NLWJC - Kagan
DPC - Box 067 - Folder-013

Women's Issues-Contraception [1]

Women's issues – contraception

March 22, 1999

Mr. John Podesta
Chief of Staff
The White House
1st Floor, West Wing
Washington, D.C. 20502

Dear Mr. Podesta:

As supporters of family planning and equity in women's health care, the undersigned organizations are writing to ask the Administration to continue its long-standing support for both domestic and international family planning by endorsing the "Equity in Prescription Insurance and Contraceptive Coverage Act" (EPICC), a bill to remedy an existing gender inequity in private insurance coverage of contraceptives. The Administration's endorsement of EPICC would be a strong statement in opposition to this discriminatory treatment. It also would build upon the Administration's support last year for this same coverage for federal employees participating in FEBHP – support which was key to its inclusion in the FY 1999 omnibus appropriations bill.

As you are well aware, family planning is basic, preventive health care for American women, and most American women use family planning at some point in their reproductive years. However, many private insurance policies either exclude coverage for prescription contraceptives and related services *entirely* or single out these services for limited coverage. At the same time, almost all of these same policies offer coverage for prescription drugs and devices.

The exclusion of prescription contraceptive coverage makes little sense when the benefits of such services are examined. Timing and spacing births is critical in improving women's and children's health and avoiding unintended pregnancies. Pregnancies that are unintended, spaced too closely together, or occur very early or very late in a woman's reproductive years often have adverse health, social, or economic consequences for both women and children – consequences which can include lower levels of educational and job attainment as well as a greater risk for these families of living in poverty. The use of family planning also increases the likelihood that the estimated 15 million Americans who contract a sexually transmitted disease each year will be diagnosed and treated, and reduces the incidence of unintended pregnancy and abortion. The United States has an extremely high rate of unintended pregnancy compared with other developed countries – approximately half of all pregnancies in our country are unintended and half of these end in abortion. By improving and increasing access to a full range of contraceptive services, women's risk of unintended pregnancy is reduced, as is the rate of abortion.

Despite the myriad health and social benefits associated with contraception, it is the only non-experimental prescription drug benefit that is regularly excluded by insurers. Almost half of all fee-for-service plans and Preferred Provider Organizations (PPOs), 20 percent of Point-of-Service plans (POS), and seven percent of Health Maintenance Organizations (HMOs) **do not offer *any* coverage for reversible contraception**. Of those plans that do offer some coverage for contraception, many

do not cover all five major methods of reversible contraception. Fewer than 20 percent of fee-for-service plans or PPOs and fewer than 40 percent of POS networks and HMOs routinely cover all five major methods – oral contraceptives (OCs), diaphragms, intrauterine devices (IUDs), Norplant, and Depo Provera.

In an important step toward remedying this inequity, family planning advocates in Congress, along with the Administration, succeeded in providing contraceptive coverage to the 1.2 million women of reproductive age participating in the Federal Employees Health Benefits Program, the largest employer sponsored health insurance plan in the world. It is now time to expand this common sense provision to the rest of privately insured Americans – of whom more than eight in ten support contraceptive coverage.

Bipartisan legislation was introduced in 1997 and is about to be reintroduced in the 106th Congress to help remedy this fundamental inequity in health care coverage and to create a level playing field for American women and their families. The Senate bill will be sponsored by Senators Olympia Snowe (R-ME) and Harry Reid (D-NV), while the House bill will be sponsored by Representatives Jim Greenwood (R-PA) and Nita Lowey (D-NY). EPICC would require insurance plans that offer prescription drug coverage to cover prescription contraceptive drugs and devices. Similarly, the measure would require that health plans offering coverage for outpatient medical services also provide coverage for outpatient contraceptive services. The bill defines contraception as "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." Moreover, research indicates that the cost of such coverage would be minimal.

We would like to meet with you at your earliest convenience to discuss the Administration's endorsement of EPICC. Judith DeSarno, the President of NFPRHA, will be happy to serve as the contact point with the groups to set up the meeting. She can be reached at 293-3114.

Thank you for your consideration.

The Alan Guttmacher Institute
American College of Obstetricians and Gynecologists
American Association of University Women
American Nurses Association
Center for Reproductive Law and Policy
National Abortion and Reproductive Rights Action League
National Family Planning and Reproductive Health Association
National Partnership for Women and Families
National Women's Law Center
Planned Parenthood Federation of America

cc:

Monica Dixon, Deputy Chief of Staff, Office of the Vice President
Maria Echaveste, Assistant to the President and Deputy Chief of Staff
Pat Ewing, Deputy Chief of Staff for Communications, Office of the Vice President
Audrey Tayse Haynes, Chief of Staff to Mrs. Gore
Christopher Jennings, Deputy Assistant to the President for Health Policy Development
Elena Kagen, Deputy Assistant to the President for Domestic Policy
Ron Klain, Assistant to the President and Chief of Staff and Counselor to the Vice President
Jenny Luray, Deputy Assistant to the President and Director of Women's Initiatives and Outreach
Bruce Reed, Assistant to the President for Domestic Policy
Melanne Verveer, Assistant to the President and Chief of Staff to the First Lady

Women's issues –
contraception

Cynthia Dailard 10/21/98 12:45:30 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP, Neera Tanden/WHO/EOP, Laura Emmett/WHO/EOP, Elena Kagan/OPD/EOP

cc:
Subject: Re: FEHBP contraceptive coverage

I wanted to forward to you this exchange I had with Dan re implementation of contraceptive coverage in FEHBP. OMP is moving quickly!

---------- Forwarded by Cynthia Dailard/OPD/EOP on 10/21/98 12:44 PM ----------

Daniel N. Mendelson

10/21/98 12:24:55 PM

Record Type: Record

To: Cynthia Dailard/OPD/EOP
cc: Lisa B. Fairhall/OMB/EOP, Gina C. Mooers/OMB/EOP
bcc:
Subject: Re: FEHBP contraceptive coverage

This is consistent with their usual operating procedure. I have spoken with them to urge them to approve all FDA approved methods and to act quickly. If you want to reach for the actual documents, we can do that c/o Lisa Fairhall, our branch chief for OPM. In addition, I got a call from planned parenthood -- they will be sending a letter specifying some concerns in implementation [Gina -- please make sure that Lisa and Cynthia have a copy of this letter when it comes in.]
Cynthia Dailard

Cynthia Dailard 10/21/98 10:11:32 AM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP@EOP

cc:
Subject: FEHBP contraceptive coverage

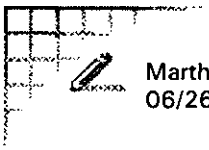
I know that the omnibus bill hasn't even been signed into law yet, but that didn't stop me from calling Abby Bloch at OPM to find out what the next step would be regarding contraceptive coverage in FEHBP. She said that there isn't any formal regulatory process regarding OPM benefits. Instead, she simply sends out a contract modification (which she has already drafted) which will go to plans shortly after the bill is signed, notifying them that they have to cover all FDA approved prescription contraceptives starting January 1, 1999. The plans will be required to sign the contracts by November 20. I was pleased to learn that the provision will go into effect in the

1999 plan year (rather than 2000, which would naturally occur if they didn't modify the contracts that have been negotiated for 1999).

