Draft guidance on contraceptives

I. Introduction

Under Title VII of the Civil Rights Act of 1964,[1] employers are barred from discriminating on the basis of sex with regard to the terms, conditions, or privileges of employment. Under the Pregnancy Discrimination Act (PDA),[2] moreover, women who are affected by "pregnancy, childbirth, or related medical conditions" must be treated the same as others who are similarly able or unable to work, including in the receipt of benefits under fringe benefit programs. Where an employer offers health insurance benefits to its employees, therefore, it must cover pregnancy and related medical conditions in the same way, and to the same extent, that it covers other medical conditions.

As has been recognized by the Supreme Court, a woman's potential for pregnancy is covered by the PDA. The PDA thus bans discrimination in the terms and conditions of employment that relate to a woman's capacity to become pregnant, and requires equal treatment of expenses resulting from a woman's decision to prevent a pregnancy.

Prescription contraceptives are a means of pregnancy prevention and control. As a result, an employer's health insurance plan must cover employees' expenses for prescription contraceptives on the same terms that it covers employees' expenses for other prescription drugs or devices that are used for preventive or health maintenance purposes.

II. Analysis

Based on current medical knowledge, individuals who wish to avoid conception may choose from a range of contraceptive alternatives. These alternatives include surgical procedures, like vasectomies and tubal ligations, and prescription contraceptives like diaphragms, birth control pills, intra-uterine devices, and Norplant implants. Prescription contraceptives are available only to women. While most health plans cover surgical forms of contraception, significant numbers of them exclude coverage of prescription contraceptives.[3] Where a health plan covers other prescription

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[1] 42 U.S.C. § 2000e *et seq*

[2] 42 U.S.C. § 2000e(k).

[3] *See, e.g.*, Alan Guttmacher Institute, *Uneven and Unequal: Insurance Coverage and Reproductive Health Services* 12 (1994); Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 1999 Annual Survey* 84 (comparing coverage of contraceptives to coverage of other drugs and services in various types of health insurance plans).

drugs or devices used for preventive or health maintenance purposes, this exclusion violates the PDA.[4]

A. The Commission concludes that contraception is covered by the PDA based on the statutory language of the PDA, legislative history, and relevant case law. The PDA requires equal treatment of women "affected by pregnancy, childbirth, or related medical conditions." This language was enacted to ensure that women would not be disadvantaged in the workplace because of -- or based on conditions resulting from -- their capacity to become pregnant. To achieve this, the PDA prohibits discrimination against women based on "the whole range of matters concerning the childbearing process."[5] The fact that it is women, rather than men, who have the potential for pregnancy cannot be used to penalize them in any way, including in the terms and conditions of employment.

The Supreme Court has confirmed that the PDA covers a woman's potential for pregnancy, as well as pregnancy itself. Recognizing that the PDA prohibits "discrimination on the basis of a woman's ability to become pregnant," the Court concluded that an employment policy that excluded women capable of bearing children from certain jobs was an impermissible classification based on the potential for pregnancy.[6] An employment policy that excludes insurance coverage for prescription contraceptives similarly discriminates on the basis of ability to become pregnant by differentiating coverage for health needs related to a woman's capacity to become pregnant from other health coverage provided by the employer.

This conclusion is further confirmed by additional language in the PDA that specifically exempts employers from any obligation to offer health benefits for abortion in most circumstances. Congress understood that absent an explicit exemption, the PDA *would* require coverage of medical expenses resulting from a woman's decision to terminate a pregnancy. Because Congress included

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[4] Such an exclusion will also violate numerous state laws. To date, ten states have passed comprehensive legislation mandating insurance coverage of contraception where a policy covers prescription drugs or devices. *See* Cal. Ins. Code § 10123.196 (California); 1999 Conn. Acts 99-79 (June 3, 1999) (Connecticut); Ga. Code Ann. § 33-24-59.6 (Georgia); Hawaii Rev. Stat. §§ 431:10A-116.6, 431:10A-116.7, 432:1-604.5 (Hawaii); Me. Rev. Stat. Ann., title 24, § 2332-J, Me. Rev. Stat. Ann., title 24-A, §§ 2756, 2847-G, 4247 (Maine); Md. Code Ann., Ins., § 15-826 (Maryland); Nev. Rev. Stat. Ann. § 689A.0415 *et seq.* (Nevada); N.H. Rev. Stat. Ann., title 37, §415:18-i (New Hampshire); 1999 N.C. Sess. Laws 90 (June 30, 1999) (North Carolina); 8 Vt. Stat. Ann. § 4099c (Vermont).

