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Contraceptive Coverage Under Student Health Insurance Plans: Title IX as a Remedy for Sex Discrimination

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Abstract: Sex discrimination in health insurance coverage is an industry norm. Private health plans that reimburse for the costs of prescription drugs typically exclude coverage for prescription contraceptives. Student health insurance plans are no exception. This Article argues that student health benefit plans that single out prescription contraceptives for coverage distinct from other prescription medications discriminate on the basis of sex, and therefore, violate Title IX, as amended by the Civil Rights Restoration Act of 1987. The Article begins by examining the system of health care financing in the United States, and how this system leaves middle-income college-age women without access to contraceptive financing. It then examines the extent of contraceptive coverage under student health insurance plans, a major source of health insurance for middle-income college-age women, and proposes the use of Title IX as a vehicle for challenging those plans that discriminate on the basis of sex by limiting coverage for birth control drugs, devices, and supplies. Finally, this Article concludes by advancing a comprehensive schedule of benefits that would remedy the current inequity in prescription contraceptive coverage.

Middle-income college-age women are least likely to be insured.[1]

* J.D., University of Baltimore, School of Law, 1997; LL.M., New York University School of Law, 1999. Cecile M. Bergin is especially thanked for her unyielding support and encouragement throughout the drafting process and beyond. The author also thanks Deborah Ellis, Esquire, whose comments on earlier drafts of this article contributed much to its final form, as well as the participants of the 1998 Women and the Law Seminar at New York University School of Law for their commitment to women's equality through legal reform.

1. *See* ELISE F. JONES ET AL., PREGNANCY, CONTRACEPTION AND FAMILY PLANNING SERVICES IN INDUSTRIALIZED COUNTRIES: A STUDY OF THE ALAN GUTTMACHER INSTITUTE 85 (1989) [hereinafter PREGNANCY, CONTRACEPTION AND FAMILY PLANNING]. In 1997, 14.88% of women in the United States were uninsured, with women between the ages of eighteen and

One reason for the low rates of coverage is that these women tend to be young, unmarried, and unemployed, and therefore, typically do not qualify for benefits under traditional health care financing schemes.[2] For women enrolled in institutions of higher education, student health insurance plans provide a cost-effective and practical alternative to conventional plans. A majority of students plans, however, deny or substantially limit reimbursement for the most commonly prescribed birth control drugs and devices.[3] Title IX, as amended by the Civil Rights Act of 1987, prohibits sex-discrimination in "all of the operations" of an educational institution that receives federal funds.[4] This Article suggests that the limitation and exclusion of coverage for prescription contraceptives under university sponsored student health insurance plans constitutes sex discrimination in violation of Title IX.

The sex bias underlying policy limitations on coverage for prescription contraceptives is apparent. Immediately upon its debut in March of

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twenty-four least likely to have health coverage. *See* Robert L. Bennefield, *Health Insurance Coverage: 1997*, CURRENT POPULATION REPORTS (U.S. Census Bureau), Sept. 1, 1997, at 1; *see also* Peter J. Cunningham, *Next Steps in Incremental Health Insurance Expansions: Who is Most Deserving?*, ISSUE BRIEF No. 12 (Center for Studying Health System Change, Washington, D.C.) Apr. 1998, at 1 [hereinafter NEXT STEP]; KAISER FAMILY FOUND., SURVEY OF WOMEN ABOUT THEIR KNOWLEDGE, ATTITUDES, AND PRACTICES REGARDING THEIR REPRODUCTIVE HEALTH 3 (1997) [hereinafter SURVEY OF WOMEN].

2. *See infra* text accompanying notes 73-83.

3. The birth control pill is the most common form of reversible contraception used by women. *See* Linda Piccinino & William D. Mosher, *Trends in Contraceptive Use in the United States: 1982-1995*, 30 FAM. PLAN. PERSP. 4, 5 (1998). In 1995, 10.4 million women relied on birth control pills as a primary method of contraception. *See id.* Among women between the ages of fifteen and forty-four the distribution of reversible contraceptive use by method is as follows: birth control pill, 10.4 million; injectables, 1.1 million; diaphragm, .72 million; IUD, .31 million; implant, .5 million. *See id.* A woman's choice of preferred contraceptive method is strongly race and age correlative. In general, the pill is used primarily by single white women under age thirty, who have one or more years of college education. *See id.* at 8, 9. In contrast, female sterilization is most common among formerly married women over thirty with less education and income, and Hispanic and black women generally. *See id.* at 8, 9. The proportion of white contraceptive users relying on birth control pills in 1995 stood at 57% for women between the ages of twenty to twenty-four and 6% for women between the ages of forty to forty-four. *See id.* The proportion of women relying on female sterilization was 3% at ages twenty to twenty-four and 45% at ages forty to forty-four. *See id.* at 7. In contrast, pill use among black women between the ages of twenty and twenty-nine dropped significantly in 1995, but those declines were partially offset by increased reliance on injectables and implants. *See id.* at 6, 7. Throughout this Article, "birth control drugs and devices" and "contraceptive services and supplies" are used inclusively in reference to all five FDA-approved reversible methods of contraception.

4. *See* 20 U.S.C. § 1687 (1994). Title IX provides that "[N]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any education program or activity receiving Federal financial assistance. . . ." 20 U.S.C. § 1681 (1994). For purposes of the statute, "the term 'program or activity' and 'program' mean all of the operations of . . . a college, university, or other postsecondary institution, or a public system of higher education. . . ." 20 U.S.C. § 1687 (2)(A), (B) (1994).

1998, insurers rushed to expand coverage under existing policies to include reimbursement for the costs of the male impotency drug Viagra.[5] Yet to this day, forty years after the introduction of the birth control pill, a majority of conventional indemnity plans continue to deny similar coverage for female contraceptives.[6] Industry heads defend this pattern by citing bottom line fears that expanded contraceptive coverage would result in premium cost hikes that, in turn, would force potential enrollees to forego coverage altogether.[7] This contention, that contraceptive coverage would be prohibitively more expensive, however, is belied in both practice and prediction. Not only is the actual cost of full contraceptive coverage deminimus,[8] but an overwhelming majority of women and men favor insurance coverage for birth control drugs and devices even if premium costs were to increase by as much as five dollars per month.[9]

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5. *See* IMS AMERICA, PRESS RELEASE, *IMS Health Forecasts Viagra Sales to Reach $1 Billion in First Year*, 1 (visited July 6, 1998), *available in* <http://ims-america.com/communications/pr_viagra_July6.htm> (1998). One-half of all men who take Viagra are reimbursed, at least in part, by their insurers. *See id.*

6. While approximately 96% of traditional indemnity plans include coverage for prescription drugs, only 33% cover oral contraceptives. *See* THE ALAN GUTTMACHER INSTITUTE, UNEVEN & UNEQUAL: INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 16 (1995) [hereinafter UNEVEN & UNEQUAL]. The disparity between coverage for oral contraceptives and the impotency drug Viagra is perplexing given the increased cost of providing coverage for the latter. A single Viagra pill, which must be injested each time before intercourse, carries a price tag of ten dollars, while a full month's supply of oral contraceptives costs approximately $30. *See* Judy Mann, *The Pharmaceutical Double Standard*, WASH. POST, May 22, 1998, at E3. Insurers seem to be catching on. Some have limited or significantly restricted coverage for Viagra, justifying the restrictions as needed to deter doctors from writing prescriptions for patients who are seeking to obtain the pill simply to increase their sexual performance rather than to remedy a sexual dysfunction. *See* Daniel Wise, *The Lawyer Behind The Suit for That Drug*, 219 N.Y. L.J. 1 (1998). In 1998, two lawsuits were filed wherein the plaintiffs claimed that ERISA bars insurers from limiting or restricting coverage for Viagra in any way. *See* Sibley-Schreiber v. Oxford Health Plans, Inc., No. 98-CV-3671 (E.D.N.Y. 1999); Roe v. Aetna Life Insurance Co., No. 98-2223 (N.D. Cal. 1998).

7. *See* Sen. Olympia Snowe & Sen. Harry Reid, *Contraception Must be Included by Insurers*, ROLL CALL (visited October 19, 1998), *available in* <http://www.rollcall.com/0mW2A110/policybr/pbstory_f.html>.

