452 U.S. 177, 181 (1981) (citation omitted). Providing health benefits in a discriminatory manner is well within the "spectrum of disparate treatment" that Title VII seeks to remedy.

III. Denial of Comprehensive Contraceptive Coverage is Discrimination Based on "Pregnancy" and "Pregnancy-Related Medical Conditions"

Employer-sponsored plans that deny contraceptive coverage for female employees while providing male employees with comprehensive prescription coverage violate the Pregnancy Discrimination Act as well as Title VII. In 1976, in *General Electric v. Gilbert*, 429 U.S. 125 (1976), the Supreme Court ruled that an employer's disability plan that excluded pregnancy coverage did not discriminate under Title VII against female employees because of their sex. The Court based its ruling on its earlier opinion in *Geduldig* v. *Aiello*, 417 U.S. 484 (1974), that had refused to invalidate under the Equal Protection Clause of the Fourteenth Amendment an employer-sponsored policy that excluded coverage for maternity care. *Gilbert*, 429 U.S. at 134-35. The Court found that discrimination on the basis of pregnancy was not sex-based discrimination, rather it was merely a distinction drawn between "pregnant persons and non-pregnant persons." *Id.* at 133 (quoting *Geduldig*, 417 U.S. at 496-97 n.20).

In 1978, after rejection of the Supreme Court's rationale by the public, legal scholars and state courts,[4] Congress enacted the Pregnancy Discrimination Act ("PDA"), to clarify that the definition of sex discrimination under Title VII includes discrimination based on "pregnancy, childbirth, or related medical conditions." 42 U.S.C. 2000e-(k). In enacting the PDA, Congress recognized the discriminatory effect of providing greater health benefits for men while denying full coverage for women's unique physical needs:

> A woman who is obliged to apply her own income to doctor and hospital bills although male employees are not is obviously earning less for the same work.

Report of Senate Committee on Human Resources, 95-331 at 5. As Congress further recognized in enacting the PDA:

> [T]he overall effect of discrimination against women because they might become pregnant, or do become pregnant, is to relegate women in general, and pregnant women in particular, to a second class status with regard to career advancement and continuity of employment and wages. These practices reach all working women . . .

Cong. Rec. -- Senate (9/15/77) at 29385 (statement of Senator Williams) (emphasis added).[5] In subsequent decisions, the Supreme Court acknowledged that in enacting the PDA, Congress explicitly rejected the premise of *Gilbert*. *See California Federal Savings and Loan Assoc.*, 479

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[4] Many state courts independently rejected the rationale of *Geduldig*. *See, e.g., Preterm Cleveland v. Voinovich*, 89 Ohio App. 3d 684, 713, 627 N.E.2d 570, 589 (1993) ("*Geduldig* has not been accorded much favor in the larger picture of constitutional law. . . It would be an entirely positive development in the law if we reject the *Geduldig* analysis in the present context and treat abortion as a sexual equality issue."); *Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd.*, 41 N.Y.2d 84, 359 N.E.2d 293 (1976) (noting similarity of state Human Rights Law and Title VII but rejecting ruling in *Gilbert* excluding pregnancy and childbirth from coverage.); Cong. Rec. 95-331(1977) (discussing the PDA and noting that "[t]wenty-five States currently interpret their own fair employment practices laws to prohibit sex discrimination based on pregnancy and childbirth . . . Authorities have refused to adopt the approach taken by the Supreme Court in the *Gilbert* case."); *see also* Lex K. Larson, EMPLOYMENT DISCRIMINATION § 41.02 at 47-8 (2d ed. 1996) ("[T]he majority of state courts, interpreting their own state fair employment statutes, were not persuaded by *Gilbert*, and reached the opposite conclusion.").

[5] As Congress recognized: "Women are still subject to the stereotype that all women are marginal workers. Until a woman passes the childbearing age, she is viewed by employers as potentially pregnant. Therefore, the elimination of discrimination based on pregnancy in these employment practices in addition to disability and medical benefits will go a long way toward providing equal employment opportunities for women, the goal of Title VII of the Civil Rights Act of 1964." P.L. 95-555 at 4755.