[5] H.R. Rep. No. 948, 95th Cong., 2d Sess. 5 (1978).

[6] *Int'l Union, UAW v. Johnson Controls*, 499 U.S. 187, 211 (1991).

no such exemption for pregnancy *prevention*, the PDA covers expenses resulting from a woman's need to control and manage her capacity to become pregnant.

Coverage of contraception is also necessary to implement Congressional intent in enacting the PDA. Congress wanted to equalize employment opportunities for men and women, and to address discrimination against female employees that was based on assumptions that they would become pregnant.[7] Congress thus gave women "the right . . . to be financially and legally protected before, during, and after [their] pregnanc[ies]."[8] It was only by extending such protection that Congress could ensure that women would not be disadvantaged in the workplace either because of their pregnancies or because of their ability to bear children.

For all of these reasons, the Commission concludes that the PDA covers prescription contraceptives.

B. What the PDA requires is that expenses related to pregnancy, childbirth, and related medical conditions -- including the capacity to become pregnant -- be treated the same as expenses related to other medical conditions. An employer that fails to extend such equal treatment is liable for facial discrimination under the PDA.

Contraception is a means to prevent, and to control the timing of, the medical condition of pregnancy.[9] In evaluating whether an employer has provided equal insurance coverage for

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[7] H.R. Rep. No. 948, 95th Cong., 2d Sess. 3 (1978) ("[t]he assumption that women will become pregnant and leave the labor force leads to the view of women as marginal workers, and is at the root of the discriminatory practices which keep women in low-paying and dead-end jobs"); *see also id.* at 6-7; 123 Cong. Rec. 29,385 (1977) (statement of Senator Williams, chief sponsor of the Senate bill that led to the PDA) ("[b]ecause of their capacity to become pregnant, women have been viewed as marginal workers not deserving of the full benefits of compensation and advancement . . .").

[8] 124 Cong. Rec. H38,574 (daily ed. October 14, 1978) (statement of Rep. Sarasin, a manager of the House version of the PDA).

[9] Medical professionals have long regarded pregnancy as a medical condition that poses risks to, and consequences for, a woman's body. *See, e.g., Equity in Prescription Insurance and Contraceptive Coverage Act 1998: Hearings on S. 766 before the Senate Committee on Labor and Human Resources*, 105th Cong., 2d Sess. 25 (1998) (statement of Richard H. Schwarz, M.D.); 144 Cong. Rec. S9,194 (daily ed. July 29, 1998) (statement of Senator Snowe) (there is "nothing 'optional' about contraception. It is a medical necessity for women during 30 years of their lifespan.

(continued...)

prescription contraceptives, therefore, investigators should look to the employer's coverage of other prescription drugs and devices that are used to prevent the occurrence of other medical conditions -- or, more broadly, that are used to maintain an individual's current healthy condition. Such drugs or devices include:

- vaccinations and immunizations;
- hormone replacement therapies to prevent or delay the onset of osteoporosis or other effects of the aging process;
- drugs, such as tamoxifen, that reduce the risk that currently healthy individuals will develop particular medical conditions; and/or
- anti-smoking drugs.

An employer must cover the expenses of prescription contraceptives to the same extent, and on the same terms, that it covers the expenses of the types of drugs and devices identified above.[10] An employer must also offer the same coverage for contraception-related outpatient services as are offered for other outpatient services. Where a woman visits her doctor to obtain a prescription for contraceptives, in other words, she must be afforded the same coverage that would apply if she, or any other employee, had consulted a doctor for other preventive or health maintenance services.

Where an employer covers other preventive drugs and devices, investigators should also bear the following in mind in evaluating whether the employer has offered adequate coverage for prescription contraceptives:

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[9](...continued)
To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable.") (quoting statement by American College of Obstetricians and Gynecologists).

[10] It is not a defense that an employer may exclude some of these types of drugs. If an employer covers any category of preventive drugs or devices, it must also cover contraception.

Investigators may also treat as comparators drugs that are taken on an elective basis to improve a person's appearance or functioning, but that do not address any underlying dysfunction. Where, for example, an employer covers Viagra without requiring a diagnosis of impotence -- or covers drugs to correct hair loss -- it must offer the same coverage for contraception.