8. Under a standard cost-sharing arrangement, the actual cost to employers of expanding group coverage to include prescription contraceptives increases by less than one percent. *See* Jacqueline E. Darroch, *Cost of Employer Health Plans of Covering Contraceptives*, 1998 The Alan Guttmacher Inst. 1. The average cost to the insurance company of unintended pregnancy among women using no contraceptive method is more than $3,225.00 for each woman who becomes pregnant. *See* Snowe and Reid, *supra* note 7. This figure does not take into account the savings which may be achieved through prevention of pregnancy. *See id.* Estimates of the total annual cost of providing complete contraceptive coverage range from approximately $17 to $21 per employee. *See* Darroch, *supra* at 1. Employee contributions increase by $4.28 per year or $0.36 per month. *See id.*

9. Forty-five percent of respondents to a recent survey conducted by the Kaiser Family Foundation would "strongly favor" a contraceptive insurance mandate; thirty percent would "somewhat favor" a mandate. *See* KAISER FAMILY FOUND., *1998 National Survey on Insurance Coverage for Contraceptives*, *available in* <http://www2.kff.org/content/archive/1404/

Moreover, contraceptive coverage pays for itself. "[A] 15 percent increase in the number of oral contraceptive users in a health plan would provide enough savings in pregnancy costs alone to provide oral contraceptive coverage for all users in the plan."[10] Thus, the exclusion of contraceptives from health insurance plans is economically indefensible.

The federal government, for its part, seems complacent in this pattern of sex-discrimination. For example, Congress has refused to enact broad based legislation that would mandate coverage for FDA-approved contraceptives under private insurance plans.[11] In addition, although the 1999 Budget deal required insurers participating in the Federal Employees Health Benefits Program to offer prescription contraceptive coverage on par with other prescription medications,[12] that advance may be short-lived. Adversaries have already introduced legislation to repeal the law, despite their commitment to encouraging state-run Medicaid programs to cover costs for Viagra.[13] Among the minority of states that have codified minimum contraceptive coverage requirements,[14] federal pre-

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insurance.html> [hereinafter *Coverage for Contraceptives*]. Overall, both women (81%) and men (68%) supported a contraceptive mandate. Seventy five percent agreed that insurers should cover contraceptives, while only forty-nine percent favored coverage for Viagra. *See id.*

10. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *Nation's Ob-Gyns Assail Gender Bias in Insurance coverage*, July 6, 1998, *available in* <http://walden.mvp.net/~rocman/COVERG.htm> [hereinafter ACOG]. The cost savings of contraceptive coverage and resulting use is borne out in the public sector as well. *See infra* text accompanying notes 17-19.

11. In 1997, Sen. Olympia Snowe (R-Maine) and Sen. Harry Reid (D-Nev) introduced the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), which, if passed, would have prohibited plans that already provide coverage for prescription drugs from excluding or restricting coverage for the most commonly used FDA-approved contraceptives and related services. A companion bill was introduced in the House of Representatives by Rep. Nita Lowry (D - NY) and Rep. Jim Greenwood (R-Pa). *See* S./H.R. Res. 2174, 105th Cong. (1997). Both measures were soundly defeated.

12. *See* Ominbus Consolidated & Emergency Supplemental Appropriations Act of 1999, P.L. 105-277, 112 Stat. 2681.

13. The federal government encourages state-run Medicaid programs to cover costs for Viagra. *See Pharmaceutical Product News: Pfizer Viagra Medicaid Coverage, Health News Daily*, FDC REPORTS, July 6, 1998 (reporting on letter sent by Health and Human Services Secretary Donna Shalala to National Governor's Association indicating that "under current law, . . . Viagra is covered by Medicaid when a physician renders a diagnosis that the drug is medically necessary."). Some estimate that the fiscal impact of Viagra coverage on state Medicaid programs could reach $ 100 million annually. *See APSA and NASMD Denounce Decision to Mandate Medicaid Coverage of Viagra*, AMERICAN PUBLIC WELFARE ASSOCIATION, July 2, 1998, *available in* <http://www.apwa.org/hotnews/viagra.htm>. As a result, several states have balked at the Viagra directive, giving rise to the possibility of multi-million dollar suits by the federal government to enforce compliance. *See* Ed Anderson, *Medicaid Viagra Coverage Might Be Cut, Lawmakers Cite Fraud and Abuse*, NEW ORLEANS TIMES, Feb. 27, 1999, at A3; Thomas P. Wyman, *Legislative Menu Items to Be Finalized Today*, INDIANAPOLIS STAR, March 8, 1999, at A1; Avram Goldstein, *Medicaid Covers Viagra in Maryland and D.C., Not in Virginia*, WASH. POST, May 9, 1998, at A1.

14. In 1998, Maryland became the first state to pass legislation requiring private insurers to provide comprehensive coverage for contraceptives. *See* MD. CODE ANN., HEALTH § 19-706

emption laws[15] and conscious clause limitations[16] thwart state-wide efforts to ensure that women and men are offered comparable health insurance coverage.

Turning a blind eye to these discriminatory insurance practices carries a high price tag. The success of publicly funded family planning programs is testimony to the cost savings that would result from a contraceptive coverage mandate. By facilitating access to and financing for prescription contraceptives, publicly funded family planning services prevent an estimated 1.5 million unintended pregnancies[17] and over one-half million abortions each year.[18] In fiscal terms, federal and state gov-

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(1998); MD. CODE ANN., INSURANCE § 15-826 (1998). Texas requires insurers to include coverage for oral contraceptives if all other prescription drugs are covered. *See* 28 TEX. ADMIN. CODE. § 21.404 (3) (West 1998). Virginia and Hawaii require insurers to offer employers the option of including coverage in employee benefits plans, but stopped short of mandating coverage. *See* VA. CODE ANN. § 38.2-3407.5:1 (Michie 1997); HAW. REV. STAT. § 432:1-604.5, 431:10A-116.6 (1998). The following states' legislatures submitted bills during the 1999 legislative season that, if enacted into law, would afford some measure of contraceptive coverage: Alaska, S.B. 82/ H.B. 29, 21st Leg., 1st Sess. (Alaska 1999); California, S.B. 41/AB 39, 1999-00 Leg., Reg. Sess. (Cal. 1999); Connecticut, H.B. 5502, 1999 Leg., Reg. Sess. (Conn. 1999); Florida, H.B. 101, 371, 83/S.B. 1160, 1999 Leg., Reg. Sess (Fla. 1999); Georgia, H.B. 374, 1999 Leg., Reg. Sess. (Ga. 1999); Hawaii, H.B. 488/S.B. 822, 20th Leg., Reg. Sess. (Haw. 1999); Idaho, S.B. 1142, 55th Leg., 1st Sess. (Idaho 1999); Illinois, H.B. 61/S.Res. 517, 91st Leg., Reg. Sess. (Ill. 1999); Indiana, H.B. 1443/S.B. 415, 111th Leg., 1st Sess. (Ind. 1999); Maine, S.B. 389 119th Leg., 1st Sess. (Me. 1999); Missouri, H.B. 87, 630, 90th Leg., 1st Sess. (Mo. 1999); Montana, H.B. 400, (1999) Leg., Reg. Sess. (Mont. 1999); Nevada, A.B. 60/S.B. 28, 70th Leg., 1st Sess. (Nev. 1999); New Jersey, A.B. 2333, 2267/S.B.1335, 208th Leg., Reg. Sess. (N.J. 1999); New Mexico, H.B. 293, 44th L3g., 1st Sess. (N.M. 1999); New York, A.B.1844/S.B. 324, 349, 1099, 222nd Leg., 1st Sess. (N.Y. 1999); Ohio, H.B. 42, 123d Leg., Reg. Sess. (Ohio 1999); Oklahoma, S.B. 222, 47th Leg., 1st Ses. (Okla. 1999); Oregon, S.B. 521, 70th Leg., Reg. Sess. (Or. 1999); Pennsylvania, H.B. 11,109, 1999 Leg., Reg. Sess. (Pa. 1999); Rhode Island, H.B.5633/S.B. 343, 1999-00 Leg., Reg. Sess. (R.I. 1999); South Carolina, H.B. 3149, 1999 Leg., Reg. Sess. (S.C. 1999); Utah, S.B. 31, 1999 Leg., Gen. Sess. (Utah 1999); Vermont, H.B. 104, 189, 65th Leg., Reg. Sess. (Vt. 1999); Washington, H.B. 1590/S.B. 5512, 55th Leg., Reg. Sess. (Wash. 1999).