U.S. 272, 278 n.6, 284 (1987). The Supreme Court stated that "[t]he 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions." *Newport News*, 462 U.S. at 685; *see also* Larson, *supra* at 41-2 ("[I]t would seem that discrimination based on pregnancy should constitute *per se* sex discrimination . . . however . . . it took an act of Congress to make it clear that this was so."). "Therefore, if a fringe benefit of employment is health insurance coverage, and the policy does not provide coverage for pregnancy-related conditions, the health insurance coverage is discriminatory on the basis of sex." *E.E.O.C. v. South Dakota Wheat Growers Ass'n*, 683 F.Supp. 1302, 1304 (D.S.D. 1988). "The entire thrust behind this legislation is to guarantee women the basic right to participate fully and equally in the workforce, without denying them the fundamental right to full participation in family life." *Guerra*, 479 U.S. at 290 (quoting 123 Cong. Rec. 29658 (1977)).

Furthermore, the Supreme Court has held that the PDA's prohibition on pregnancy discrimination applies both to policies that affect pregnant women and those that affect women's ability to become pregnant. A policy that explicitly classifies employees by their potential for pregnancy "[u]nder the PDA must be regarded, for Title VII purposes, in the same light as explicit sex discrimination." *Johnson Controls*, 499 U.S. at 199 (invalidating requirement that women certify that they have been sterilized to retain job with lead exposure).

Interpreting the PDA broadly to prohibit discrimination against a woman because she intends to become pregnant or to prevent pregnancy, or simply because she has the potential to become pregnant, is also consistent with Title VII's remedial purpose. As the Courts of Appeals for both the Fifth and Eleventh Circuits have noted, it is "the duty of the courts to make sure that the Act works, and the intent of Congress is not hampered a combination of a strict construction of the statute in a *battle with semantics*." *Parr v. Woodmen of the World Life Insurance Co.*,

791 F.2d 888, 892 (11th Cir. 1986) (quoting *Culpepper v. Reynolds Metal Co.*, 421 F.2d 888, 891 (5th Cir. 1970) (italics in original)).

This broad interpretation of discrimination against "pregnancy, childbirth, and related medical conditions" is analogous to the broad protection Title VII provides against race and gender discrimination. *See McDonald v. Santa Fe Trail Transp. Co.*, 427 U.S. 273, 278-79 (1976) (Title VII prohibits discrimination against whites as well as blacks because the statute's terms were not limited to discrimination against members of any particular race); *Parr*, 791 F.2d at 888 (white plaintiff could bring a Title VII claim for discrimination based on his interracial marriage even if claim is not based on discrimination because of *his* race); *Nicol v. Imagematrix, Inc.*, 773 F.Supp. 802, 805 (E.D. Va. 1991) (Title VII interracial relationship cases are instructive for plaintiff's PDA claim that he was discriminatorily fired because of his wife's pregnancy); *Pierce v. Marsh*, 706 F.Supp. 673, 676 n.1 (E.D. Ark. 1987) ("Since plaintiff is alleging reverse discrimination in his sex discrimination claim, the fact that he is a male does not preclude recovery."); *Foreman v. Anchorage Equal Rights*, 779 P.2d 1199, 1201 (Alaska 1989) ("discrimination against unmarried couples constitutes discrimination based on marital status").

While no court has specifically addressed the issue of whether the PDA's prohibition of discrimination on the basis of "pregnancy" or "pregnancy-related conditions" expressly encompasses contraception, several decisions interpreting the PDA to protect against discriminatory treatment of fertility services support the view that the act protects women who are treated differently because of their potential for pregnancy. For example, in *Cleese v. Hewlett-Packard Co.*, 911 F. Supp. 1312 (D. Or. 1995), the plaintiff's PDA claim asserted that her employer had discriminated against her after she requested a transfer to avoid working with potentially hazardous chemicals while she was undergoing fertility treatments. *Id.* at 1315. The court noted that "if the employer has the requisite intent to discriminate against an employee

because she is currently pregnant or is planning to become so in the near future, *it does not matter if she has actually physically conceived* at the time of the discrimination." *Id.* at 1318 (emphasis added). The court found that while infertility may be gender-neutral, "the ability to become pregnant clearly is not." *Id.* at 1317. Although *Cleese* involved discrimination resulting from an employee's attempt to become pregnant rather than to prevent its occurrence, the findings that, first, the PDA covers women who are not pregnant and, second, the ability to become pregnant is gender-based support the argument that contraceptive coverage should be included under the PDA.