- **the employer's coverage must extend to the full range of prescription contraceptive choices.** The PDA requires that employers that cover preventive drugs and devices also cover the drugs and devices that women need to control and prevent pregnancy. Because the health needs of women change -- and because different women may need different prescription contraceptives at different times in their lives -- this means that employers must cover each of the available options for prescription contraception.

- **the employer must offer coverage of prescription contraceptives in each of the types of health plans it sponsors.** Where an employer offers its employees a choice between health maintenance organizations and fee-for-service plans, for example, it must include coverage for prescription contraceptives in each of these options to the same extent that each includes coverage of other preventive prescription medications. It is no defense to a failure to include contraceptive coverage in a fee-for-service plan that women may instead choose to enroll in an employer-sponsored health maintenance organization plan that includes such coverage.[11]

C. An employer that excludes contraceptives while offering coverage for other preventive prescription drugs and devices will thus be liable for a facial violation of the PDA. Even if such an employment policy were treated as facially neutral, however, it would be likely to violate Title VII's prohibition on gender-based discrimination under a disparate impact theory.

As a class, women whose contraceptive needs are not covered will have greater out-of-pocket medical costs than men, and will receive health packages that are less comprehensive than those provided to male employees.[12] Additionally, an employer's exclusion of prescription contraceptives increases the risk of unwanted pregnancies. Accordingly, the employer's female employees of childbearing age bear a risk of interruption of their careers, as a result of pregnancy, that is not shared by their male colleagues. Thus, a failure to cover prescription contraceptives will create a disparate impact on the basis of sex.

In addition, an employer is unlikely to be able to show that exclusion of prescription contraceptives is job-related and consistent with business necessity. Contraception is medically

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[11] *See* 29 C.F.R. part 1604, App. Q&A 24 (1999); *cf. Arizona Governing Committee v. Norris*, 463 U.S. 1073, 1082 n.10 (1983) (no defense to discrimination in an annuity plan that employer offered nondiscriminatory lump-sum alternative; "an employer that offers one fringe benefit on a discriminatory basis cannot escape liability because he also offers other benefits on a nondiscriminatory basis").

[12] *See* Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev. 363, 374 (1998) (as a result of exclusion of contraception, "women bear a disproportionate share of the out-of-pocket financial costs of health care services").

necessary, and an employer cannot reasonably claim that it is not.[13] Even assuming that a cost defense is available as a matter of law, moreover, an employer is unlikely to be able to cost-justify exclusion of prescription contraceptives.[14] Thus, any such exclusion is likely to be unlawful under a disparate impact approach.

D. To avoid liability for sex discrimination, moreover, an employer must also cover contraceptives that are prescribed to treat dysfunctions in women to the same extent that it covers treatments for comparable impairments in men. If a woman is taking contraceptives to correct a hormonal imbalance, for example, it is sex discrimination to deny coverage of her costs where a plan covers medications for hormonal imbalances in men. Failure to cover contraceptives used for such purposes would mean that men would be covered for all medically accepted treatments for their impairments, while women would not. This is unlawful under basic Title VII principles.

III. Conclusion

Where an employer's health plan covers prescription drugs or devices that are used for preventive or health maintenance purposes, the PDA and Title VII's ban on sex discrimination require that the plan also cover prescription contraceptives. Where a charge alleges a failure to cover prescription contraceptives, investigators should determine whether, and how, the employer's health plan covers other preventive prescription drugs and devices. If the extent or terms of that coverage differ from those applicable to contraceptives, the investigator should find cause.

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[13] *See* note 9, *supra*. In any event, this argument will be unavailing to the extent that an employer's plan covers other treatments that are also not "medically necessary" under the employer's plan -- *e.g.*, that are used for something other than the treatment of current disease.

[14] Studies have shown that the financial costs associated with childbirth are much greater than the costs of many years of contraception. *See* Law, *Sex Discrimination and Insurance for Contraception*, 73 Wash. L. Rev.363, 365 & n.13 (1998) (citing studies). In addition, costs for contraceptives are very low. *See* Alan Guttmacher Institute, *Cost to Employer Health Plans of Covering Contraceptives* (June 1998) (estimating that average added cost to employers of covering contraceptives is $1.43 per employee per month).