15. Much of traditional state authority to regulate the content of self-insured employee benefits plans is preempted by the federal Employee Retirement Insurance Security Act (ERISA). *See* 29 U.S.C. §§ 1001-1461 (1994). ERISA prohibits states from mandating coverage for particular benefits or services, and from defining discrimination more broadly than it is defined under federal law. *See generally* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

16. Conscious clause exemptions permit individuals, health care facilities, and health plans to decline to cover or to withhold services against which the provider has a religious, ethical, or moral objection. *See* KAISER FAMILY FOUND., *An "EPICC" Debate, The Equity in Prescription Insurance and Contraceptive Coverage Act,* <http://www.kft.orglarchiev/repro/briefing/insuted/ insured.html>, 1998; RACHEL BENSON GOLD, *Contraceptive Coverage: Toward Ensuring Access While Respecting Conscience,* THE GUTTMACHER REPORT ON PUBLIC POLICY No. 6 (The Guttmacher Institute), Dec. 1998, at 2.

17. *See* Jennifer J. Frost & M. Bolzan, *The Provision of Public-Sector Services by Family Planning Agencies in 1995,* 29 FAM. PLAN. PERSP. 6 (1997).

18. *See* Jacqueline Darroch Forrest & Renee Samara, *The Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures,* 28 FAM. PLAN. PERSP. 188 (1996).

ernments avoid over $1 billion dollars worth of annual medical expenses associated with unplanned births and abortions. For every dollar spent on publicly funded contraceptive services, an average of $4.40 is saved in public costs for medical care, welfare and supplementary nutritional programs for newborns.[19]

Until the inequity in prescription contraceptive coverage receives serious political consideration, the prospect of litigation might provoke health insurance companies to formulate equitable benefits packages. In a 1998 Article published by the *Washington Law Review*, Professor Sylvia Law challenged the denial of contraceptive coverage as discriminatory against women, and called for the application of Title VII to employment-based benefit plans that limit coverage for birth control drugs and devices.[20] Law's proposal would ensure contraceptive coverage for the millions of women who depend on employer-sponsored group health insurance plans to finance medical costs. Yet, even with the success of Law's innovative approach, seventy-eight percent of women still would be subject to a double-standard in insurance coverage.[21] Among them are middle-income college-age women who rely on student health insurance plans that unfairly exclude coverage for prescription contraceptives. This Article mirrors the structure of Law's Article and builds on her thesis that the exclusion of contraceptives from otherwise comprehensive health plans constitutes sex-discrimination. This Article urges the application of Title IX to discriminatory student health insurance plans that restrict coverage for birth control drugs and devices.

Following this introduction, Part I describes the structure of the American health care financing system as a primary vehicle for facilitating access to prescription contraceptives. This system of private and public health care financing channels services to older, wealthier women on the one hand, and younger, lower-income women on the other. Strict income guidelines and qualification criteria, however, keep traditional health care options out of reach from female college students. These women often rely on student health insurance plans to offset medical costs even though few student health plans include coverage for birth control drugs and devices. Part II introduces Title IX, as amended by the Civil Rights Restoration Act, and proposes a rubric for challenging discriminatory student health plans under that statute. Part III predicts some defenses that might be raised to a claim that restrictions on cover-

19. *See* Frost & Bolzan, *supra* note 17, at 1.

20. Sylvia A. Law, *Sex Discrimination and Insurance For Contraception*, 73 WASH. L. REV. 363 (1998).

21. *See ACLU Support Health Equity in Contraceptive Coverage, available in* <http://www.aclu-wa.org/legislative/Alerts/Intro/InsuranceEquity.stml>.

age for prescription contraceptive services and supplies violates Title IX and then goes on to explain the shortcomings of these defenses. This Article concludes in Part IV by proposing a schedule of benefits that might be incorporated into student health benefits plans. The proposed plan complies with Title IX by emphasizing coverage that is clear, compulsory, complete, and comprehensive, to ensure that every college-age woman's choice of "birth control" is tailored to her particular needs and life style.

I. HEALTH CARE FINANCING IN THE UNITED STATES

The health care financing scheme in the United States facilitates access to and financing for prescription contraceptives. The two main vehicles of contraceptive financing, employer-based group plans and public-sector subsidies, channel services towards older wealthier women on the one hand, and adolescent lower-income women on the other.[22] While both forms of medical assistance make available a relatively comprehensive package of family planning services to their target populations, middle-income college-age women rarely qualify as eligible beneficiaries. In the end, the health care financing system leaves post-secondary women with a Hobsian choice: forego health care coverage altogether or enroll in a student-based program that unfairly excludes coverage for prescription contraceptives.

A. *Private Insurance Coverage*

Nearly 200 million people finance health care costs through independent or employer-sponsored insurance plans.[23] While twenty-five million people obtain medical coverage through independent private policies,[24] the vast majority — just over 165 million — finance health care costs by participating in employer-sponsored group health plans.[25] In the late 1980s, rising premium costs may have forced many working families with access to employer-based coverage to disenroll.[26] Yet, even after a decade of decline in the number of individuals with group-based coverage, employee-sponsored insurance programs remain the

22. *See infra* text accompanying notes 44-49, 67-72.

23. In 1997, 188.5 million people were enrolled in private insurance plans. *See* BUREAU OF THE CENSUS, ANNUAL DEMOGRAPHIC SURVEY, MARCH SUPPLEMENT (1998) [hereinafter MARCH SUPPLEMENT].

24. In 1997, a total of 8.7 percent of all persons were insured under independent private plans. *See* Bennefield, *supra* note 1, at 1.

25. In 1997, 165.1 million people were covered either in their own name or as a dependent under an employer-based insurance plan. *See* MARCH SUPPLEMENT, *supra* note 23, tbl. NC6.

26. *See* AFL-CIO, PAYING MORE AND LOSING GROUND: HOW EMPLOYER COST SHIFTING IS ERODING HEALTH COVERAGE OF WORKING FAMILIES 16 (1999) [hereinafter AFL-CIO].

predominate healthcare financing vehicle.[27]

Employer-sponsored medical benefits packages take a variety of forms, the most prevalent being the managed care health plan.[28] Ever since the federal government began encouraging its development in 1973, managed care has gained a near monopoly over the health benefits market.[29] Managed care organizations administer roughly fifty percent of employer-sponsored plans[30] and provide coverage to nearly sixty-seven million workers and their families.[31] In 1997, eighty-five percent of workers[32] and seventy-three percent of all commercially insured individuals were enrolled in managed care health plans.[33]

Cost sharing mechanisms common to group health plans apportion premium expenses between the employer and employee at a ratio of about eight to one.[34] The cost to employees of participating in an employer-sponsored health plan remains significantly less than the cost

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27. *See* Bennefield, *supra* note 1, at 2; Paul Fronstin, *The Decline in Health Insurance and Labor Market Trends*, STATISTICAL BULLETIN No. 3 (Metropolitan Life Ins. Co.) July 18, 1996 at 1.

28. "Managed care" generally refers to a payment system whereby the health plan attempts to control or coordinate health services used by its enrolled members in order to contain medical costs. *See* BETH C. FUCHS, MANAGED HEALTH CARE: FEDERAL AND STATE REGULATION, CONG. RES. SERVICE (Oct. 8, 1997). Managed care organizations come in a variety of forms, including: Health Maintenance Organizations ("HMOs"), Preferred Provider Organizations ("PPOs"), Provider Sponsored Organizations ("PSOs"), and Point-of-Service Options ("POSs"). Beneficiaries of such programs must relinquish varying degrees of autonomy with respect to health care decisionmaking, depending upon the provider network selected. For a detailed description of managed care options, see Curtis D. Rooney, *The States, Congress, or the Courts: Who Will Be First to Reform ERISA Remedies?*, 7 ANNALS HEALTH L. 73, 79-81 (1998); RACHEL GOLD & F.L. RICHARDS, *Improving the Fit: Reproductive Health Services in Managed Care Settings* 5-9; ISSUES IN BRIEF ALAN GUTTMACHER INST., March 1996, at 1-4.

29. *See* Health Maintenance Organizations Act of 1973, 42 U.S.C. § 300e (1994).