Similarly, in *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393 (N.D. Ill. 1994), the district court interpreted the PDA as requiring coverage for infertility treatment. The Court reasoned that the PDA requires neutrality towards pregnancy:

> The PDA does not affirmatively instruct employers to treat pregnancy, childbirth, or related medical conditions in any particular way; rather, it instructs employers to treat those things in a neutral way.

Id. at 1400; *see also Johnson Controls*, 499 U.S. at 199. The *Pacourek* court noted that Congress's intent in passing the PDA was to repudiate the theory as well as the holding in *Gilbert*, in an attempt to eradicate pregnancy-based stereotypes that had hampered women's economic development. *Pacourek,* 858 F. Supp. at 1401. The PDA "is to be applied broadly . . . the language is expansive . . . 'Related' is a generous choice of wording, suggesting that interpretation [of "pregnancy related"] should favor inclusion rather than exclusion in the close cases." *Id.* at 1402 (quotations omitted). Interpreting the PDA to include discrimination based on a woman's potential to become pregnant, the district court stated:

> [C]lassifications based on pregnancy and related medical conditions are never gender-neutral. Discrimination against an employee because she intends to, is trying to, or simply has the potential to become pregnant is therefore illegal discrimination. It makes sense to conclude that the PDA was intended to cover a woman's intention or potential to become pregnant, because all that conclusion means is that discrimination against

> a person who intends to or can potentially become pregnant is discrimination against women, which is the kind of truism the PDA wrote into law.

Id. In support of its position, the court cited legislative history that suggested that the PDA protects a woman "*before*, during, and after her pregnancy." *Id.* at 1402 (emphasis in original) (citing statement of Representative Ronald Sarasin, 124 Cong.Rec. 38574 (1978), reprinted in Legislative History of the Pregnancy Discrimination Act of 1978 at 208). The court emphasized that the repeal of *Gilbert* indicated that potential or intended pregnancy is a status protected by Title VII. *Id.* In addition, the *Pacourek* court held that infertility is a pregnancy-related medical condition for purposes of the PDA. *Id.* at 1403. Finding that the PDA included protection for termination of a pregnancy, the court reasoned that the PDA should also include protection for the initiation of a pregnancy. *Id.*

In contrast, in *Krauel v. Iowa Methodist Medical Center*, 95 F.3d. 674 (8th Cir. 1996), the Eighth Circuit rejected plaintiff's claim that denial of coverage for infertility treatments constituted sex discrimination. *Id.* at 679. Although the plaintiff had asserted that a causal connection existed between pregnancy and the medical condition causing her infertility, the court ruled that the PDA's application to "pregnancy" and "related medical conditions" was not intended to encompass infertility. *Id.* The court reasoned that infertility is "gender neutral" because both men and women can be infertile, and the defendant employer's policy had denied fertility treatments for men as well as for women. *Id.* at 680.[6] The court stated that:

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[6] Although the plaintiff had asserted that the policy constituted intentional sex discrimination, the court found that the plaintiff had failed to present sufficient evidence of defendant's discriminatory intent. Similarly, while plaintiff argued that the policy disparately impacted female employees because women are more likely to undergo fertility treatment even if their male partner is infertile, and that women bear the larger portion of the costs for these treatments, the court found that the plaintiff had failed to offer meaningful statistical evidence on these points and, therefore, had failed to establish a prima facie case of disparate impact. *Krauel*, 95 F.3d at 681. In contrast, as outlined above, as to contraception coverage, we will have no difficulty establishing a case of disparate impact. Most, if not all, insurance plans only deny full contraceptive coverage for women since such devices and prescriptive drugs are not yet available for men.

> The plain language of the PDA does not suggest that "related medical conditions" should be extended to apply outside the context of "pregnancy" and "childbirth." Pregnancy and childbirth, which occur after conception, are strikingly different from infertility, which prevents conception.