I asked her if I could get a copy of the draft contract/letter, and she declined because she (understandably) wants to see the legislative language signed by the President before she distributes it, and OPM contracts do not go through any formal clearance process anyway. She did answer my questions regarding specific provisions in the contract -- she said that the letter will require plans to cover "the full range" of FDA approved prescription contraceptives, but it will not specify them by name (this sounds fine); she also said that the letter will not be sent to the 5 religious plans specifically mentioned in the language, and other plans will be told to contact OPM if they believe they qualify for an exemption for religious plans (it will then be up to OPM to determine if they do in fact qualify); also, she said that plans will be required to notify enrollees regarding the change in benefits, but she hadn't decided whether they would be required to notify folks by a particular date or through specified materials, or whether they could just rely on the regular means of communicating with beneficiaries (which means the notification could get buried in the annual benefits manual sent out to beneficiaries). I didn't ask her what OPM would communicate to plans regarding the conscience clause for providers (on moral and religious grounds), but I would be interested in finding this out.

I wanted to give you the heads up on this, since OPM appears prepared to move rather quickly. While I am very, very pleased that OPM is acting so expeditiously, I was surprised that we would not get to review what they are sending to plans (given how politicized the issue was and how difficult it was to get the legislative language just right). I have not dealt with OPM very much, so I do not have a good sense of how independent their actions are. FYI.

women's issues - contraception



Martha Foley
06/26/98 09:14:51 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: FEHBP

You may have recalled my muttering about the Treasury Postal rule during our meeting yesterday. Indeed, it was overwhelmingly defeated, 125-291. A new rule will have to be crafted and passed after the Fourth recess. It will not be easy for the leadership to figure out how to get the votes. While Dems opposed the striking of emergency funding for "Y2K" in the bill by the rule, many Republicans were opposed on choice issues: liberals because the rule made Coburn in order (although he had been indicating he would not offer it) and conservatives because it protected the Lowey language in the bill against a point of order. When many Dems realized on the floor that the effect of defeating the rule might be a new rule that allowed Lowey to be struck, they began switching their votes to "yes" in large numbers, but not fast enough and in large enough numbers to pass the rule.

Bottom line: very unstable situation on this rule and possibly, therefore, on Lowey. More as it develops.

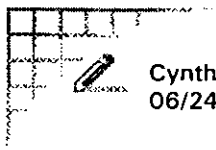
Message Sent To:

Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Audrey T. Haynes/WHO/EOP
Joshua Gotbaum/OMB/EOP
Daniel N. Mendelson/OMB/EOP

Women's issues - contraceptives

THE WHITE HOUSE

WASHINGTON



Cynthia Dailard
06/24/98 09:49:32 AM

Record Type: Record

To: Sarah A. Bianchi/OPD/EOP, Christopher C. Jennings/OPD/EOP, Laura Emmett/WHO/EOP

cc:

Subject: contraceptives - Treasury/Postal

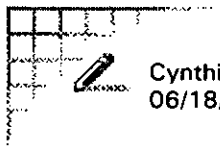
When the House Treasury/Postal bill goes to the floor, we can expect the following excitement:

1) a Northup motion to strike the Lowey provision requiring contraceptive coverage in FEHB.

2) an Obey compromise which adds a conscience clause to the Lowey provision (which Lowey has agreed to).

3) a Coburn amendment which scales back Lowey so that it only covers methods that don't allow implantation.

Women's issues – contraceptive



Cynthia Dailard
06/18/98 06:03:52 PM

Record Type: Record

To: Christopher C. Jennings/OPD/EOP, Sarah A. Bianchi/OPD/EOP, Daniel N. Mendelson/OMB/EOP, Elena Kagan/OPD/EOP

cc: Laura Emmett/WHO/EOP
Subject: contraceptive coverage

The Lowey amendment to the Treasury Postal Appropriations bill on contraceptive coverage passed by a vote of 28-26 in Committee. (The amendment says that FEHB plans covering prescription drugs must cover prescription contraceptives.) The victory came as something of a surprise to the women's groups. Of course, now they will have to fight to protect the amendment on the floor. They could very well face a motion to strike or an amendment to add a conscience clause exempting religious plans.

In addition to the thanks we received yesterday from the women's groups for our assistance with OPM during the markup, Nita Lowey's office called today to express their sincere gratitude as well.

FYI -- these are the facts the women's groups are circulating:

- 10% of FEHB plans provide no coverage of contraceptives.
- 81% of FEHB plans do not cover all five leading reversible methods of contraceptives (oral contraceptives, diaphragm, IUD, Depo-Provera, and Norplant). And coverage of specific types of contraceptives varies widely among FEHB plans -- 88% cover oral contraceptives, but only 28% cover the IUD.
- FEHB plans provide near universal coverage of sterilization. They exclude coverage of abortion.
- CBO said that the cost to the federal government of the Lowey amendment would be zero.

Women's issues - contraception

Audrey T. Haynes 06/17/98 06:17:10 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Contraception in FEHB.

I'm passing these on to you since you will probably get calls on this. I am getting calls from Planned Parenthood, etc. about OPM opposing this and as to why?.....When talking to Dan, he made it clear to me and we will to the groups that we are not aganist this in principle, but rather we don't want the Congress in the business of saying what is covered and what is not. It could come back to bit us in a different political climate. thanks

---------- Forwarded by Audrey T. Haynes/WHO/EOP on 06/17/98 06:17 PM ----------

Daniel N. Mendelson

06/17/98 05:51:51 PM

Record Type: Record

To: Audrey T. Haynes/WHO/EOP

cc: See the distribution list at the bottom of this message
Subject: Contraception in FEHB.

Per your request, here are preliminary talking points on FEHB contraception coverage. If anyone has comments or edits, please email them to Gina Mooers and she will put together a final version for internal use.

- Representative Lowey (D-NY) is introducing language into OPM's appropriations bill that would mandate coverage for contraception in FEHB.
- OPM believes this language is unnecessary, as virtually all plans can already cover pharmaceutical contraception options (with surgical options there is some variation).
- Perhaps more important, this language sets a bad precedent for legislating specific coverage rules: (1) time passes and these benefits get stale; (2) this practice that could lead to the politicization of health coverage.
- Given that we currently provide contraception, that there are some mandates for health coverage (e.g., nurse midwives), and that we would certainly not be willing to make a big deal of this, **we will not oppose** this provision.
- Ironically, pressure for this provision comes from a perception that health plans are providing Viagra but not providing coverage for contraception -- in FEHB the opposite is generally true as contraception is generally covered and new treatments for impotence may not.

Women's issues – contraception

THE WHITE HOUSE

WASHINGTON

June 22, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Chris Jennings

RE: Legislation to require health plan coverage of contraceptives

Later this week, an appropriations bill may come to the floor with an amendment that would require contraceptive coverage by all plans participating in the Federal Employee Health Benefits Plan. This amendment was sponsored by Congressman Lowey and passed by the House Appropriations Committee last week by a vote of 28 to 26. At the same time, Senator Snowe is considering introducing on the Senate floor a bill that would require this coverage by all health plans. For the reasons that follow, your advisors (DPC, Women's Office, Communications, OMB) generally agree that we should support the Lowey amendment, but be silent on -- or, if pushed take a "do not support" position on -- the Snowe bill.