NATIONAL WOMEN'S LAW CENTER

Hon. Ida L. Castro, Chairwoman
Vice Chair Paul M. Igasaki
Commissioner Reginald E. Jones
Commissioner Paul S Miller
Equal Employment Opportunity Commission
1801 L St. NW
Washington, D.C 20507

June 10, 1999

Dear Chairwoman Castro and Members of the Commission:

We are writing to urge the EEOC to issue a policy guidance setting out the Commission's position that it is an unlawful employment practice under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(a), for an employer covered by Title VII to exclude prescription contraceptives from insurance coverage provided to its employees, when other prescription drugs and devices are covered. This practice, which studies document to be widespread, singles out female employees and the female dependents of employees for disadvantageous treatment. As such, it constitutes sex discrimination in violation of Title VII, and specifically the provisions of Title VII added by the Pregnancy Discrimination Act of 1978 (PDA), 42 U S.C. § 2000e(k). The EEOC policy guidance we request will ensure that employers are fully aware of their legal obligation to provide contraceptive coverage, and therefore could prove tremendously helpful in bringing about an end to this form of sex discrimination in employment.

Background

A very high proportion of large group health insurance plans cover prescription drugs and devices in general but exclude coverage of prescription contraceptive drugs and devices. A 1994 study by the Alan Guttmacher Institute (AGI) found that roughly half of typical large-group plans (49%) do not routinely cover any contraceptive method at all, and only 15% cover all five reversible methods.[1] AGI found that oral contraceptives, the most commonly used reversible

[1] Alan Guttmacher Institute, Uneven and Unequal: Insurance Coverage and Reproductive Health Services (New York, N Y., 1994). The methods of prescription contraception covered in AGI's survey were intrauterine devices, diaphragms, Norplant, Depo-Provera, and oral contraceptives. All of these methods, as well as new barrier methods (cervical caps) are usable only by women. Other forms of contraception are sterilization procedures (tubal ligation, vasectomy), which are available to both men and women and are generally covered by health

method in the United States, are routinely covered by only 33% of large-group plans, while 97% of large group plans typically include coverage of prescription drugs in general. Thus, according to AGI's data, "66% of plans that cover prescription drugs in general do not routinely cover oral contraceptives in their typical policy."[2] AGI also found that while 92% of typical large-group plans routinely cover medical devices in general, only 18% routinely cover IUDs, 15% cover diaphragms, and 24% cover the Norplant device.[3]

Health care professionals consider contraception to be an important component of health care for women and a critical contributor to improved maternal and child health.[4] But in the absence of insurance coverage, purchasing contraceptives can be expensive. In 1993, the average total cost of the contraceptive implant exceeded $700, the cost of an IUD was about $500, and a one-year supply of oral contraceptives and the associated physical examination cost nearly $300.[5]

A number of policy makers and commentators have noted the resulting unfairness to women, especially in the wake of the FDA's approval of the male impotence drug Viagra and indications that a large percentage of Viagra prescriptions are covered by insurance. Senator Olympia Snowe (R-ME) has expressed dismay that although the birth control pill was introduced nearly 40 years ago, "we still haven't seen something as fundamental as fair and equitable coverage by America's insurance companies of prescription contraceptives."[6] Senator James

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insurance, and condoms, which, like other non-prescription drugs and devices, typically are not covered by health insurance.

[2] Uneven and Unequal at 17. See also the 1998 survey by the Segal Company, a consulting firm, which found that 41% of the health plans it surveyed specifically excluded coverage of oral contraceptives. Survey of Health Plan Exclusions for Medication and Services Related to Reproduction and Sexual Dysfunction (The Segal Company, New York, N.Y., Aug. 1998)..

[3] Uneven and Unequal at 17.

[4] According to the Director of Women's Health Issues, American College of Obstetricians and Gynecologists, "[t]here's nothing 'optional' about contraception. It's a medical necessity for women during 30 years of their lifespan." 144 Cong. Rec. S9181, 9194 (July 29, 1998) (Senate Debate on Treasury-Postal Appropriations Bill, Statement of Sen. Snowe).

[5] James Trussell et al., The Economic Value of Contraception: A Comparison of 15 Methods, 85 Am. J. of Pub Health 494 (Apr. 1995).

[6] Snowe: Contraceptive Coverage "Fundamental" in Resolving Health Care Inequities, Gov. Press Release (July 21, 1998) (Statement of Sen. Snowe before the Labor Comm. on S 766, Equity in Prescription Insurance and Contraceptive Coverage Act).