Id.[7]

Although the court found that the PDA did not prohibit the employer's policy denying coverage for infertility treatment, it distinguished "potential pregnancy" from infertility. The court stated that "[p]otential pregnancy, unlike infertility, is a medical condition that is sex-related because only women can become pregnant." *Id.* at 680 (distinguishing its ruling from the Supreme Court's holding in *Johnson Controls*). Similarly, the benefits and the burdens of whether pregnancy occurs or is successfully prevented fall entirely upon women.[8]

The PDA's prohibition of discrimination against women for having an abortion further demonstrates that the ability to "prevent" pregnancy is sex-based. EEOC guidelines state that an employer "may not discharge, refuse to hire or otherwise discriminate against a woman because she has had or is contemplating having an abortion." 29 C.F.R. Part 1604 Appendix. In *Turic v. Holland Hospitality*, 85 F.3d 1211 (6th Cir. 1996), the court interpreted the PDA to protect from

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[7] Other courts have rejected expanded interpretations of the PDA to include the following as pregnancy-related medical conditions: menstrual cramps, *Jirak v. Federal Express Corp.*, 805 F. Supp. 193 (S.D.N.Y. 1992), care of a newborn, *Barnes v. Hewlett-Packard*, 846 F. Supp. 442 (D.Md. 1994), and breast-feeding, *Wallace v. Pyro Mining Co.*, 789 F. Supp. 867 (W.D. Ky. 1990), *aff'd without opinion*, 951 F.2d 351 (6th Cir. 1991); *Brinkman v. Kansas Dep't. of Corrections*, 66 F.E.P. 214 (D. Kan. 1994) (plaintiff offered no evidence that pain in her knees and ankles, which began during pregnancy and continued to impair her job performance, was a condition related to her pregnancy). *See also* Larson, *supra* § 47.04 at 47-12.

[8] The court also rejected plaintiff's claim that denial of fertility coverage violated the Americans with Disabilities Act. *Krauel*, 95 F.3d at 677 (discussing 42 U.S.C. § 12112 (1994)). The court ruled that "reproduction and caring for others are not among the examples of listed activities" within the ADA. *Id.* The First Circuit in *Abbott v. Bragdon*, however, reached the opposite conclusion, finding that under the ADA:

> Reproduction (and the bundle of activities that it encompasses) constitutes a major life activity because of its singular importance to those who engage in it, both in terms of its significance in their lives and in terms of its relation to their day-to-day existence.

1997 U.S. App. LEXIS 3870 (1st Cir. 1997) at *16 (finding that the denial of plaintiff's HIV positive status constituted a disability under the ADA because it substantially limited plaintiff's participation in the major life activity of reproduction). Thus, the First Circuit's opinion, offering a broad interpretation of the ADA to include potential pregnancy, supports the broad interpretation of the PDA necessary here.

discrimination an employee who merely contemplated having an abortion, which precipitated a controversy among other employees. The court interpreted the PDA expansively, holding that:

> A woman's right to have an abortion encompasses more than simply the act of having an abortion; it includes the contemplation of an abortion as well. Since an employer cannot take adverse employment action against a female employee for her decision to have an abortion, it follows that the same employer also cannot take adverse employment action against a female employee for merely thinking about what she has a right to do.

Id. at 1214. Thus, the courts have interpreted the protections offered by the PDA broadly, and have included protection for employees who exercise their right to an abortion as well as to those who merely contemplate exercising this right. Since the PDA prohibits discrimination against a a woman for having an abortion, *a fortiori*, it prohibits discrimination against a woman for preventing pregnancy.

The exclusion of abortion *coverage* from the PDA similarly indicates that Congress did not intend to exclude contraceptive coverage from the Act. The PDA specifically states:

> This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided*, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

42 U.S.C. § 2000e(k) (italics in original).

The abortion coverage exclusion was inserted to allay the concerns of members of Congress that abortion coverage would be mandated by the PDA. P.L. 95-555 at 7 ("Many members of the committee were troubled, however, by any implication that an employer would have to *pay* for abortions . . .") (italics in original). In opposing the abortion exclusion, Representative Weiss noted that:

> The discriminatory aspect of the anti-abortion language is obvious: Male employees--regardless of whether they have contributed to their health plans or not--would be covered for all surgical procedures; female employees--even if there is no employer contribution--would be subject to

> employer discretion concerning coverage for abortion. The discriminatory aspect could not be more blatant.