Most health plans cover at least some kind of prescription contraceptives. An estimated 93 percent of HMOs cover at least one prescription contraceptive, and about 40 percent cover all five of the most commonly used methods: the pill, diaphragm, IUDs, Norplant and Depo-Provera. The plans that participate in FEHBP are fairly representative of most plans: 90 percent cover some type of contraception and about 20 percent cover all five methods.

The benefits of contraceptive coverage are clear. Approximately 60 percent of all pregnancies in the U.S. are unintended, and these pregnancies surely result in many unnecessary abortions. In addition, the cost of requiring plans to cover prescription contraceptives may be negligible. CBO, when assessing the Lowey amendment, found that the cost of the coverage would be fully offset by the reduction in the cost of childbirth.

These pieces of legislation nonetheless raise two difficult issues. First, the health policy community usually opposes mandating particular benefits for fear that coverage decisions will become political rather than substantive and, in most cases, will add to the cost of health insurance. We generally agree with the policy community on this point, and worry that if we go down this road any further, we will find it difficult to oppose benefits mandates that are politically popular but poor policy. Second, Republicans would almost inevitably charge that this mandate -- especially if extended to all health plans, rather than only those in the FEHBP -- is reminiscent of the "micromanagement benefit design approach" taken in the Health Security Act. But some argue, in response, that a governmental role is more warranted for this benefit than for most others, because of concerns about gender discrimination in health decisions.

Taking these concerns into account, your advisors recommend that we support the Lowey amendment but remain silent (or, if pushed, take a "do not support" position) on the Snowe bill. While these positions may appear contradictory, we believe that we can distinguish between them. We would be saying that contraception is an important benefit that all plans should cover, but that the best way to promote such coverage is through making FEHBP a model, rather than imposing a private mandate. Of course, this stance will make it harder for us to reject other coverage requirements on FEHBP plans in the future, but because we often make coverage decisions for Federal programs, this precedent is not as troublesome as it would be in the private arena. And while this stance will not fully satisfy the women's groups (who would also like us to endorse Snowe), we will be supporting the proposal with the greater likelihood of success.

We therefore recommend that you support a contraceptive coverage requirement for FEHBP plans, but not a mandate for private sector plans. We also all agree -- and think that Lowey will as well -- that it is necessary to have a conscience exception to this requirement so that Catholic health plans can participate in FEHBP. If you agree with our recommendation, we propose that HHS and OPM, rather than the White House, convey this policy position to Congress.

Agree _____

Disagree _____

Let's Discuss _____

Women's issues - contraception

THE WHITE HOUSE

WASHINGTON

6-23-98

June 22, 1998

copied Reed Jennings COS

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6-23-98

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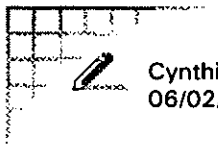
Agree ✓ → remain silent on Snowe for now. do not do "do not support" on Snowe

Disagree ____

Let's Discuss ____

Women's issues - contraception



Cynthia Dailard
06/02/98 05:58:46 PM

Record Type: Record

To: Laura Emmett/WHO/EOP

cc: Sarah A. Bianchi/OPD/EOP, Christopher C. Jennings/OPD/EOP
Subject: contraceptive coverage

Please let Elena know that the women's groups are interested in the President issuing an Executive Order requiring contraceptive coverage in the Federal Employees Health Benefits Program. Specifically, they want to require those plans which participate in the FEHBP and provide coverage of prescription drugs to provide similar coverage of prescription contraceptives. I don't want Elena to be blindsided if/when the groups call her directly.

Chris –

Are we generally as opposed to doing this as we are to requiring all private plans to provide a certain kind of coverage?

Elena

Women's issues —
contraception

12/16 Family Planning - groups meeting

Bmm- Prevention theme —
making ab less necessary
SOTU — made safe + legal
now must make rare

Every time have ab vote —
do the prevention routine —
put them on defensive

↑ T. X funding - by 25m (now at $203 LW) (HHS request)
Coverage Act

22?
January - 25th anniv of Roe

THE PRESIDENT HAS SEEN
7-7-97

g, not slashing
ture and manpower

	1997	2003†	QDR*
ons	10	10	10
iers			
ve)	11/1	11/1	11/1
arines	73	52	50
ships	128	131	116
r wings	13	13	12
	202	187	187
ps			
y forces	3	3	3
000			
	1,450	1,420	1,360
	900	890	835
	800	720	640

*Proposed †On current plans

o he has created a task force to . by December, on how to im- ency further.

R makes two groups of people : defence contractors are de- : not a single equipment pro- s been cancelled. So are the ser- who like to buy lots of current and generally dislike radical

re are two groups of disgruntled husiasts for the revolution in airs think it ridiculously expen- practical, to stick to the policy e to fight two wars at once. They xisting programmes and forces AD on unmanned aircraft and ure. "We should be prepared to hort-term risks, now that no su- reatens, in order to prepare for hallenges," says Andrew , director of the Centre for Stra- udgetary Assessments, a think- ld we go ahead with so many s for fighters when their for- —and aircraft carriers—would le to missile attack?" he asks.

ond sulking group, those who ke the Department of Defence nt, are dismayed that, although ays the right things, he has pro- modest changes. Since 1989 the active military personnel has %, but the number of bases has 1%. Eric Pages, of Business Exec- ational Security, a consultancy, t more aggressive base closures, n and outsourcing could save -30 billion a year. "The DOD s on its core business of war," he of its 650,000 staff performing l functions could be replaced by ractors."

ir to Mr Cohen, he knows—as a former senator—how hard it will be to get even the QDR's limited proposals past Congress. Senator Strom Thurmond and Representative Floyd ised to resist ba plan could easil pork. Similarly, fighter progran army divisions would face hea vice chiefs and

A careful rea impression tha have been more at least, is set a reforms. And th gress has set up a independent experts (including Mr Krepinevich), to assess the QDR and provide an alternative view by the end of the year.

Copied Kagan COS

Jen — see last paragraph. Elena

Abortion

From mother to child

WASHINGTON, DC

HAS the earth moved in the abortion debate? On May 20th, after two weeks of acrimonious and sanctimonious rhetoric, the Senate voted 64-36 in favour of a bill proposed by Rick Santorum, a Republican from Pennsylvania. The Santorum bill would outlaw a medical procedure which the bill calls "partial-birth abortion" unless a woman's life—not merely her health—is at risk.