30. *See* U.S. DEP'T. OF LABOR, A LOOK AT EMPLOYERS' COSTS OF PROVIDING HEALTH BENEFITS 2 (1996) [hereinafter EMPLOYERS' COSTS]; BUREAU OF THE CENSUS, STATISTICAL ABSTRACTS OF THE UNITED STATES: 1998, Tbl. 183, at 126 [hereinafter STATISTICAL ABSTRACTS]. In 1995, the average cost per employee (both employers' and employees' share) of participating in an HMO was nineteen percent, or $804.00 lower than traditional indemnity plans. *See* EMPLOYERS' COST, *supra* at 3. The average cost for coverage in a PPO was eighteen percent, or $781.00 lower than a traditional indemnity plan. *See id*; *see also* FOSTER HIGGINS 1996 NATIONAL SURVEY OF EMPLOYER SPONSORED HEALTH PLANS 5-7 (1995). Nonetheless, the real average deductible payed by employees in HMO plans rose eight percent between 1989 and 1993, from $202.00 to $218.00 respectively. *See* EMPLOYERS' COSTS, *supra* at 4.

31. ELSEWHERE IN MANAGED CARE, HEALTH LAW NEWS 23 (Jan. 1998). By 1997, just over fifteen percent of workers were enrolled in traditional indemnity plans. *See Health Benefits Costs Rise in* 1997, COLLECTIVE BARGAINING REP. No. 1 (1998).

32. *See* Rooney, *supra* note 28, at 79.

33. *See* R.B. Gold et al., *Mainstreaming Contraceptive Services in Managed Care, Five States Perspectives*, 30 FAM. PLAN. PERSP. 204, 204 (1998); G.A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 16 HEALTH AFF. 125, 126 (1997).

34. In 1994, the average employer contributed eighty percent of the premium costs for employee coverage in an HMO, eighty-three percent for coverage in a PPO, and eighty-eight percent for coverage in a fee for service plan. *See* EMPLOYERS' COSTS, *supra* note 30, at 6.

of obtaining non-group coverage. One national labor organization estimates the employee's annual contribution to be $453.00 for individual coverage, and $1,615.00 for family coverage.[35] With the transition to managed care, however, employers are shifting the risk of health care inflation to employees[36] by increasing policy deductibles and co-payments, and thereby compounding the actual expense of participating in a group plan.[37]

The proliferation of managed care as the dominant employer sponsored health care option, while not without its drawbacks,[38] has positive implications for the accessibility and financing of contraceptive drugs and devices. A majority of health maintenance organizations cover the most common types of reversible contraception.[39] Specifically, eighty-four percent of HMOs that provide coverage for prescription drugs provide equal coverage for oral contraceptive pills.[40] By comparison, almost one-half of all fee-for-service arrangements which cover the costs of prescription drugs exclude coverage for the most commonly prescribed contraceptives.[41] A full two-thirds of conventional plans exclude coverage for birth control pills.[42] On balance, coverage for the full range of birth control drugs and devices under managed care, while not comprehensive, far outweighs contraceptive coverage under traditional indemnity plans.[43]

Women participate in employer-sponsored managed care plans in significant numbers, either as direct beneficiaries or as dependents of covered employees, and are reimbursed for a substantial portion of out-

35. *See* AFL-CIO, *supra* note 26, at 16.

36. *See id.* at 9; STATISTICAL ABSTRACTS, *supra* note 30, tbl. 182, at 125.

37. *See* AFL-CIO, *supra* note 26, at 3.

38. A recent study found that one in three managed care enrollees experienced some degree of difficulty in obtaining contraceptive services through their plan. The most common complaints related to costs, confidentiality, delay, or denial of services. *See* Gold et al., *supra* note 33, at 209-210. Perhaps these inadequacies stem from the perverse incentive created by the managed care financing scheme where the marginal revenue of a medical procedure is zero: "From a short-term financial standpoint . . . the [managed care organization's] incentive is to keep you healthy but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible." Blue Cross and Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1410 (7th Cir. 1995).

39. *See* UNEVEN & UNEQUAL, *supra* note 6, at 9.

40. *See id.* at 9.

41. *See id.* at 12. Only fifteen percent of traditional indemnity plans cover the costs of the five reversible contraceptive methods. *See id.*

42. *See id.* at 16.

43. For example, while thirty-nine percent of HMOs cover all five reversible methods of contraception - oral contraceptives, IUD, Norplant, DepoProvera and diaphragm - only thirty-three percent of POS networks, eighteen percent of PPOs and fifteen percent of indemnity plans provide such coverage. *See* Rachel Benson Gold, *The Need for and Cost of Mandating Private Insurance Coverage for Contraception,* THE GUTTMACHER REPORT ON PUBLIC POLICY, No. 4 (The Alan Guttmacher Institute), August 1998, at 2. *See also* SURVEY OF WOMEN, *supra* note 1, at 3.

of-pocket contraceptive costs. Eighty-two million women, including three-fourths of all women within the reproductive age bracket, receive health care from group providers.[44] Because most private insurance is linked to employment, however, these women tend to be employed full time,[45] or have a life-partner who is employed.[46] For the same reason, older women are more likely to be covered by private insurance than younger women,[47] as are women from higher economic backgrounds than women with relatively lower incomes.[48] The proportion of women with private individual coverage is lowest among unemployed single women.[49]

B. *Government Subsidized Health Care*

A substantial number of women in lower income brackets receive health care, including contraceptive services and devices, through a network of publicly financed family planning providers.[50] The Medicaid program[51] alone subsidizes the health care and pregnancy prevention

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44. *See* MARCH SUPPLEMENT, *supra* note 23, at 3; PREGNANCY, CONTRACEPTION AND FAMILY PLANNING, *supra* note 1, at 85. Women between the ages of fifteen and forty-five are considered to be of reproductive age. *See id.*

45. Full-time employment bears a direct correlation to insurance coverage, with three times as many full-time workers covered by employment-based health plans than part-time workers (62% and 18.6% respectively). *See* Sarah C. Snider, *The Part-time Work-force and its Workers' Health and Pension Benefits*, STATISTICAL BULLETIN No. 3 (Metropolitan Life Ins. Co.) July 1995, at 22.

46. A number of states, municipalities, and private corporations, including Microsoft, Levi-Strauss, Xerox, IBM, Walt Disney, and Chevron extend employee benefits to married workers, as well as same-sex domestic partners. *See* James P. Baker, *Equal Benefits for Equal Work? The Law of Domestic Partner Benefits*, A.B.A. LAB. LAW. 1 (1998); *see also* Cindy Tobisman, *Marriage vs. Domestic Partnership: Will We Ever Protect Lesbian Families?*, 12 BERKLEY WOMEN'S L.J. 112, 116 (1997).

47. *See* PREGNANCY, CONTRACEPTION AND FAMILY PLANNING, *supra* note 1, at 85. Roughly eighty percent of women covered by private insurance are over thirty years of age, compared to less than sixty-six percent who are under age twenty-five. *See id.*

48. *See id.* Over 90% of women with incomes at or above 250% of the poverty level were covered by private insurance, compared to 26% percent of women with incomes below 100% of poverty. *See id.*

49. *See id.* In 1997, 28.4% of poor women, or 14.8% of women generally, in the United States were uninsured, with young adults between the ages of eighteen to twenty-four least likely to have health coverage. *See* Bennefield, *supra* note 1, at 2.

50. *See* S.K. Henshaw and A. Torres, Family Planning Agencies: Services, Policies and Funding, 26 FAM. PLAN. PERSP. 52 (1994). In addition to the Medicaid and Title X program, discussed *infra* text accompanying notes 51-72, hospital outpatient clinics, health department clinics, Planned Parenthood clinics, and community and migrant health centers constitute major health care resources for Medicaid recipients and other low-income women. *See id.* at 52-53. *See also*, Frost & Bolzan, *supra* note 17, at 6.

51. *See* 42 U.S.C. § 1396 (1994). The Medicaid program is a joint federal and state initiative to provide health care services to eligible low-income Americans. States participating in the program establish and administer a plan for medical assistance in accordance with federal guidelines, and pay participating healthcare providers for certain services rendered to eligible

costs of nearly seventeen million low-income women annually,[52] including sixteen percent of all women of reproductive age.[53] An additional 4.2 million women are eligible to receive discounted reproductive health and contraceptive services at family planning clinics supported by Title X operating grants.[54]

The costs of providing general health care and contraceptive services through Medicaid and under the Title X program are absorbed primarily by the public.[55] Combined federal and state Medicaid expenditures top $160 billion annually,[56] with a substantial amount allocated towards contraceptive costs.[57] Federal funding for eligible Title X clinics exceeds $118 million.[58] Only a portion of the cost of providing contraceptive supplies and services is borne directly by Medicaid beneficiaries and clinic clientele. Under provisions of both the Medicaid and Title X programs, less needy women who seek clinic services are assessed a discounted fee proportionate to their income status.[59] Women whose income falls below 100 percent of poverty are provided services free of charge.[60]

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individuals. In turn, the federal government reimburses participating states for a portion of their Medicaid expenditures.