Id. at 4762. The language of this provision -- specifically exempting coverage of all but life saving abortions and abortion complications -- demonstrates that discriminatory exclusion of abortion would have been within Title VII's protection had no explicit exclusion been placed in the Act. Although Congress voted to specifically exclude employer-sponsored abortion benefits from protection, there is no comparable exclusion for contraceptive coverage in the statute. The absence of such an exclusion further suggests that Congress intended the PDA to mandate the coverage of these benefits. *See Freightliner Corp. v. Myrick*, 115 S. Ct. 1483, 1488 (1995) (discussing "the familiar principle of *expressio unius est exclusio alterius:* Congress' enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted."); SUTHERLAND STAT. CONST. § 47.23 at 217 (5th ed. 1992) ("The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded.").

IV. None of the Defenses Available Under the Act are Sufficient to Justify Denial of Contraceptive Coverage

Although Title VII contains several defenses to discrimination, none of these justify the denial of contraceptive coverage by employers who otherwise provide prescription drug coverage. Providing employee benefits to only one gender "constitutes discrimination and is unlawful unless exempted by the Equal Pay Act of 1963 or some other justification." *Manhart*, 435 U.S. at 711. "The Equal Pay Act requires employers to pay members of both sexes the same wages for equivalent work, except when the differential is based on a seniority system, a merit system, or a system that measures earnings by quantity or quality of production. 29 U.S.C. §206(d). However, none of these exceptions apply to the denial of contraceptive coverage. The Equal Pay Act also permits the employer to justify discriminatory provision of benefits if based

on neutral factor "other than sex." *Manhart*, 435 U.S. at 711-12. While an employer arguably could claim it denies all prescription medications to employees with conditions related to a unique physical characteristic, the fact that the suspect plans provide medications for male-only conditions and other female-only conditions belies this argument.[9] Any claims by an employer that it refuses coverage because contraceptive medications are preventive in nature is equally without merit. Many covered medications -- for high blood pressure, diabetes, asthma, or allergies -- are "preventive" in nature and yet are fully covered by employers' plans.[10]

Moreover, employers cannot avoid a finding of discrimination because they are unable to find a third-party insurer to provide coverage. In *Norris*, the Supreme Court stated clearly that an employer may be held liable for discrimination even if the policy is structured by a third party insurer. "Since employers are ultimately responsible for the 'compensation, terms, conditions, and privileges of employment'... the employer that adopts a fringe-benefit scheme that discriminates among its employees on the basis of race, religion, sex, or national origin violates Title VII regardless of whether third parties are also involved in the discrimination." *Norris*, 463 U.S. at 1089 (citations omitted). In fact, the Court specifically found it "inconsistent with the broad remedial purposes of Title VII to hold that an employer who adopts a discriminatory fringe-benefit plan can avoid liability on the ground that he could not find a third party willing to treat his employees on a nondiscriminatory basis." *Id.* at 1090-91.

Similarly, employers cannot avoid liability for a discriminatory practice merely because providing the benefit imposes an additional cost upon them. In some instances, because the

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[9] For example, most plans provide coverage for women for childbirth and for estrogen therapy, and for male impotency.

[10] Further, an employer that is paying a wage rate differential in violation of the Equal Pay Act may not reduce the wage of any employee in order to comply with the Act. 29 U.S.C. § 206(d); *see also Manhart*, 435 U.S at 712 n.23. This prohibition would preclude an employer from curtailing all coverage for prescription drugs and devices, male-only coverage or preventative medications in response to a court requirement that health care benefits include full prescription contraceptive coverage.

employee shares the cost of health insurance, any new cost burden will be borne partially by the employee. But even when the employer bears the full expense, additional cost cannot justify ongoing discrimination. *See Norris*, 463 U.S. at 1084-85 n.14 ("Congress' decision to forbid special treatment of pregnancy despite the special costs associated therewith provides further support for our conclusion in *Manhart* that the greater costs of providing retirement benefits for female employees does not justify the use of a sex-based retirement plan."). The *Norris* Court noted that by enacting the PDA "Congress recognized that requiring employers to cover pregnancy on the same terms as other disabilities would add approximately $200 million to their total costs. Nevertheless it concluded that the PDA was necessary 'to clarify the original intent' of Title VII." *Id.* (quotation omitted). Although the cost differential of providing complete health insurance coverage for employees "may properly be analyzed in passing on the constitutionality of a State's health insurance plan, no such justification is recognized under Title VII once discrimination has been shown." *Newport News*, 462 U.S. at 685 n.26.[11]