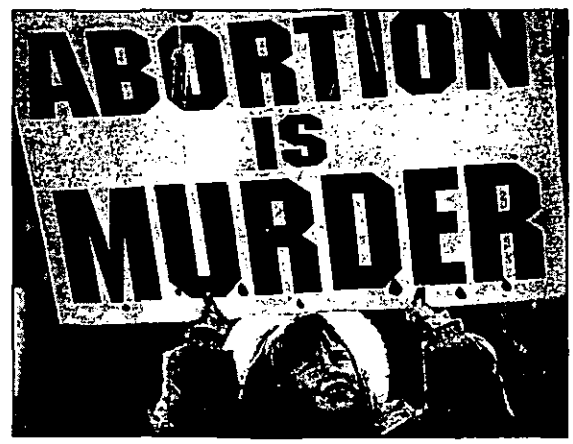
The day before, the American Medical Association changed its long tradition of neutrality on abortion legislation, supporting the bill after technical changes were made to narrow the definition of the procedure and to protect doctors from liability. However, the American College of Obstetricians and Gynaecologists, which represents the doctors who are actually involved, opposed the bill, calling it "ill-advised and dangerous".

Both sides of the debate were hampered by lack of hard data, and both were disingenuous. The National Coalition of Abortion Providers argued that the procedure in question was very rare; but their executive director later announced that it was performed far more often than he had said, and usually on healthy mothers with healthy fetuses. On the other side, the Santorum bill itself is a disingenuous piece of legislation. In medical parlance, "partial-birth abortion" has no meaning; the term is an invention of the anti-abortion movement. The rhetoric and images have all been about one method of abortion, known technically as intact dilation and extraction. But the wording of the bill is vague, and would actually apply to other methods of abortion that are used in the second trimester (12-24 weeks), before the fetus is viable, and are therefore protected under law.

Taken as a whole, the 24 years since Roe v *Wade*, when the Supreme Court decided that abortion was a constitutional right, have actually seen an increasing number of restrictions on it. But the change has happened gradually. The most recent moves, the recurring debates over late-term abortions, are an attempt to alter attitudes more radically, by shifting the focus of the argument away from the health of the mother to that of the developing child.

The tension in all thinking about abortion is between the health and well-being of the mother and that of the fetus. As a pregnancy progresses, this balance changes, and current American law already recognises this. Late-term abortions of any kind are relatively rare. In a given year, just 1% of all abortions in America take place after 20 weeks; fewer than 600 are thought to happen after 26 weeks, and at that stage are almost always because of severe fetal abnormalities. As Mr Santorum has admitted, his bill would do nothing to reduce the total number of abortions in America.

Yet that is not his point. By shifting the attention from mother to child, the anti-abortion lobby hopes to increase the discomfort that most Americans to some degree feel about abortion. With the politicians, this approach is succeeding. In each of the previous two votes on this issue in the Senate, the vote has inched upwards. With the public, however, little has changed. Belief in the right to an abortion remains stronger than distaste for it. Efforts to restrict earlier abortions will be more difficult. In any case, RU486, the so-called abortion pill for use early in pregnancy, is likely to be available in America by the end

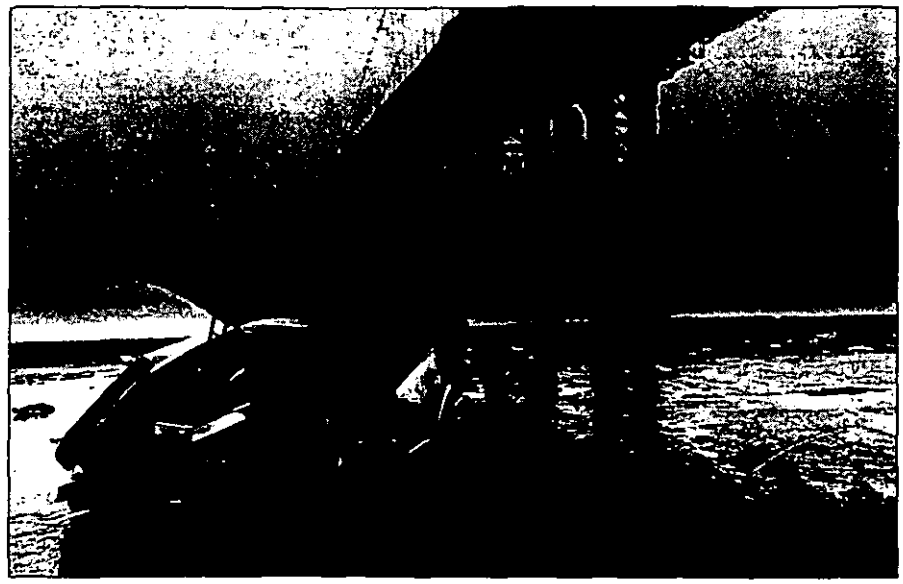


Should Congress agree?

Abortion — partial birth — press. and Women's Issues — contraceptive

of the year.

The current debate also ignores the fact that most abortions could be prevented with better contraception. The range of contraceptives available in America is much smaller than in most of Western Europe; education is scanty; access is harder and more expensive. Unsurprisingly, the rate of unintended pregnancies is far lower in Europe. Many insurance companies and managed-care organisations will pay for abortions, but few cover the cost of contraceptives. When will some enterprising politician take up that cause?



Last exit to Brooklyn

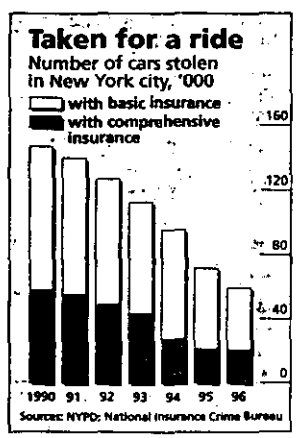
Car insurance

Auto-da-fé

NEW YORK

BACK in the 1980s, the life expectancy of a Chevrolet Corvette parked on one of New York's meaner streets was rumoured to be less than 30 minutes. Cars are a little less vulnerable these days. A mere 59,440 were stolen in the city last year, down from a peak of 146,925 in 1990 (see chart). Oddly, the car-insurance premiums paid by New Yorkers have yet to reflect this hefty decline. The State Insurance Department estimates that the annual premium for a 35-year-old male rose by an average of 47% between 1994 and 1996—a period in which vehicle theft fell by 38%. So, in an election-year defence of the man in the driving seat, Mayor Rudolph Giuliani aims to set motorists on the road to a refund.

Fittingly for the man who, as a prosecutor, busted Michael Milken, the mayor is filing suit against seven of America's biggest car-insurance firms, among them State Farm, Aetna, Allstate and GEICO. The lawsuit, which aims to force insurers to cut New York's comprehensive rates by as much as half, is being brought alongside a class-action suit filed on behalf of motorists who hold comprehensive policies (as opposed to basic car insurance, which does not cover theft). Around 80% of the claims made on comprehensive policies in New York are the result of theft—so, reasoned the mayor's task-force on insurance rates, which was formed last September, when theft declines, rates ought to follow suit.



Mr Giuliani claims that the city's lawsuit is the first of its kind, but it is by no means the only attempt by state or local authorities to curb soaring car-insurance rates. Two years ago, in the wake of a successful anti-car-theft drive in Houston—and subsequent lobbying by the city's mayor—the Texas Department of Insurance cut "benchmark" car-insurance rates by one-third. Such an outcome would be impossible in New York, however, according to a report produced by Mr Giuliani's task-force. It is highly critical of the State Insurance Department's pro-insurer stance on rate regulation.