52. *See* MARCH SUPPLEMENT, *supra* note 23, at tbl. NC6.

53. *See* Gold et al., *supra* note 33, at 204.

54. *See* Lisa Kaeser, *Title X and the U.S. Family Planning Effort*; 1997 The Alan Guttmacher Instit. 4. Administered by the Department of Health and Human Services, the Title X Family Planning Program operates by awarding federal project grants to public and private nonprofit organizations that provide contraceptive services, as well as training, technical assistance and other family planning support to low and middle-income women. *See id.*

55. Most agencies that receive Title X funding also receive funds from other public sources including the federal Maternal and Child Health program, Social Services Block grants, and state and community health care programs. *See* Forrest & Samara, *supra* note 18, at 188; Kaeser, *supra* note 54, at 1, 2.

56. *See* HEALTH CARE FINANCING ADMINISTRATION, NATIONAL HEALTH EXPENDITURES, tbl. 10 (1998). In 1997, Federal Medicaid expenditures reached 91.1 billion, while state and local government expenditures topped 61.2 billion. *See id.*

57. In 1994, approximately $322 million worth of contraceptive funding was expended through the Medicaid program. *See* Katharine Levit et al., *Trends, National Health Expenditures in 1997: More Slow Growth*, HEALTH AFFAIRS, Nov.-Dec. 1998. In 1987, total public sector expenditures for contraceptive services totaled $412 million. *See Publicly Funded Contraceptive Services, supra* note 18, at 188.

58. *See* Frost & Bolzan, *supra* note 17, at 6; Jennifer J. Frost, *Family Planning Clinic Services in the United States, 1994*, 28 FAM. PLAN. PERSP. 92, 92 (1996).

59. *See* Frost & Bolzan, *supra* note 17, at 10. At publicly funded clinics, women whose income falls between 100-250% of poverty are charged discounted fees "based on ability to pay." 42 C.F.R. § 59.5 (a)(7) (1998). Charges to women whose annual income exceeds 250% of poverty are made in accordance with a fee schedule designed to recover "the reasonable costs" of providing services. *See id.* The median fee charged to low-income women is about $20.00 for an initial contraceptive examination, $10.00 for pill supplies. Women with incomes of 250% of poverty or more are assessed about $60.00 for an initial exam, $22.00 for oral contraceptives. *See* Frost & Bolzan, *supra* note 17, at 6.

60. Eighty-nine percent of agencies awarded Title X operating grants provide initial

By federal mandate, both the Medicaid and Title X programs make the provision of family planning and pregnancy prevention services to low-income women an organizational priority.[61] Full implementation of this mandate is carried out by a series of legislative initiatives and policy guidelines, including a 1972 Amendment to the Medicaid statute that made coverage for medically approved contraceptive devices, supplies, and related care a mandatory component of all state programs.[62] Liberal reimbursement rates encourage compliance with the family planning mandate. States are reimbursed for ninety percent of the costs of providing family planning services, nearly double the matching rate for non-family planning related benefits.[63] In addition, cost-sharing requirements, which could otherwise be implemented for covered benefits, are prohibited for Medicaid funded family planning services.[64] The provision of "medically approved family planning methods and services,"[65] including contraceptive supplies and devices, is also a mandatory program requirement for Title X clinic funding.[66]

The primary beneficiaries of publicly funded medical assistance programs are categorically needy women and adolescents. Notwithstanding continued federal eligibility expansions,[67] the average income

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contraceptive counseling examinations free of charge to clients whose income falls below 75% of the federal poverty level; 87% assess no charge for oral contraceptives. Only four percent provide free examinations to women whose income is above 250% of poverty. *See* Frost & Bolzan, *supra* note 17, at 12, 13. Under Medicaid, user fees are also assessed pursuant to a cost-sharing mechanism. With regard to certain beneficiaries, "there may be imposed an enrollment fee, premium, or similar charge, which is related to the individual's income." 42 U.S.C. § 13960 (b)(1) (1994). *See* 42 U.S.C.A. § 13960 (a)(1) (1994), (2); 42 C.F.R. § 59.5 (a)(6) (1998).

61. *See* 42 U.S.C. § 1396 (1994); 42 C.F.R. § 59.5 (a)(5) (1998).

62. *See* 42 U.S.C. § 1396d (a)(4)(C) (1994).

63. *See* 42 U.S.C. § 1396b (a)(5) (1994). Services reimbursed at the ninety percent "family planning" services rate include: patient counseling and education, examination, treatment, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services including sterilization and reversals. *See id.*

64. *See* 42 U.S.C. § 13960 (a)(2)(D) (1994); *see* Gold et al., *supra* note 33, at 205.

65. 42 C.F.R. § 59.5 (a)(1) (1998); 42 C.F.R. § 447.53 (a)(5) (1998).

66. *See* 42 C.F.R. § 59.5 (a)(10)(b) (1998). Family planning clinics typically offer a range of prescription contraceptives to clients. Oral contraceptives are universally available at publicly supported family planning clinics, while other commonly prescribed contraceptive products are available at a majority of clinics: 99% provide depo-provera, 96% provide the diaphragm, 63% provide Norplant. *See* Frost & Bolzan, supra note 17, at tbl. 1. Fewer than 50% of clinics provide the IUD, emergency contraception pills, female condoms, cervical caps, and tubal ligation. *See id., see also* Kaeser, *supra* note 54, at 3; S.K. Henshaw and A. Torres, *Family Planning Agencies: Services, Policies and Funding*, 26 FAM. PLAN. PERSP. 52-59 (1994).

67. The Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2106 (1989), raised the mandatory eligibility level to 133% of poverty, and gave states the option of increasing eligibility to 185% of poverty. *See*, Forrest & Samara, *supra* note 18 at 188; Jennifer J. Frost et al., *State Implementation of the Medicaid Eligibility Expansions for Pregnant Women*, 1993 ALAN GUTTMACHER INST. 14-15 (discussing impact of expanded eligibility on state Medicaid programs).

ceiling for Medicaid eligibility stands at forth-six percent of the federal poverty level.[68] In 1997, more than half of Medicaid enrollees living at or below the federal poverty level were women.[69] Services at publicly funded family planning clinics are also geared towards and disproportionately utilized by adolescents and economically disadvantaged women.[70] Sixty percent of clients specifically seeking contraceptive services at publicly funded clinics have incomes below poverty,[71] and almost one-half are under the age of nineteen.[72]

C. *Middle-Income College-Age Women Lack Access to Contraceptive Financing*

Middle-income college-age women are least likely to qualify for benefits under conventional health care financing schemes. Although a majority of women pursuing a post-secondary education are employed,[73] most work part-time in temporary and low paying jobs where health insurance is not offered as a compensation benefit.[74] Likewise, few college-age women qualify for indirect group-based coverage under a parent's plan. Dependent coverage typically extends only to full time students, leaving 3.6 million women enrolled part-time in post-secondary degree programs ineligible for coverage.[75]

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68. *See* Kaeser, *supra* note 54, at 2.

69. *See* MARCH SUPPLEMENT, *supra* note 23, at 6.

70. *See* Forrest & Samara, *supra* note 18, at 8; INSTITUTE OF MEDICINE, BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 231 (Sarah S. Brown & Leon Eisenberg eds., 1995). An evaluation of twenty-three of the most successful community outreach programs geared towards reducing unwanted pregnancies found that nine out of ten clinics operating at the national level targeted outreach efforts to teenage clients. Almost none of the programs had a clear focus on meeting the unmet contraceptive needs of adults. *See* Carol J. Rowland Hogue, *Missing the Boat on Pregnancy Prevention*, 13 ISSUES IN SCI. & TECH. 41, 46 (1997).

71. *See* Frost & Bolzan, *supra* note 17, at 8. Data for 1994 and 1995 indicate that among clients overall, fifty-seven percent have family incomes below the federal poverty level, and one-third have family incomes between 100-250% of poverty. However, only one-quarter of these clients are Medicaid recipients. *See id.*

72. Public family planning clinics are a primary source of contraceptives for more than 60% of older teens. *See* Forrest & Samara, *supra* note 18, at 193.

73. *See* STATISTICAL ABSTRACTS, *supra* note 30, No. 320, at 198. The Bureau of Labor Statistics indicates that fewer than 50% of full-time and 82% of part-time college students are labor force participants. *See* INDEPENDENT INSURANCE AGENTS OF AMERICA, PARENTS, COLLEGE STUDENTS & INSURANCE: A NATIONAL SURVEY (1997) [hereinafter COLLEGE STUDENTS].