Some employers, particularly religious-based hospitals or universities, may try to assert religious objections to providing contraceptive coverage. It is unlikely, however, that this defense would succeed. Title VII does not apply "to a religious corporation, association, educational institution, or society with respect to the employment of individuals of a particular

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[11] Any claim that provision of prescription contraceptives will significantly increase costs may well be overstated. The Alan Guttmacher Institute does not have data on the actual cost to employers or insurers of providing the full range of contraceptives. However, in a 1996 memo to the California Assembly Insurance Committee, submitted in opposition to the state's proposed legislation to mandate coverage for contraceptives in prescription drug plans, the Health Insurance Association of America estimated that the average increase in per employee cost would be $16.20 per annum." Memorandum to Members of the Assembly Insurance Committee from Chris Michel of Carpenter Snodgrass and Associates on behalf of the Health Insurance Association of America (April 2, 1996) ("HIAA Memo"). HIAA estimates that providing coverage for oral contraceptives, calculated at an average of $25 per month with a $5 co-payment, would cost $1.35 per month per employee, assuming that 45% of covered employees are female and that 15% of female employees will use the benefit. *Id.*

Similarly, the Virginia Bureau of Insurance estimates that "contraceptive coverage would cost group insurance holders 'between six cents and $3.90 a month' and individual policies would rise 'between 82 cents and $1.50 a month." *Women Lobby for Coverage of Birth Control*, American Political Network, Inc., Health Line (Aug. 22, 1996).

religion to perform work connected with the carrying on by such corporation, association, educational institution, or society of its activities." 42 U.S.C. § 2000e-1(a). The religious exemption provision, however, was interpreted narrowly in *E.E.O.C. v. Freemont Christian School*, 781 F.2d 1362, 1366 (9th Cir. 1986), where the Ninth Circuit invalidated a health insurance benefit plan that, because of a religious belief that the male was the head of household, provided benefits only to single persons and married men. The court found that this policy did not fit within Title VII's narrow religious exemption. *Id.* The court emphasized that Title VII exempts religious employers "only with respect to discrimination based on religion, and then only with respect to persons hired to carry out the employer's 'religious activities.'" *Id.* (quotations omitted). Broad religious exemptions for the majority of employees thus are impermissible because most employees of religious-based institutions are not hired to carry out religious activities.

Nor is it clear that the provision of prescription contraception *burdens* a central tenet of an employer's faith. Recently, the Ninth Circuit rejected a Religious Freedom Restoration Act claim by students who asserted that their religious beliefs prevented them from financially contributing to abortion services provided by their university's health care services. *Goehring v. Brophy*, 94 F.3d 1294 (9th Cir. 1996), *cert. denied,* 65 U.S.L.W. 3665 (U.S. 1997). The Court held, that the students' payments, made through student registration fee subsidies, did not impose a substantial burden on a central tenet of their religion as required by the Religious Freedom Restoration Act of 1993. *Id.* at 1300; *see also St. Agnes Hospital of City of Riddick v. Baltimore*, 748 F. Supp. 319 (D. Md. 1990) (denial of hospital accreditation for refusal to provide abortion training did not violate hospital's religious freedom).

V. Summary

The denial of prescription contraceptive coverage by employer-sponsored health plans that offer prescription coverage for other drugs and devices discriminates against women in violation of Title VII. But for a female employee's sex, her employer would provide her with complete coverage for prescription drugs and devices. As a result, women either pay large out of pocket costs for prescription contraceptives or risk unplanned pregnancy, and continue to be confronted with gender stereotypes that Title VII and the PDA were designed to eradicate.