Several states have also introduced—or are drafting—legislation that would reduce car-insurance rates for drivers agreeing to a "no-fault" policy that restricts their right to sue (and ability to be sued) for the "pain and suffering" caused by a car accident. Insurers claim that the increasing incidence of such lawsuits, which are often frivolous, is the main reason why all types of vehicle premiums have risen in recent years. The Auto Choice Reform Act, a bill introduced last month by a bipartisan group of senators (among them Daniel Patrick Moynihan and Mitch McConnell), would allow nationwide use of no-fault policies—and save drivers up to $45 billion a year, according to the Joint Economic Committee of Congress.

Unsurprisingly, Mr Giuliani supports such legislation, which is unlikely to become law any time soon. But what are the chances that his own attack on insurance rates will succeed? Testifying before the mayor's task-force, the car insurers maintained that the average cost of each claim had risen sharply during the 1990s—by 69% in the four years to 1995, according to Allstate—and that this had more than offset the effect of declining theft. But such an argument is specious: to offset New York's 60% reduction in theft this decade, the average cost of each claim would have to have soared by 150%. Nor did insurers explain why, despite their boast that comprehensive rates have been cut in New York in recent years, the average car-insurance premium is higher than ever.

Using the insurance industry's own definition of what represents "excellent profitability" as a guide, Mr Giuliani's task-force calculates that car insurers in New York city made windfall (ie, excess) profits of well over $40m in each of the past two years alone—and it is these that the mayor intends to recoup for car owners.

Mr Giuliani may not be fighting solo for long. In Chicago—where car theft has fallen by 30% since 1990—consumer-affairs agencies have already contacted New York officials to seek advice on launching their own attack on insurers; authorities in other cities where car theft has fallen sharply, such as Dallas and San Diego, are watching closely. Insurers, naturally, view New York's lawsuit as no more than an irritant. But that is what tobacco companies used to think about anybody who sued them, too.

California politics

An eerie silence

SAN FRANCISCO

THESE are strange days in California politics: so strange, that people are calling them the "dark time". Malign astrological influences? No; it is simply that no money is being collected for or against candidates in next year's elections. Indeed, no money is even being sought. In normal

File: Women's Issues - Contraception

David S. Broder

A Real Woman's Issue

Washington is consumed with women. Between Paula Corbin Jones, whose lawsuit has the White House in a tizzy, and Susan Molinari, whose job change has stirred up a huge media controversy, you hardly hear of anything else.

The TV talk shows that are not focused on Jones's allegations of improper advances by Bill Clinton in an Arkansas hotel room are spending their time on Molinari's decision to leave her New York House seat and Republican leadership position for a job as a CBS Saturday morning TV news anchor.

Personally, I wish there were fewer people jumping the line between politics and the press in either direction.

Prescription contraceptives should be covered by health insurance.

And I wish there were no occasion for *Jones vs. Clinton* to be in the courts.

But if I may say so, there are issues affecting women that may be even more important than these. Like access to family planning, for example.

In this country, according to the best estimates, about 3.6 million unintended pregnancies occur each year. Half end in abortion. Those unwanted pregnancies are concentrated among women who do not use contraceptives. In any year, 85 percent of sexually active women not using contraceptives become pregnant. That is about 15 times the rate for women using contraceptives.

The link between making birth control available and reducing the number of abortions and unwanted pregnancies is clear. Yet a recent study shows that prescription contraceptives rarely are covered by health insurance.

That is the background for legislation introduced last month by Sens. Olympia Snowe (R-Maine) and Harry Reid (D-Nev.) that would require insurance companies to treat contraceptive prescriptions and devices the same as any other prescriptions they cover in their policies.

Snowe and Reid (now joined by 10 other sponsors) come at the question from different backgrounds. She is a pro-choice Republican of Greek Orthodox faith. He is a pro-life Democrat and a devout Mormon. But on this question, they see eye to eye.

A study by the Alan Guttmacher Institute, cited by the two senators, found that 97 percent of health insurance plans offer prescription coverage (often with a co-payment), but only half include contraceptive drugs and devices and only one-third oral contraceptives. The expense of the pill or an IUD is an important reason that women of reproductive age spend two-thirds more in out-of-pocket health-care costs than their male counterparts.

As Reid commented when he joined Snowe in introducing the bill, "Insurance companies [typically] cover sterilization and abortion procedures, but they are not covering the cost of prescription contraception. This just doesn't make sense. . . . If men were the ones who had to pay for prescription contraception, it would have been covered a long time ago."

The Health Insurance Association of America, a spokesman says, has taken no stand yet on the Snowe-Reid bill but routinely opposes measures that impose specific mandates on the industry. The two senators are hopeful that public opinion will convince other lawmakers that this is not just a matter of gender equity but a sound public policy.

The problem they are addressing—the unavailability of contraception—is a far greater issue on the world scene than it is in the United States, as a report last month from the United Nations's Population Fund made clear.

The report had some good news. Thanks to programs to increase the availability and awareness of contraception, growth of world population is slowing. Since 1970 the fertility rate (births per woman) has fallen from six to three. The annual growth in world population averaged 81 million in the first five years of this decade, down from 87 million in the previous five years.

But Stirling Scruggs, the U.N. official who conducted the Washington briefing, pointed out that one-third or more of the couples in less developed countries lack access to contraception, that each year there are at least 75 million unwanted pregnancies and that 45 million of them result in abortions—and because so many of the abortions are unsafe, 70,000 women die each year.

The United States, once the leader in worldwide efforts for reproductive health, now contributes only half as much to the U.N.'s work in this area as Denmark. Last week, the U.S. House of Representatives once again tried to tie the president's hands in distributing family planning funds by raising the straw man of subsidized abortions—something explicitly outlawed by existing policy.

Both at home and abroad, we have a long way to go before women have the help they need and every child who comes into the world is a welcome addition, with a fair chance of surviving and thriving.

6/22/97

Elena,
Chris,

Are we supportive of the legislation referred to here in? Can it pass? Should we help?

Sarah

Jen—
What should I tell her?
Elena

Women's Issues – Contraceptives

Jen – Has Tom given this to you? It's the same thing Sylvia asked about. Supposedly the VP is interested. What do you think?

Elena

cc: Bruce

MEMORANDUM

TO: BRUCE REED, ELENA KAGAN

FROM: TOM FREEDMAN, MARY L. SMITH

RE: CONTRACEPTIVES PAID BY PRIVATE INSURANCE COMPANIES

DATE: JUNE 30, 1997

SUMMARY

Senators Olympia Snow (R-ME) and Harry Reid (D-NV) have sponsored a bill that would require any private insurance company to cover contraceptive drugs and services to the same extent that other prescriptions are covered. Apparently, only one-third of insurance companies with a prescription drug plan include oral contraceptives. In large part because of the lack of coverage for contraception, women currently spend two-thirds more in out-of-pocket health care than men.