Jeffords (R-VT) has commented, "[i]t is disturbing how rapidly some insurance plans began covering Viagra when it has taken so long for many of them to begin covering contraceptives."[7] One syndicated columnist called the refusal of many insurance plans to cover contraceptives for women "one of the great stupidities in the health care system."[8] Others have labeled the refusal to cover contraception "discrimination against women" and "an issue of gender equity."[9] Recognizing this inequity, Congress recently acted to explicitly require that all health insurance plans made available to federal employees, through the Federal Employees Health Benefits Plan, include coverage of prescription contraceptives if other prescription drugs are covered.[10]

Public opinion polls demonstrate that a substantial majority of Americans share the view that exclusion of contraceptive coverage is inequitable. A June 1998 survey by the Kaiser Family Foundation found that 75% of those polled "strongly" or "somewhat strongly" favored requiring insurers to provide contraceptives as part of prescription coverage. A Kaiser Family Foundation official summarized the results this way: "Both men and women think comprehensive coverage for contraception makes sense; they think it should be part of prescription coverage, and they say they are willing to pay for it."[11]

Analysis

It is well settled that under Title VII's prohibition against discrimination on the basis of sex with respect to an employee's compensation, terms, conditions, or privileges of employment, 42 U.S.C. § 2000e-2(a)(1), it is unlawful for an employer to discriminate between men and

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[7] 144 Cong. Rec. S9181, 9196-97

[8] David S. Broder, Thanks, Viagra (Op-ed), Wash. Post, July 26, 1998, at C7.

[9] See, 144 Cong. Rec. S9181, 9197 (Statements of Sens. Frank Lautenberg (D-NJ) and Barbara Boxer (D-CA)).

[10] Pub. L. No. 105-277, Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (signed Oct 21, 1998). This measure, which enjoyed broad, bipartisan support, does not apply to private sector employees, but legislation that would impose such a requirement in all private insurance has also received broad, bipartisan support. The Equity in Prescription Insurance and Contraceptive Coverage Act was introduced in the 105th Congress by Sens. Olympia Snowe (R-ME) and Harry Reid (D-NV) and co-sponsored by 34 other Senators. It was introduced in the House by Reps. Jim Greenwood (R-PA) and Nita Lowey (D-NY) and co-sponsored by 127 other House members

[11] Contraceptive Coverage: Poll Finds Support for Mandated Coverage, Daily Reprod Health Rep. (Kaiser Fam. Found., Wash., D.C., June 19, 1998); see also, e.g., Editorial, Contraception Muddle, Wash. Post, Oct. 11, 1998, at C6 ("Attempts to expand and ensure access to contraception have broad support from Americans generally. . . .").

women with regard to fringe benefits, including health insurance. See Newport News Shipbuilding and Dry Dock Co. v. EEOC, 462 U.S. 669, 682 (1983) ("[h]ealth insurance and other fringe benefits are 'compensation, terms, conditions, or privileges of employment'"); see also EEOC Guidelines on Discrimination Because of Sex, 29 C.F.R. § 1604.9(b).

Title VII, as amended by the Pregnancy Discrimination Act of 1978 (PDA), specifically provides that Title VII's prohibition against discrimination "on the basis of sex" includes discrimination "on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work. . . ." 42 U.S.C. § 2000e(k). This language was enacted by Congress to overrule the decision in General Elec. Co. v. Gilbert, 429 U.S. 125 (1976), holding that the exclusion of disabilities arising from pregnancy from an employees' disability plan did not violate Title VII. As the Supreme Court has held, the PDA now makes it clear that, for Title VII purposes, such singling out of pregnancy coverage is sex discrimination on its face. Newport News, 462 U.S. at 684-85 & n.26; see also International Union, UAW v. Johnson Controls, Inc., 499 U.S. 187, 199 (1991).

The PDA, moreover, is not limited to discrimination based on pregnancy; it expressly applies to discrimination based on "pregnancy, childbirth, *or related medical conditions*." As the Supreme Court said in Newport News, "[t]he 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions," 462 U.S. at 684, and the EEOC has interpreted the PDA to mean that "any health insurance provided [to employees] must cover expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions." Questions and Answers on the Pregnancy Discrimination Act, 29 C.F.R. Part 1604, App.