74. *See* NATIONAL CENTER FOR EDUCATIONAL STATISTICS, THE CONDITION OF EDUCATION, Supp. tbl. 50-3 (1997); Taking Stock in America's Youth, Metropolitan Life Insurance Company STATISTICAL BULLETIN, No. 2 (Metropolitan Life Ins. Co.), April 1, 1995; *see also* NEXT STEP, *supra* note 1, at 2.

75. *See* NATIONAL CENTER FOR EDUCATION STATISTICS, DIGEST OF EDUCATION STATISTICS 1997, tbl. 177 (1998); *see also* LAURA H. HORN & C. DENNIS CARROL, NATIONAL CENTER FOR EDUCATIONAL STATISTICS, NONTRADITIONAL UNDERGRADUATES: TRENDS IN ENROLLMENT FROM

Increases in non-traditional student enrollment is another reason why middle-income college-age women do not qualify for group-based insurance coverage.[76] More than six million older students, most of them women,[77] forfeit indirect coverage upon reaching the maximum age of eligibility set by group underwriters.[78] Women matriculating after a period of work-force participation fare no better, notwithstanding previous enrollment in an employer-sponsored plan, because health insurance portability rules applicable to discharged workers do not apply when an employee voluntarily leaves the workforce to participate in a program of higher education.[79]

Just as college-age women are not likely to qualify for employer-sponsored group health insurance, it is equally likely that they will not meet the eligibility guidelines for publicly subsidized contraceptive care. To qualify for Medicaid in most states, a woman must be a single mother or be pregnant and have an income below state requirements.[80] To qualify for discounted services at Title X clinics, a woman must meet strict income guidelines set far below the median family income of most post-secondary students.[81] For those women who do qualify for discounted family planning services, few health clinics tailor services to meet the contraceptive needs of adult females.[82] As a result, neither the Medicaid program nor publicly funded clinics serve as a practical family planning resource for post-secondary women.[83]

This combination of age, income, and employment related eligibility criteria explains why, in large part, college-age women are, more

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1986 TO 1992 AND PERSISTENCE AND ATTAINMENT AMONG 1989-1990 BEGINNING POST SECONDARY STUDENTS 19-20 (1996).

76. *See* HORN & CARROL, *supra* note 75, at 19-20.

77. In 1996, 6.24 million students age 25 and older were enrolled in higher education programs. *See* STATISTICAL ABSTRACTS, *supra* note 30, tbl. 256, at 165, tbl. 304, at 190; *see* HORN & CARROL, *supra* note 75, at 9, 15.

78. Most employer plans limit indirect coverage to dependents under age 23. *See* COLLEGE STUDENTS, *supra* note 73, at 2.

79. *See* Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1985) (codified as amended at 29 U.S.C. §§ 1161-1168 (1994 & Supp. II 1996)). COBRA mandates that under certain circumstances a discharged worker may be entitled to continued medical insurance under the employer's health plan for up to three years after termination; *see* Paul Fronstin *Individuals with COBRA Coverage*, 1994-1995 STATISTICAL BULLETIN No. 2 (Metropolitan Life Ins. Co.), April, 1998 (surveying the beneficiaries of COBRA).

80. *See* 42 U.S.C. §§ 1396a (a)(10)(A) (1994); Kaeser, *supra* note 54, at 2.

81. For example, the family income of the average undergraduate students attending the University of California is reportedly $62,000.00 per year. Nearly one-fourth of students come from families with annual incomes higher than $90,000.00. *See* Daniel M. Weintraub, *Proposal for Free College Tuition Isn't as Egalitarian as it Seems*, ORANGE COUNTY REG., May 24, 1998, A04.

82. *See* Hogue, *supra* note 70, at 42.

83. *See* Frost & Bolzan, *supra* note 17, at 8; SURVEY OF WOMEN, *supra* note 1, at 3.

than any other identifiable group, least likely to qualify for private or public health subsidies, and thereby least likely to obtain financing for contraceptive services.

D. *Student Health Insurance Plans: A Major Source of Insurance Coverage for Women*

Student health insurance plans offer a practical and cost effective health care financing alternative for post-secondary women who do not qualify for group-based coverage or publicly funded services. For example, each of the fifteen four year institutions with the highest student enrollment in the United States permit eligible students to enroll in a university sponsored health plan, either on a voluntary basis or as a pre-condition of matriculation.[84] Although significantly less expensive than the cost of obtaining traditional coverage,[85] student health benefits, particularly those relating to contraceptive services, are limited. Of the fifteen plans surveyed, only one plan provides coverage for prescription

84. *See* UNIVERSITY OF MINNESOTA, STUDENT HEALTH INSURANCE PLAN 1998-99 [hereinafter MINNESOTA]; OHIO STATE STUDENT HEALTH INSURANCE PROGRAM 1999-2000 [hereinafter OHIO]; UNIVERSITY OF TEXAS, STUDENT HEALTH INSURANCE 1998-99 INSURED'S GUIDE [hereinafter TEXAS]; ARIZONA STATE UNIVERSITY STUDENT HEALTH INSURANCE 1999-2000 [hereinafter ARIZONA STATE]; HEALTH ACCIDENT AND SICKNESS PLAN FOR STUDENTS AND THEIR DEPENDENTS OF THE TEXAS A& M UNIVERSITY SYSTEM 1999-2000 [hereinafter TEXAS A & M]; PENN STATE UNIVERSITY, STUDENT INJURY AND SICKNESS INSURANCE PLAN 1999-2000 [hereinafter PENN]; UNIVERSITY OF FLORIDA, STUDENT INJURY AND SICKNESS INSURANCE PLAN 1999-2000 [hereinafter FLORIDA]; UNIVERSITY OF WISCONSIN, SHIP DOMESTIC 1999-2000 [hereinafter WISCONSIN]; UNIVERSITY OF ILLINOIS 1998-99 STUDENT HEALTH INSURANCE [hereinafter ILLINOIS]; UNIVERSITY OF MICHIGAN, STUDENT HEALTH INSURANCE PLAN BROCHURE 1998-99 [hereinafter UNIVERSITY OF MICHIGAN]; DOMESTIC STUDENT INJURY AND SICKNESS INSURANCE PLAN, PURDUE UNIVERSITY 1998-99 [hereinafter PURDUE]; NEW YORK UNIVERSITY, STUDENT HEALTH SERVICES AND INSURANCE INFORMATION 1999-2000 [hereinafter NEW YORK]; UNIVERSITY OF INDIANA, STUDENT HEALTH INSURANCE 1998-99 [hereinafter INDIANA]; UNIVERSITY OF SOUTHERN FLORIDA STUDENT INJURY AND SICKNESS EXCESS INSURANCE 1999-2000 [hereinafter SOUTHERN FLORIDA]; UNIVERSITY OF ARIZONA STUDENT HEALTH INSURANCE 1998-99 [hereinafter UNIVERSITY OF ARIZONA]. The U.S. Department of Education Statistics ranked the foregoing post-secondary educational institutions among those with the highest student enrollment based on statistics for the fall 1995 semester. *See* U.S. DEPARTMENT OF EDUCATION, DIGEST OF EDUCATION STATISTICS 225 (1997).

85. As indicated in the respective University's student health insurance handbook, the following premiums were charged per individual student coverage during the 1999-2000 academic year: Arizona State, $302.00 (per semester); University of Arizona, $302.00 (per semester); University of Florida, $175.00 - $ 888.00 (per annum); University of Illinois, $127.00 (per quarter); University of Indiana, $319.00 (per annum); University of Michigan, $585.00 (per annum) (1998-1999); University of Minnesota, $216.00 (per quarter) (1998-1999); New York University, $453.00 - $1084.00 (per annum); Ohio State University, $297.00 (per semester); Pennsylvania State University, $622.00 (per annum); Purdue University, $655.00 - $954.00 (per annum); Southern Florida, $631.00 (per annum); Texas A & M, $620.00 - $812.00 (per annum); University of Texas, Austin, $435.00 (per annum); University of Wisconsin, Madison, $795.00 - $1928.00 (per annum).

contraceptives on par with other prescription medications.[86] Three include coverage for prescription contraceptives, but impose additional deductibles or co-payments when prescription contraceptives are obtained from off-campus providers.[87] Two plans limit coverage by reducing the cap on reimbursements applicable to prescription contraceptives.[88] Nine plans expressly exclude coverage for birth control drugs and devices.[89]

This exclusion of contraceptive coverage under student health insurance plans is particularly troubling given the acute need for contraceptive financing among middle-income college-age women. Almost all of the eight million women currently enrolled in programs of higher education are in their prime child bearing years,[90] and the majority face a high risk of unintended pregnancy.[91] In fact, among women between

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86. *See* WISCONSIN, *supra* note 84.