STATISTICS

- A study by the Alan Guttmacher Institute found that 97% of health insurance plans offer prescription coverage (often with a co-payment), but only one-half include contraceptive drugs and devices, and only one-third include oral contraceptives.
- Women of reproductive age spend 68% more in out-of-pocket costs for health care than men do, with much of the difference attributable to reproductive health expenditures.
- Currently, more than 80% of private insurance plans refuse to pay for all five of the most frequently used prescription contraceptive methods.
- According to best estimates, about 3.6 million unintended pregnancies occur each year (over 57% of all pregnancies in America). Almost one half of them end in abortion. Those unwanted pregnancies are concentrated among women who do not use contraceptives. In any year, 85% of sexually active women who do not use contraceptives become pregnant, approximately 15 times the rate for women using contraceptives.
- The average annual cost of birth control pills is $300.
- Senator Snow estimates that the increased costs of the bill would be $16 a year in higher premiums.
- For every dollar invested in family planning in the public sector, between $4 and $14 are saved in health care and related costs.

S.776 "EQUITY IN PRESCRIPTION INSURANCE AND CONTRACEPTIVE COVERAGE"

This bill would require private insurance to cover FDA-approved contraceptive drugs and services

to the same extent that their prescription drug plans cover other prescriptions. This bill does not, however, require private insurance to offer prescription drug plans if they do not currently offer one.

CO-SPONSORS

Boxer D-CA
Bryan D-NV
Chafee R-RI
Cleland D-GA
Collins R-ME
Durbin D-IL
Hutchison R-TX
Jeffords R-VT
Kerry D-MA
Mikulski D-MD
Moseley-Braun D-IL
Murray D-WA
Robb D-VA
Warner R-VA

STATES THAT HAVE SIMILAR LEGISLATION

- **California**: California's bill AB 160 passed the Senate Insurance Committee in June and is expected to come up for a vote on the Senate floor in July.
- **Virginia**: In February, the Virginia senate passed a similar bill.

3RD DOCUMENT of Level 1 printed in FULL format.

Bill Tracking Report

105th Congress
1st Session

U. S. Senate

S 766

1997 Bill Tracking S. 766; 105 Bill Tracking S. 766

EQUITY IN PRESCRIPTION INSURANCE AND CONTRACEPTIVE COVERAGE ACT OF 1997

<=1> Retrieve full text version

ATE-INTRO: May 20, 1997

AST-ACTION-DATE: June 16, 1997

TATUS: Referred to committee

PONSOR: Senator Olympia J. Snowe R-ME

OTAL-COSPONSORS: 15 Cosponsors: 10 Democrats / 5 Republicans

YNOPSIS: A bill to require equitable coverage of prescription contraceptive rugs and devices, and contraceptive services under health plans.

CTIONS: Committee Referrals:
5/20/97 Senate Labor and Human Resources Committee

egislative Chronology:

st Session Activity:

5/20/97	143 Cong Rec S 4748	Referred to the Senate Labor and Human Resources Committee
5/21/97	143 Cong Rec S 4898	Cosponsor(s) added
5/05/97	143 Cong Rec S 5370	Cosponsor(s) added
5/10/97	143 Cong Rec S 5465	Cosponsor(s) added
5/16/97	143 Cong Rec S 5703	Cosponsor(s) added

ILL-DIGEST: (from the CONGRESSIONAL RESEARCH SERVICE)

ıort title as introduced :

Equity in Prescription Insurance and Contraceptive Coverage
\ct of 1997

igest :

sn00743

RS Index Terms:

ealth policy
ibulatory care
isiness
vil rights
nsumer education
nsumers
ntraceptives
iscrimination in insurance
scrimination in medical care
ployee health benefits
nance
vernment information
vernment paperwork
ealth insurance industry
ealth insurance--Standards
surance companies
dical care
dicine
ysical examinations

-SPONSORS: Original Cosponsors:

Chafee R-RI	Collins R-ME	Durbin D-IL
Jeffords R-VT	Mikulski D-MD	Murray D-WA
Reid D-NV	Warner R-VA	

ded 05/21/97:

Hutchison R-TX

ded 06/05/97:

Moseley-Braun D-IL	Cleland D-GA

ded 06/10/97:

Boxer D-CA	Kerry D-MA

ded 06/16/97:

Bryan D-NV	Robb D-VA

2ND DOCUMENT of Level 1 printed in FULL format.

FULL TEXT OF BILLS

105TH CONGRESS: 1ST SESSION
IN THE SENATE OF THE UNITED STATES
AS INTRODUCED IN THE SENATE

S. 766

1997 S. 766; 105 S. 766

<*1> Retrieve Bill Tracking Report

NOPSIS:
BILL To require equitable coverage of prescription contraceptive drugs and
vices, and contraceptive services under health plans.

TE OF INTRODUCTION: MAY 20, 1997

TE OF VERSION: MAY 22, 1997 -- VERSION: 1

ONSOR(S):
. SNOWE (FOR HERSELF, MR. REID, MR. WARNER, MS. MIKULSKI, MR. CHAFEE,
. DURBIN, MS. COLLINS, MRS. MURRAY, AND MR. JEFFORDS) INTRODUCED THE
LLOWING BILL; WHICH WAS READ TWICE AND REFERRED TO THE COMMITTEE ON
LABOR AND HUMAN RESOURCES

XT:
Be it enacted by the Senate and House of Representatives of the United*
tates of America in Congress assembled,*
CTION 1. SHORT TITLE.
This Act may be cited as the "Equity in Prescription Insurance and
ntraceptive Coverage Act of 1997".
C. 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".

EC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 974.

(a) IN GENERAL.-SUBPART B OF PART 7 OF SUBTITLE B OF TITLE I OF THE MPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (AS ADDED BY SECTION 03(A) OF THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 AND MENDED BY SECTION 702(A) OF THE MENTAL HEALTH PARITY ACT OF 1996) IS URTHER AMENDED BY ADDING AT THE END THE FOLLOWING NEW SECTION:

EC. 713. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.

"(a) REQUIREMENTS FOR COVERAGE.-A GROUP HEALTH PLAN, AND A HEALTH SURANCE ISSUER PROVIDING HEALTH INSURANCE COVERAGE IN CONNECTION WITH A ROUP 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 OVIDING HEALTH INSURANCE COVERAGE IN CONNECTION WITH A GROUP HEALTH AN, 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 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 UNDER GROUP HEALTH PLAN.-THE IMPOSITION OF THE REQUIREMENTS THIS SECTION SHALL BE TREATED AS A MATERIAL MODIFICATION IN THE TERMS THE PLAN DESCRIBED IN SECTION 102(A)(1), FOR PURPOSES OF ASSURING TICE OF SUCH REQUIREMENTS UNDER THE PLAN, EXCEPT THAT THE SUMMARY SCRIPTION REQUIRED TO BE PROVIDED UNDER THE LAST SENTENCE OF SECTION 4(B)(1) WITH RESPECT TO SUCH MODIFICATION SHALL BE PROVIDED BY NOT TER THAN 60 DAYS AFTER THE FIRST DAY OF THE FIRST PLAN YEAR IN WHICH CH REQUIREMENTS APPLY.