It would be difficult to dispute that contraception -- the prevention of pregnancy, by its dictionary definition -- is "pregnancy-related." Indeed, since the underlying "pregnancy-related condition" at issue must be considered the potential for pregnancy, the Supreme Court has already settled the question by treating an employer's classification of employees on the basis of potential for pregnancy as covered by the PDA's language. In Johnson Controls, the Court noted that an employer's policy barring women capable of bearing children from certain jobs was a classification on the basis of potential for pregnancy, and concluded that "[u]nder the PDA, such a classification must be regarded, for Title VII purposes, in the same light as explicit sex discrimination." 499 U.S. at 199. The Court cited PDA legislative history to show that "*this statutory standard was chosen to protect female workers from being treated differently from other employees simply because of their capacity to bear children.*" Id. at 205 (emphasis added).

The PDA's treatment of abortion is further evidence that the PDA's prohibition against discrimination on the basis of "pregnancy, childbirth, or related medical conditions" was intended to include a prohibition against unfavorable treatment of contraception. Included in the PDA is an explicit exception for insurance coverage of abortion: "[The PDA] 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." 42 U.S.C. § 2000e(k). Congress thus understood that absent such an exception, the PDA could require employers to pay for health insurance benefits for abortion to avoid discrimination on the basis of "pregnancy, childbirth, or related medical conditions." If benefits for abortion (pregnancy termination) would be covered absent an express abortion exception, then, clearly, benefits for contraception (pregnancy prevention) must be covered, since Congress did not include any statutory exception for insurance coverage of contraception. The PDA thus plainly encompasses unfavorable treatment of contraception within its prohibition against discrimination on the basis of pregnancy, childbirth, or related medical conditions.

We are aware of no cases directly addressing the question whether the exclusion of contraceptive coverage in an employees' health insurance plan violates Title VII. One court has held that the exclusion of insurance coverage for an employee's fertility treatments falls outside the PDA's protection because infertility is not pregnancy, childbirth, or a related medical condition. Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674 (8th Cir. 1996). But that court distinguished potential pregnancy from infertility (and thereby distinguished Johnson Controls), noting that "[p]otential pregnancy, unlike infertility, is a medical condition that is sex-related because only women can become pregnant" while "denying insurance benefits for treatment of fertility problems applies to both female and male workers and thus is gender-neutral." 95 F.3d at 680. The better view, we submit, is that discrimination on the basis of a woman's infertility is covered by the PDA, and other courts have agreed (in cases involving forms of discrimination other than health insurance coverage, such as discriminatory application of leave policies). Pacourek v. Inland Steel Co., 858 F. Supp. 1393 (N.D. Ill. 1994); Erickson v. Board of Governors, 911 F. Supp. 316 (N.D. Ill. 1995); Cleese v. Hewlett-Packard Co., 911 F. Supp. 1312 (D. Or 1995). But even under the reasoning of Krauel, an employer's unfavorable treatment of contraception in its employees' health insurance plan is discrimination on the basis of potential pregnancy in violation of the PDA.

Employers might attempt to explain or justify the exclusion of contraceptive coverage on the ground that other prescription drugs and devices covered by insurance are intended to treat or cure diseases, whereas contraception is used by healthy women to prevent unwanted pregnancies. But while the traditional health insurance framework in this country once may have had principally a curative focus, today virtually all employment-based insurance plans cover a wide range of preventive services, and many include coverage of preventive drugs and devices. Covered preventive benefits typically include well child visits and immunizations, adult preventive physical examinations, screening exams to detect problems in healthy adults (such as mammograms, Pap smears, prostate and colon cancer screening), and estrogen replacement therapy to forestall osteoporosis. The exclusion of contraceptives thus cannot be justified on the

ground that contraception is uniquely preventive in nature.[12]

Nor is there any other defense or justification available. An employer cannot hide behind the fact that an insurance company may have written the plan. See Arizona Governing Comm. v. Norris, 463 U.S. 1073, 1088-91 (1983) (employer that adopts discriminatory fringe benefit plan cannot avoid liability because it could not find a third party willing to treat its employees on a nondiscriminatory basis). Equally unavailing would be an argument that the discriminatory practice is justified by cost savings. See Norris, 463 U.S. at 1084-85 n.14; Newport News, 462 U.S. at 685 n.26.[13]