Although courts have not yet specifically addressed whether denial of contraceptive coverage is a "pregnancy" or "pregnancy-related" condition under the PDA, case law addressing the denial of fertility treatment supports such an interpretation. In addition, the specific exclusion of some abortion coverage under the PDA supports the view that contraceptive coverage was not intended to be excluded from Title VII protections.

None of the defenses -- not those of cost, religion or neutral non-sex-based justifications -- absolve employers from liability for this discriminatory treatment. As a result, a challenge that denial of contraceptive coverage violates both Title VII and the PDA would require only a minor extension of existing federal case law and appears an entirely feasible, as well as timely, opportunity to eradicate this form of gender discrimination.

Fil-Women's Issues-Contraceptive

Sen/Nicole -
FYI.
Elena
II

105TH CONGRESS
1ST SESSION

S. 766

To require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

IN THE SENATE OF THE UNITED STATES

MAY 20, 1997

Ms. SNOWE (for herself, Mr. REID, Mr. WARNER, Ms. MIKULSKI, Mr. CHAFEE, Mr. DURBIN, Ms. COLLINS, Mrs. MURRAY, and Mr. JEFFORDS) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Equity in Prescription Insurance and Contraceptive Coverage Act of 1997".

SEC. 2. FINDINGS.

Congress finds that—

(1) each year, approximately 3,600,000 pregnancies, or nearly 60 percent of all pregnancies, in this country are unintended;

(2) contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancy;

(3) studies show that contraceptives are cost effective: for every $1 of public funds invested in family planning, $4 to $14 of public funds is saved in pregnancy and health care-related costs;

(4) by reducing rates of unintended pregnancy, contraceptives help reduce the need for abortion;

(5) unintended pregnancies lead to higher rates of infant mortality, low-birth weight, and maternal morbidity, and threaten the economic viability of families;

(6) the National Commission to Prevent Infant Mortality determined that "infant mortality could be reduced by 10 percent if all women not desiring pregnancy used contraception";

(7) most women in the United States, including two-thirds of women of childbearing age, rely on some form of private employment-related insurance

(through either their own employer or a family member's employer) to defray their medical expenses;

(8) the vast majority of private insurers cover prescription drugs, but many exclude coverage for prescription contraceptives;

(9) private insurance provides extremely limited coverage of contraceptives: half of traditional indemnity plans and preferred provider organizations, 20 percent of point-of-service networks, and 7 percent of health maintenance organizations cover no contraceptive methods other than sterilization;

(10) women of reproductive age spend 68 percent more than men on out-of-pocket health care costs, with contraceptives and reproductive health care services accounting for much of the difference;

(11) the lack of contraceptive coverage in health insurance places many effective forms of contraceptives beyond the financial reach of many women, leading to unintended pregnancies; and

(12) the Institute of Medicine Committee on Unintended Pregnancy recently recommended that "financial barriers to contraception be reduced by increasing the proportion of all health insurance policies that cover contraceptive services and supplies".

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a) of the Newborns' and Mothers' Health Protection Act of 1996 and amended by section 702(a) of the Mental Health Parity Act of 1996) is further amended by adding at the end the following new section:

"SEC. 713. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

"(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) exclude or restrict benefits for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, if such plan provides benefits for other outpatient prescription drugs or devices; or

"(2) exclude or restrict benefits for outpatient contraceptive services if such plan provides benefits for other outpatient services provided by a health care professional (referred to in this section as 'outpatient health care services').

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan because of the individual's or enrollee's use or potential use of items or services that are covered in accordance with the requirements of this section;

"(2) provide monetary payments or rebates to a covered individual to encourage such individual to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribed contraceptive drugs or devices, or provided contraceptive services, described in subsection (a), in accordance with this section; or

"(4) provide incentives (monetary or otherwise) to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services, described in subsection (a).