87. The University of Minnesota plan, for example, charges a $12.00 co-payment for the costs of prescriptions obtained at the student health services center. However, students bear full responsibility for the costs of prescription contraceptives obtained elsewhere. *See* MINNESOTA, *supra* note 84, at 10, 11. The Ohio State Plan requires a $10.00 co-payment when contraception prescriptions are filled by an off campus provider, see OHIO, *supra* note 84, and the Texas A & M plan reduces reimbursement rates by ten percent when medical care is sought from a provider outside the network. *See* TEXAS A & M, *supra* note 84, at 2. Policies that limit compensation for medical services obtained off-campus or by an out of network provider discriminate against women even when the limitations apply regardless of whether the services sought relate to family planning. This is so university health clinics rarely make the full range of contraceptive options available, thereby forcing women to incur an added expense for prescription drugs under the plan.

88. For example, University of Texas plan charges a co-payment of $2.00 - $5.00 for generic drugs, and $5.00 - $10.00 for name brand drugs dispensed at the student health center. However, the insurance company contributes a maximum of only $3.00 toward the cost of birth control pills. *See* TEXAS, *supra* note 84, at 11. In addition, expenses for prescription drugs dispensed at the student health center are reimbursed up to a $300.00 maximum per policy year, while prescriptions dispensed outside the student health center, including prescription contraceptives unavailable on campus, are limited to $210.00 per year. *See id.* Under the University of Michigan plan, prescription drugs are reimbursed up to a maximum of $1,000.00 per policy year, but coverage for prescription contraceptives is "not to exceed $200.00 per policy year." UNIVERSITY OF MICHIGAN, *supra* note 84, at 21.

89. *See* PURDUE, *supra* note 84, at 8; ILLINOIS, *supra* note 84, at 13; PENN, *supra* note 84, at 9; NEW YORK, *supra* note 84, at 25; SOUTHERN FLORIDA, *supra* note 84, at 9; UNIVERSITY OF ARIZONA, *supra* note 84, at 9; ARIZONA STATE, *supra* note 84; FLORIDA, *supra* note 84, at inset; INDIANA, *supra* note 84, at 6.

90. Between 1983 and 1996, the number of women pursuing higher education degrees increased 25%, from 6.4 million to eight million respectively. *See* NATIONAL CENTER FOR EDUCATION STATISTICS, PROJECTIONS OF EDUCATION STATISTICS TO 2008, at 2; DIGEST OF EDUCATION STATISTICS 1997, TABLE 172; STATISTICAL ABSTRACTS, *supra* note 30, No. 252, at 162. Of the total number of women enrolled in programs of higher education in 1996, 7.8 million were between the ages of twenty to twenty-nine. *See id.*, No. 256, at 165.

91. Women at risk of unintended pregnancy are defined as: 1) having had sexual intercourse; 2) fertile, i.e., neither they nor their partner has been contraceptively sterilized and are not infertile for any other reason; and, 3) neither intentionally pregnant nor trying to become pregnant. *See* Forrest & Samara, *supra* note 70, tbl. 29, at 28. Figures for 1990 placed the following number of women at risk for unintended pregnancy: 2.5 million women between the ages of 18-19; 14.1

the ages of twenty and twenty-nine, the risk of unintended pregnancy is higher for middle-income women than for women of any other financial strata.[92] Over fifty-percent of the pregnancies that occur among non-poor college-age women are unintended.[93] This data underscores the urgency of making the availability of contraceptive financing for middle-income college-age women a national family planning priority.

II. TITLE IX AND DISCRIMINATION IN CONTRACEPTION COVERAGE

This part of the Article considers the meaning of sex discrimination under Title IX in the context of university sponsored health insurance programs that provide comprehensive coverage for prescription medication generally but exclude coverage for prescription contraceptives, supplies and services. Applying a disparate impact proof model to student insurance plans demonstrates how the refusal to reimburse for the costs of prescription contraceptives forces women to bear a disproportionate share of health care costs. The following section will consider possible defenses an educational institution might raise against a claim that a student health insurance plan discriminates against women in violation of Title IX.

A. *The Basic Title IX Claim*

Title IX prohibits sex discrimination in certain institutions of higher education. The statute reads, "[N]o person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."[94] This prohibition on sex discrimination extends to "all the operations" of the institution, including operations

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million women between the ages of 20-29; 11.8 million women between the ages of 30-44. *See id.* at 29-30.

92. The correlation between the risk of unintended pregnancy and economic status varies with age. Women who are financially capable of pursuing a post-secondary education are at a relatively higher risk of unintended pregnancy than other women in their age group. Three fourths of women in their twenties living at 2.5 times or more above the poverty level are at risk of unintended pregnancy, compared with two thirds of women in their twenties living below the poverty level. Slightly lower proportions of less affluent women under twenty are at risk. Among females aged thirteen to nineteen, a higher proportion of teens from families in poverty are at risk; forty-six percent of teens between fifteen to seventeen with incomes below the poverty level are at risk of unintended pregnancy, compared with about one third of teens with family incomes at or above 2.5 times the poverty level. *See* Forrest & Samara, *supra* note 70, at 29-30.

93. *See id.* at 31. In 1988, the majority of pregnancies occurring among women from middle-income backgrounds were unintended; 64% of the total number of unwanted pregnancies occurred among women with incomes at 100-200% of poverty. Among women whose incomes exceeded 200% of the poverty level, 45% of all pregnancies were unintended. Among women aged twenty-five to thirty-four, between 42 to 45% of all pregnancies were unintended. *See id.* at 31-33.

94. 20 U.S.C. § 1681 (1994).

that are not, by their nature, educational.[95]

Title IX prohibits educational institutions from discriminating against women intentionally or explicitly. Sex-specific distinctions in the provision of student services can be enforced only in limited statutorily enumerated circumstances.[96] The statute also prohibits facially neutral policies and practices that have a discriminatory effect on women. Proof of discriminatory effect will suffice to establish liability when a suit is brought to enforce one of the implementing regulations promulgated pursuant to Title IX, rather than a specific provision of the statute itself.[97]

Neither Title IX nor its implementing regulations speak directly to the terms of contraceptive coverage under university sponsored health plans. The regulations do, however, prohibit sex discrimination in the administration of a university sponsored health or medical insurance "benefit, service, policy or plan".[98] Reimbursement for family planning services that are provided for under such plans must be made on a sex-neutral basis, even if those services are typically used by women more than men.[99] The regulations also prohibit federally funded colleges and universities from administering a plan that treats "pregnancy, childbirth,

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95. See *infra* Part III.C.

96. *See* 20 U.S.C. § 1681 (a)(1) - (9) (1994). Excepted from Title IX's sex-neutral mandate are: educational institutions transitioning from single-sex to co-educational; religious educational institutions with contrary religious tenets; military service academies; traditionally single-sex institutions; social fraternities, sororities and voluntary youth organizations; Girls or Boys conferences; mother-daughter or father-son activities; and, "Beauty" pageant scholarship awards. *See id.*

97. Lower courts regularly undertake an impact analysis of facially neutral educational policies that adversely affect women in breach of Title IX's implementing regulations. *See, e.g.*, Sharif v. New York State Educ. Dep't, 709 F.Supp. 345, 361 (S.D.N.Y.1989) (undertaking impact analysis when regulation specifically contemplates disparate impact claim); Haffer v. Temple Univ. 678 F.Supp. 517, 519 (E.D. Pa. 1987) (applying impact theory where implementing regulation does not specifically require intent); *cf.*, Lipsett v. Univ. of Puerto Rico, 864 F.2d 881, 883 (1st Cir. 1988) (applying disparate-impact analysis to university employee's Title IX claim); Marby v. Bd. of Community Colleges & Occupational Educ. 813 F.2d 311 (10th Cir.), *cert. denied*, 484 U.S. 849 (1987) (importing Title VII impact analysis to college employee's Title IX claim); *see generally*, James S. Wrona, *Eradicating Sex Discrimination in Education: Extending Disparate-Impact Analysis to Title IX Litigation*, 21 PEPP. L. REV. 1 (1993). The rule under Title IX that bars facially neutral practices that have a discriminatory effect on one sex is adapted from the United States Supreme Court's interpretation of Title VI, which prohibits racial discrimination in federally funded programs. In *Guardians Ass'n. v. Civil Serv. Comm'n*, 463 U.S. 582 (1983), the Court ruled that a violation of Title VI itself requires proof of discriminatory intent. A majority also agreed, however, that proof of discriminatory effect suffices to establish liability when a suit is brought to enforce the regulations promulgated under the statute. *See id*; *see also* Alexander v. Choate, 469 U.S. 287, 293-94 (1985); Latinos Unidos de Chelsea v. Secretary of Housing, 799 F.2d 774, 785 n.20 (1st Cir. 1986). The Supreme Court has not ruled, nor has Congress legislated, as to whether a disparate impact claim is cognizable under Title IX.