Thus, as shown, the exclusion of contraceptive coverage in these circumstances is sex discrimination on its face (i.e., disparate treatment). It could be considered discriminatory under a disparate impact analysis as well. See, e.g., Scherr v. Woodland Sch. Community Consol. Dist. No. 50, 867 F.2d 974 (7th Cir. 1988) (concluding, in a case involving allegations that neutral leave policies had been applied in a way that had an adverse impact on pregnant workers, that while the PDA made it clear that pregnancy-based distinctions are per se violations of Title VII, reliance on a disparate impact approach under the PDA was not foreclosed); see also 29 C.F.R. § 1604.10(c) (termination of a temporarily disabled worker under an employment policy providing inadequate leave violates Title VII if it has a disparate impact on employees of one sex and is not justified by business necessity). Considered under a disparate impact approach, the exclusion of contraceptive coverage would violate Title VII because even if such exclusion were considered

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[12] Moreover, as noted, medical professionals consider contraception important for women's health in general. As the American College of Obstetricians and Gynecologists has stated "[t]o ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable." 144 Cong. Rec. S9181, 9194. Additionally, women with conditions including diabetes, obesity, and certain heart defects and cancers are advised to avoid pregnancy due to the added stress on the body and/or the impact that medical treatment would have on the fetus. And while oral contraceptives are used most frequently to prevent pregnancy, they are also prescribed for other purposes, such as treating endometriosis, ovarian cysts and uterine bleeding, and prevention of osteoporosis. Abigail Zuger, The Pill at 40: Renewed, Improved and in Its Prime, N.Y. Times, Oct. 20, 1998, at F2; see also Steven R. Bayer & Alan H. DeCherney, Clinical Manifestations and Treatment of Dysfunctional Uterine Bleeding, 269 JAMA 1823 (1993).

[13] In any event, providing coverage for contraceptives adds very little to the cost of insurance. A recent study by AGI found that the average total cost (including administrative costs) of adding coverage for the full range of reversible medical contraceptives to health plans that do not currently cover them will increase total health coverage costs for employees and their dependents by $21.40 per employee per year -- $17.12 of employers' costs and $4.28 of employees' costs. This makes the added cost for employers $1.43 per month. Alan Guttmacher Institute, Cost to Employer Health Plans of Covering Contraceptives, June 1998.

facially neutral with respect to sex, its impact falls 100% on women -- since there are no male prescription contraceptives currently available -- and it cannot conceivably be justified by any business necessity.

Conclusion

Title VII, as amended by the Pregnancy Discrimination Act, prohibits covered employers from discriminating on the basis of sex by providing insurance coverage to their employees that includes prescription drugs and devices but excludes prescription contraceptives. This practice, which the evidence suggests is quite common, must be considered sex discrimination on its face (as well as in its disparate impact), based on the language and history of the PDA and strengthened by the Supreme Court's construction of it as prohibiting the treatment of female workers differently from other employees simply because of their capacity to bear children. At least one recent commentary has come to the same conclusion. Sylvia Law, Sex Discrimination and Insurance for Contraception, 73 Wash. L. Rev. 363 (1998).

In order to provide clear guidance to employers on this issue and prompt those who are out of compliance with Title VII to revise their policies accordingly, we urge the Commission to issue a policy guidance setting forth its position. The guidance must make it clear that an employer covered by Title VII that provides coverage for prescription drugs and devices in its employees health plan but does not provide coverage of all available methods of prescription contraception is in violation of Title VII.[14] In addition, the Commission should look for opportunities to litigate this issue in court.

We would be pleased to work with the Commission as it moves forward on this matter.

Sincerely,

Marcia D. Greenberger
Co-President

Judith C. Appelbaum
Vice President for Employment Opportunities

Susan Liss
Vice President for Health and Reproductive Rights

On behalf of the National Women's Law Center and.

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[14] It is essential that plans cover the full range of prescription contraceptive choices, because different contraceptive methods are appropriate for different women, and different methods are often appropriate for an individual woman at different points in her life.

Alan Guttmacher Institute
American Academy of Pediatrics
American Association of University Women
American Civil Liberties Union
American Civil Liberties Union Reproductive Freedom Project
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Federation of Teachers
American Medical Women's Association
American Psychological Association
American Public Health Association
American Social Health Association
American Society for Reproductive Medicine
Association of Reproductive Health Professionals
Association of Women's Health, Obstetric, and Neonatal Nurses
Business and Professional Women USA
California Women's Law Center
Catholics for a Free Choice
Center for Women's Policy Studies
Center for Advancement of Public Policy
Center for Reproductive Law and Policy
Choice USA
Coalition of Labor Union Women
Connecticut Women's Education and Legal Fund
Equal Rights Advocates
Hadassah
Jewish Women International
Lawyers' Committee for Civil Rights Under Law
Mexican American Legal Defense and Education Fund
NAACP Legal Defense and Education Fund
National Abortion and Reproductive Rights Action League
National Abortion Federation
National Association of Commissions for Women
National Association of Negro Business and Professional Women's Clubs, Inc.
National Association of Nurse Practitioners and Reproductive Health
National Black Women's Health Project
National Council of Jewish Women
National Council of Negro Women
National Council of La Raza
National Education Association
National Employee Rights Institute
National Employment Law Project
National Employment Lawyers Association