"(c) RULES OF CONSTRUCTION.—

"(1) IN GENERAL.—Nothing in this section shall be construed—

"(A) as preventing a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan from imposing deductibles, coinsurance, or other cost-sharing or limitations in relation to—

"(i) benefits for contraceptive drugs under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such drug may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription drug otherwise covered under the plan;

"(ii) benefits for contraceptive devices under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such device may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription device otherwise covered under the plan; and

"(iii) benefits for outpatient contraceptive services under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such service may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient health care service otherwise covered under the plan; and

"(B) as requiring a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, described in subsection (a), except to the extent that the plan or issuer provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

"(2) LIMITATIONS.—As used in paragraph (1), the term 'limitation' includes—

"(A) in the case of a contraceptive drug or device, restricting the type of health care pro-

fessionals that may prescribe such drugs or devices, utilization review provisions, and limits on the volume of prescription drugs or devices that may be obtained on the basis of a single consultation with a professional; or

"(B) in the case of an outpatient contraceptive service, restricting the type of health care professionals that may provide such services, utilization review provisions, requirements relating to second opinions prior to the coverage of such services, and requirements relating to preauthorizations prior to the coverage of such services.

"(d) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan, except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

"(e) PREEMPTION.—Nothing in this section shall be construed to preempt any provision of State law to the

extent that such State law establishes, implements, or continues in effect any standard or requirement that provides protections for enrollees that are greater than the protections provided under this section.

"(f) DEFINITION.—In this section, the term 'outpatient contraceptive services' means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, as amended by section 603 of the Newborns' and Mothers' Health Protection Act of 1996 and section 702 of the Mental Health Parity Act of 1996, is amended by inserting after the item relating to section 712 the following new item:

"Sec. 713. Standards relating to benefits for contraceptives.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 1998.

SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a) of the Newborns' and Mothers' Health Protection Act of 1996 and amended by section 703(a) of the

Mental Health Parity Act of 1996) is further amended by adding at the end the following new section:

"SEC. 2706. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

"(a) REQUIREMENTS FOR COVERAGE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) exclude or restrict benefits for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, if such plan provides benefits for other outpatient prescription drugs or devices; or

"(2) exclude or restrict benefits for outpatient contraceptive services if such plan provides benefits for other outpatient services provided by a health care professional (referred to in this section as 'outpatient health care services').

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

"(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan because of the individual's or

enrollee's use or potential use of items or services that are covered in accordance with the requirements of this section;

"(2) provide monetary payments or rebates to a covered individual to encourage such individual to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribed contraceptive drugs or devices, or provided contraceptive services, described in subsection (a), in accordance with this section; or

"(4) provide incentives (monetary or otherwise) to a health care professional to induce such professional to withhold from covered individual contraceptive drugs or devices, or contraceptive services, described in subsection (a).

"(c) RULES OF CONSTRUCTION.—

"(1) IN GENERAL.—Nothing in this section shall be construed—

"(A) as preventing a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan from imposing deductibles, coinsur-

ance, or other cost-sharing or limitations in relation to—

"(i) benefits for contraceptive drugs under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such drug may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription drug otherwise covered under the plan;

"(ii) benefits for contraceptive devices under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such device may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient prescription device otherwise covered under the plan; and

"(iii) benefits for outpatient contraceptive services under the plan, except that such a deductible, coinsurance, or other cost-sharing or limitation for any such service may not be greater than such a deductible, coinsurance, or cost-sharing or limitation for any outpatient health care

service otherwise covered under the plan; and

"(B) as requiring a group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, described in subsection (a), except to the extent that the plan or issuer provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

"(2) LIMITATIONS.—As used in paragraph (1), the term 'limitation' includes—

"(A) in the case of a contraceptive drug or device, restricting the type of health care professionals that may prescribe such drugs or devices, utilization review provisions, and limits on the volume of prescription drugs or devices that may be obtained on the basis of a single consultation with a professional; or

"(B) in the case of an outpatient contraceptive service, restricting the type of health

care professionals that may provide such services, utilization review provisions, requirements relating to second opinions prior to the coverage of such services, and requirements relating to preauthorizations prior to the coverage of such services.

"(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

"(e) PREEMPTION.—Nothing in this section shall be construed to preempt any provision of State law to the extent that such State law establishes, implements, or continues in effect any standard or requirement that provides protections for enrollees that are greater than the protections provided under this section.

"(f) DEFINITION.—In this section, the term 'outpatient contraceptive services' means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

SEC. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—Subpart 3 of part B of title XXVII of the Public Health Service Act (as added by section 605(a) of the Newborn's and Mother's Health Protection Act of 1996) is amended by adding at the end the following new section:

"SEC. 2752. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

"The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998.

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