"(E) PREEMPTION.-NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PREEMPT
NY PROVISION OF STATE LAW TO THE EXTENT THAT SUCH STATE LAW ESTABLISHES,
MPLEMENTS, OR CONTINUES IN EFFECT ANY STANDARD OR REQUIREMENT THAT
ROVIDES PROTECTIONS FOR ENROLLEES THAT ARE GREATER THAN THE PROTECTIONS
ROVIDED UNDER THIS SECTION.
"(F) DEFINITION.-IN THIS SECTION, THE TERM 'OUTPATIENT CONTRACEPTIVE
ERVICES' MEANS CONSULTATIONS, EXAMINATIONS, PROCEDURES, AND MEDICAL
ERVICES, PROVIDED ON AN OUTPATIENT BASIS AND RELATED TO THE USE OF
ONTRACEPTIVE METHODS (INCLUDING NATURAL FAMILY PLANNING) TO PREVENT AN
INTENDED PREGNANCY.".
(B) CLERICAL AMENDMENT.-THE TABLE OF CONTENTS IN SECTION 1 OF SUCH ACT,
AMENDED BY SECTION 603 OF THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION
T OF 1996 AND SECTION 702 OF THE MENTAL HEALTH PARITY ACT OF 1996, IS
ENDED BY INSERTING AFTER THE ITEM RELATING TO SECTION 712 THE FOLLOWING
W ITEM:
ec. 713. Standards relating to benefits for contraceptives.".
(c) EFFECTIVE DATE.-THE AMENDMENTS MADE BY THIS SECTION SHALL APPLY
TH RESPECT TO PLAN YEARS BEGINNING ON OR AFTER JANUARY 1, 1998.
C. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP
RKET.
(a) IN GENERAL.-SUBPART 2 OF PART A OF TITLE XXVII OF THE PUBLIC HEALTH
RVICE ACT (AS ADDED BY SECTION 604(A) OF THE NEWBORNS' AND MOTHERS'
ALTH PROTECTION ACT OF 1996 AND AMENDED BY SECTION 703(A) OF THE MENTAL
ALTH PARITY ACT OF 1996) IS FURTHER AMENDED BY ADDING AT THE END THE
LLOWING NEW SECTION:
EC. 2706. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.
"(a) REQUIREMENTS FOR COVERAGE.-A GROUP HEALTH PLAN, AND A HEALTH
SURANCE ISSUER PROVIDING HEALTH INSURANCE COVERAGE IN CONNECTION WITH A
OUP 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
OVIDING HEALTH INSURANCE COVERAGE IN CONNECTION WITH A GROUP HEALTH
AN, 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
rollee'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, 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 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

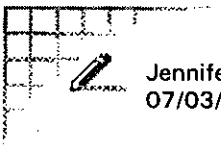
"(B) IN THE CASE OF AN OUTPATIENT CONTRACEPTIVE SERVICE, RESTRICTING THE TYPE OF HEALTH CARE PROFESSIONALS THAT MAY PROVIDE SUCH SERVICES, UTILIZATION REVIEW PROVISIONS, REQUIREMENTS RELATING TO SECOND OPINIONS PRIOR TO THE COVERAGE OF SUCH SERVICES, AND REQUIREMENTS RELATING TO PREAUTHORIZATIONS PRIOR TO THE COVERAGE OF SUCH SERVICES.

"(D) NOTICE.-A GROUP HEALTH PLAN UNDER THIS PART SHALL COMPLY WITH THE TICE REQUIREMENT UNDER SECTION 713(D) OF THE EMPLOYEE RETIREMENT INCOME CURITY ACT OF 1974 WITH RESPECT TO THE REQUIREMENTS OF THIS SECTION AS SUCH SECTION APPLIED TO SUCH PLAN.

"(E) PREEMPTION.-NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PREEMPT Y PROVISION OF STATE LAW TO THE EXTENT THAT SUCH STATE LAW ESTABLISHES, PLEMENTS, OR CONTINUES IN EFFECT ANY STANDARD OR REQUIREMENT THAT

ROVIDES PROTECTIONS FOR ENROLLEES THAT ARE GREATER THAN THE PROTECTIONS
ROVIDED UNDER THIS SECTION.
"(F) DEFINITION.-IN THIS SECTION, THE TERM 'OUTPATIENT CONTRACEPTIVE
ERVICES' MEANS CONSULTATIONS, EXAMINATIONS, PROCEDURES, AND MEDICAL
ERVICES, PROVIDED ON AN OUTPATIENT BASIS AND RELATED TO THE USE OF
ONTRACEPTIVE METHODS (INCLUDING NATURAL FAMILY PLANNING) TO PREVENT AN
NINTENDED PREGNANCY.".
(b) EFFECTIVE DATE.-THE AMENDMENTS MADE BY THIS SECTION SHALL APPLY
ITH RESPECT TO GROUP HEALTH PLANS FOR PLAN YEARS BEGINNING ON OR AFTER
ANUARY 1, 1998.
EC. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE
NDIVIDUAL MARKET.
(a) IN GENERAL.-SUBPART 3 OF PART B OF TITLE XXVII OF THE PUBLIC HEALTH
ERVICE ACT (AS ADDED BY SECTION 605(A) OF THE NEWBORN'S AND MOTHER'S
EALTH PROTECTION ACT OF 1996) IS AMENDED BY ADDING AT THE END THE
OLLOWING NEW SECTION:
SEC. 2752. STANDARDS RELATING TO BENEFITS FOR CONTRACEPTIVES.
"The provisions of section 2706 shall apply to health insurance
overage offered by a health insurance issuer in the individual market in
he same manner as they apply to health insurance coverage offered by a
ealth insurance issuer in connection with a group health plan in the
mall or large group market.".
(b) EFFECTIVE DATE.-THE AMENDMENT MADE BY THIS SECTION SHALL APPLY WITH
ESPECT TO HEALTH INSURANCE COVERAGE OFFERED, SOLD, ISSUED, RENEWED, IN
FFECT, OR OPERATED IN THE INDIVIDUAL MARKET ON OR AFTER JANUARY 1, 1998.

Women's Issues –
contraception



Jennifer L. Klein
07/03/97 02:38:26 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc:
Subject: Contraception

Chris and I need to have a longer conversation about this, but here are my initial thoughts. (I will write a little memo once I've heard back from him.) We do not have a position on the Snowe-Reid bill, and I don't think we should support it. Here are a few problems.

1. We have been somewhat careful to avoid mandating insurance companies to cover particular services. Why should we require them to cover contraceptives but not eye glasses for children? I have some concern about the President taking a stand on contraceptives.

2. This bill does not reach many people because it does not cover ERISA plans or Medicaid.

That said, it does fit with the President's message to make abortion "safe, legal and rare". We will give it more thought and get back to you.

David S. Broder

A Real Woman's Issue

Washington is consumed with women. Between Paula Corbin Jones, whose lawsuit has the White House in a tizzy, and Susan Molinari, whose job change has stirred up a huge media controversy, you hardly hear of anything else.