National Family Planning and Reproductive Health Association
National Latinas Caucus
National Latina Institute for Reproductive Health
National Organization for Women
National Partnership for Women & Families
National Political Congress of Black Women
National Women's Health Network
Northwest Women's Law Center
NOW Legal Defense and Education Fund
Planned Parenthood Federation of America
Physicians for Reproductive Choice and Health
Religious Coalition for Reproductive Choice
RESOLVE, The National Infertility Association
Sexuality Information and Education Council of the United States (SIECUS)
Society for Adolescent Medicine
Women Employed
Women's Law Center of Maryland, Inc.
Women's Law Project
Women's Law and Public Policy Fellowship Program
YWCA of the USA

freely. By more than 2-1 (23%-58%), respondents preferred the creation of a regulatory board of specialists rather than Congress to regulate the Web.

b)**Overall regulation**

Only 29% said we don't need any more regulatory boards or rules, while 64% said at least in the beginning, new regulations are necessary since they impact commerce, children, and other new issues.

63% support (40% strongly) the creation of a regulatory board to make decisions on the Internet, while only 27% would oppose it. If President Clinton supported such a body, similar to the FCC, 54% would view him more favorably (24% much more) while 34% would view him less favorably.

c) **Gambling**

Voters apparently do want to play Lotto and other games over the internet

57% oppose a ban on gambling on the internet, 34% favor one.

This is a developing area in technology that is quickly intersecting with all of the areas of family life,

Health Insurance/Contraceptives

Two issues related to family planning:

a) support could be built for covering contraceptives as part of healthcare programs

b) the $250 million for abstinence teaching is very vulnerable to attack to be replaced by proper sex education

58% believe health insurance companies should be required to provide coverage of contraceptives, 38% oppose. When told contraceptives would reduce abortions and unwanted children, support rose to 62% insurance co. should pay/33% should not pay.

Some people say that requiring insurance companies to cover contraceptives would encourage their use and reduce abortions and unwanted children so it can be very helpful; others say that contraceptives are something that health insurance should not pay for, since it is not necessary and some people oppose their use. Which is closer to your view?

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:
6/20/97 Senate Labor and Human Resources Committee

egislative Chronology:

st Session Activity:

6/20/97	143 Cong Rec S 4748	Referred to the Senate Labor and Human Resources Committee
6/21/97	143 Cong Rec S 4898	Cosponsor(s) added
6/05/97	143 Cong Rec S 5370	Cosponsor(s) added
6/10/97	143 Cong Rec S 5465	Cosponsor(s) added
6/16/97	143 Cong Rec S 5703	Cosponsor(s) added

LL-DIGEST: (from the CONGRESSIONAL RESEARCH SERVICE)

ort title as introduced :

Equity in Prescription Insurance and Contraceptive Coverage ct of 1997

gest :

sn00743

RS Index Terms:

ealth policy
ıbulatory care
ısiness
vil rights
ınsumer education
ınsumers
ntraceptives
scrimination in insurance
scrimination in medical care
ployee health benefits
nance
vernment information
vernment paperwork
alth insurance industry
alth 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
IY PROVISION OF STATE LAW TO THE EXTENT THAT SUCH STATE LAW ESTABLISHES,
IPLEMENTS, OR CONTINUES IN EFFECT ANY STANDARD OR REQUIREMENT THAT
OVIDES PROTECTIONS FOR ENROLLEES THAT ARE GREATER THAN THE PROTECTIONS
OVIDED UNDER THIS SECTION.
"(F) DEFINITION.-IN THIS SECTION, THE TERM 'OUTPATIENT CONTRACEPTIVE
RVICES' MEANS CONSULTATIONS, EXAMINATIONS, PROCEDURES, AND MEDICAL
RVICES, PROVIDED ON AN OUTPATIENT BASIS AND RELATED TO THE USE OF
NTRACEPTIVE 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 nall 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.