The TV talk shows that are not focused on Jones's allegations of improper advances by Bill Clinton in an Arkansas hotel room are spending their time on Molinari's decision to leave her New York House seat and Republican leadership position for a job as a CBS Saturday morning TV news anchor.

Personally, I wish there were fewer people jumping the line between politics and the press in either direction.

Prescription contraceptives should be covered by health insurance.

And I wish there were no occasion for *Jones vs. Clinton* to be in the courts.

But if I may say so, there are issues affecting women that may be even more important than these. Like access to family planning, for example.

In this country, according to the best estimates, about 3.6 million unintended pregnancies occur each year. Half end in abortion. Those unwanted pregnancies are concentrated among women who do not use contraceptives. In any year, 85 percent of sexually active women not using contraceptives become pregnant. That is about 15 times the rate for women using contraceptives.

The link between making birth control available and reducing the number of abortions and unwanted pregnancies is clear. Yet a recent study shows that prescription contraceptives rarely are covered by health insurance.

That is the background for legislation introduced last month by Sens. Olympia Snowe (R-Maine) and Harry Reid (D-Nev.) that would require insurance companies to treat contraceptive prescriptions and devices the same as any other prescriptions they cover in their policies.

Snowe and Reid (now joined by 10 other sponsors) come at the question from different backgrounds. She is a pro-choice Republican of Greek Orthodox faith. He is a pro-life Democrat and a devout Mormon. But on this question, they see eye to eye.

A study by the Alan Guttmacher Institute, cited by the two senators, found that 97 percent of health insurance plans offer prescription coverage (often with a co-payment), but only half include contraceptive drugs and devices and only one-third oral contraceptives. The expense of the pill or an IUD is an important reason that women of reproductive age spend two-thirds more in out-of-pocket health-care costs than their male counterparts.

As Reid commented when he joined Snowe in introducing the bill, "Insurance companies [typically] cover sterilization and abortion procedures, but they are not covering the cost of prescription contraception. This just doesn't make sense. . . . If men were the ones who had to pay for prescription contraception, it would have been covered a long time ago."

The Health Insurance Association of America, a spokesman says, has taken no stand yet on the Snowe-Reid bill but routinely opposes measures that impose specific mandates on the industry. The two senators are hopeful that public opinion will convince other lawmakers that this is not just a matter of gender equity but a sound public policy.

The problem they are addressing—the unavailability of contraception—is a far greater issue on the world scene than it is in the United States, as a report last month from the United Nations's Population Fund made clear.

The report had some good news. Thanks to programs to increase the availability and awareness of contraception, growth of world population is slowing. Since 1970 the fertility rate (births per woman) has fallen from six to three. The annual growth in world population averaged 81 million in the first five years of this decade, down from 87 million in the previous five years.

But Stirling Scruggs, the U.N. official who conducted the Washington briefing, pointed out that one-third or more of the couples in less developed countries lack access to contraception, that each year there are at least 75 million unwanted pregnancies and that 45 million of them result in abortions—and because so many of the abortions are unsafe, 70,000 women die each year.

The United States, once the leader in worldwide efforts for reproductive health, now contributes only half as much to the U.N.'s work in this area as Denmark. Last week, the U.S. House of Representatives once again tried to tie the president's hands in distributing family planning funds by raising the straw man of subsidized abortions—something explicitly outlawed by existing policy.

Both at home and abroad, we have a long way to go before women have the help they need and every child who comes into the world is a welcome addition, with a fair chance of surviving and thriving.

Women's Issues — contraception

Women's Issues - Contraceptive

AJCongress

American Jewish Congress
Stephen Wise Congress House
15 East 84th Street
New York, NY 10028-0458
212 879 4500 • Fax 212 249 3672

Commission for Women's Equality

Memorandum

June 4, 1997

TO: CWE Members Regional Directors

FROM: Lois Waldman

RE: *CONTRACEPTIVE COVERAGE BILL - S. 766*
(The Equity in Prescription Insurance and Contraceptive Coverage Act "EPICC")

Background

Family planning is basic preventive health care for American women. It improves maternal and child health, reduces infant mortality, increases the likelihood that the estimated 12 million Americans who contract a sexually transmitted disease each year will be diagnosed and treated and reduces the incidence of unintended pregnancy and abortion. Despite these many health, social and economic benefits derived from family planning and the fact that the vast majority of American women use contraception for some portion of their reproductive years, contraception is the only prescription drug benefit that is regularly excluded by insurers who offer coverage for prescription drugs and devices.

Almost half of all indemnity insurance plans and preferred provider organizations (PPO's) do not offer any coverage for reversible contraception. Twenty percent of point of service plans (POS's) and seven percent of health maintenance organizations (HMO's) do not provide such coverage. Of those plans that do offer some coverage for contraception, twenty percent of indemnity plans or PPO's and less than 40 percent of POS networks and HMO's routinely cover all five major methods: oral contraceptives, diaphragm, IUD, Norplant and Depo Provera. As a result, women spend approximately 68 percent more in out-of-pocket health care costs than men, with much of the difference accounted for by reproductive health costs.

Women who lack adequate coverage for contraception are often forced to make the financial choice of a less expensive and, based on the individual's lifestyle, a less effective contraceptive method, putting the woman at greater risk of unintended pregnancy. For example, some of the most effective and long lasting contraceptives such as the IUD and Norplant have high up-front costs but are cost effective over time. Sometimes the lack of coverage for contraceptives and services results in unintended pregnancy.

S.766 - The Equity in Prescription
Insurance and Contraceptive Coverage Act

Because of the need to make contraceptives more affordable for American women, bi-partisan legislation has been introduced that would require insurance plans which offer prescription drug coverage to also cover prescription contraceptive drugs and devices. The measure would also require that health plans which offer coverage for out patient medical services also offer coverage for out patient contraceptive services.

The bill defines contraception as "consultations, examinations, procedures and medical services provided on out patient basis and related to the sue of contraceptive methods (including national family planning) to prevent an unintended pregnancy."

The *Equity in Prescription Insurance and Contraceptive Coverage Act* has been introduced by pro-choice Senator Olympia Snowe (R-ME). Co-sponsors include Harry Reid (D-NV), John Warner (D-VA) Barbara Mikulski (D-MD), John Chafee (R-RI), Richard Durbin (D-ID), Susan Collins (R-ME), Patty Murray (D-WA) and Jim Jeffords (R-VT). The bill is now in the Senate Labor and Resources Committee.

Action

Contact your Senators. Urge them to co-sponsor S.766 if they have not already. Contact your Representatives to urge them to support the House version of this bill.

The Capitol Switchboard is: 202-224-3121

Fil: Women's Inter-Contraceptive Sen / Nicole —
FYI.
Elena

C · R · L · P

THE CENTER FOR REPRODUCTIVE LAW AND POLICY

MEMORANDUM

120 WALL STREET

NEW YORK

NEW YORK 10005 USA

212/514-5534

212/514-5538 *fax*

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***

1146 19TH STREET, NW

WASHINGTON, DC 20036

USA

202/530-2975

202/530-2976 *fax*

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

*Member Penn. bar only
†Member Alaska and Idaho bars only
§Member Calif. bar only

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

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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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