98. 34 C.F.R. § 106.39, § 106.40 (1998).

99. *See* 34 C.F.R. § 106.39 (1998).

false pregnancy, termination of pregnancy and recovery therefrom" differently than any other temporary disability.[100] Furthermore, educational institutions cannot implement a rule that affects women differently than men, simply on account of a woman's "actual or potential parental . . . status."[101] Title IX's implementing regulations therefore support a disparate impact claim against student based health insurance plans that discriminate against women.[102]

To establish a prima facie case of disparate impact discrimination under Title IX, a plaintiff must show that the effect of a facially neutral practice decidedly disfavors one sex.[103] The disproportionate burden on women of excluding prescription contraception from a comprehensive health plan is apparent. First, all medically prescribed reversible contraceptive methods are used solely by women.[104] Thus, women alone shoulder both the responsibility and the risks associated with obtaining and utilizing reversible contraception.[105] Even if technology advanced to make effective prescription contraception available to men, only women bear the risks associated with unwanted pregnancy.[106] Second, women bear a disproportionate share of health care costs. The average woman spends approximately sixty-eight percent more than men on out of pocket medical expenses, a potential lifetime difference of

100. 34 C.F.R. § 106.40(b)(4) (1998).

101. 34 C.F.R. § 106.40(a) (1998).

102. Sylvia Law argues that because the current state of technology permits prescription contraception only for women, excluding coverage for prescription contraception under a health plan that otherwise provides comprehensive prescription coverage amounts to explicit sex discrimination. *See* Law, *supra* note 20, at 374. Because such a claim is grounded in technological limitations, however, Law considers a disparate impact theory more appropriate. *See id.* at 374-75.

103. *See* Sharif v. New York State Educ. Dept., 709 F.Supp. 345, 362 (S.D.N.Y. 1989).

104. *See* Law, *supra* note 20, at 374.

105. *See id.* A majority of men fail in their responsibility to take steps to avoid unwanted pregnancy, despite that, at least in circumstances involving consensual sex, both women and men are equally accountable for the conception that might ensue from unprotected intercourse. In responding to a survey taken by the Kaiser Family Foundation, fifty-seven percent of women indicated that they alone are responsible for contraceptive use during intercourse. Among the reasons cited by both women and men respondents for why men fail to take an active role in pregnancy prevention: "men don't care," (37% of women, 45% of men); "it is the female's responsibility," (30% of women, 21% of men); "men can't become pregnant," (18% of women, 9% of men). *See* KAISER FAMILY FOUND., SURVEY ON PUBLIC KNOWLEDGE AND ATTITUDES ON CONTRACEPTION AND UNPLANNED PREGNANCY 8 (1987). Seventy percent of women in the United States feel that men are not responsible enough for birth control. *See id.* at 18.

106. *See* Law, *supra* note 20, at 374. Law calculates the risks associated with unintended pregnancy in terms of "emotional, financial and human costs," as well as "adverse social and economic consequences." *Id.* at 367. According to Law, the adverse consequences of unintended pregnancy include increased infant mortality, morbidity, and low birth weight; increased abortion rates; high financial costs; limitations on women's ability to contribute to society; and a decline in the stability of the national economy. *See id.* at 364-368; *see also Coverage for Contraceptives*, *supra* note 9, at 6.

$10,000.00.[107] More than twice as many women than men have out of pocket health care expenditures that exceed ten percent of their income.[108] A large portion of this disparity is attributed to the exclusion of prescription contraceptives from otherwise comprehensive health benefit plans.[109]

B. *The Burden Shifts*

Once a plaintiff establishes a prima facie disparate impact claim under Title IX, the burden shifts to the college or university to justify the discriminatory policy as an "educational necessity".[110] It is unlikely that an educational institution could make a plausible argument that the exclusion of prescription contraception coverage from student health insurance bears a "manifest relationship" to a legitimate educational goal.[111]

III. Possible Defenses To The Claim That Title IX Applies To Student Health Insurance Plans

Although an educational institution would have difficulty building a defense on an educational necessity theory, other conceivable defenses might be raised against a plaintiff's claim that the exclusion of coverage for prescription contraceptives from otherwise comprehensive student health insurance plans constitutes sex discrimination in violation of Title IX. These defenses might include the following: (1) the refusal to cover the costs of prescription contraception does not amount to discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy and recovery therefrom;"[112] (2) Title IX's sex-neutral mandate does not apply when the "education program or activity" under review is not directly "in receipt of Federal financial assistance;" (3) Title IX applies only to institutional programs or activities that are educational in nature, not to the administration of student health insurance plans; (4) a university is not legally responsible for discriminatory stu-

107. *See* Snowe & Reid, *supra* note 7, at 1; Women's Research and Education Institute, Women's Health Insurance Costs and Experiences 2 (1994) [hereinafter Women's Health Insurance].

108. *See* Snowe & Reid, *supra* note 7, at 6.

109. *See id.* at 10-11.

110. Sharif v. New York State Educ. Dept., 709 F. Supp. 345, 361-62 (S.D.N.Y. 1989) (citing Georgia State Conf. of Branches of NAACP v. State of Georgia, 775 F.2d 1403 (11th Cir. 1985)); *see also* Bd. of Educ. v. Harris, 444 U.S. 130, 151 (1970) (analogizing "education necessity" to "business necessity").

111. *See Sharif*, 709 F. Supp. at 362 (finding no manifest relationship between awarding merit scholarships based solely on student SAT scores and academic achievement in high school to justify disproportionate exclusion of women).

112. 34 C.F.R. § 106.40(b)(4) (1998).

dent health plans, the terms of which are dictated by a third party; and (5) because health plans that include coverage for birth control drugs and devices are not commercially unavailable, educational institutions should not be liable under Title IX for failing to offer such plans. This section considers these five defenses in turn.

A. *The Language of Title IX Does Not Include Contraception Coverage*

The first defense a defendant is likely to raise against a claim that the exclusion of coverage for prescription contraceptives under student health insurance plans violates Title IX is the language of Title IX itself. The implementing regulations of Title IX require sex-neutral treatment only with respect to official policies that pertain to "pregnancy, childbirth, false pregnancy, termination of pregnancy and recovery therefrom."[113] The absence of any specific reference to "contraception" underscores the statute's prime purpose of prohibiting discrimination against women who are already pregnant.[114] An educational institution might argue that to interpret the regulations as requiring student health plans to provide coverage for birth control drugs and devices would impermissibly extend the statute beyond its intended scope.[115]

Title IX's prohibition against sex discrimination, however, is not limited to discrimination on the basis of pregnancy and its related conditions. While the regulations make no reference to contraception, they expressly prohibit the application of any rule "concerning a student's actual or potential parental, family, or marital status which treats students differently on the basis of sex."[116] By their terms, therefore, the regulations expressly apply to policies that have a disparate impact on women who are not yet pregnant, and by implication, they apply to women who avoid pregnancy through the use of contraceptive drugs and devices.

Title IX's legislative history further supports the conclusion that excepting contraceptives from coverage under student health benefit plans constitutes discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy and recovery therefrom." In a 1987 Amendment to the statute, Congress instructed that Title IX was not to be "construed to force or require any individual or hospital or any other institution, program, or activity receiving Federal funds to perform

113. *Id.*

114. *See* Law, *supra* note 20, at 377.

115. *See* Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843, 862 (1984) (requiring consistency between agency regulation and purpose of underlying statute).

116. 34 C.F.R. § 106.40(a) (1998).

or pay for an abortion."[117] Reflected in the abortion exclusion is Congress' understanding that a law that prohibits pregnancy discrimination also prohibits discrimination against women who seek to avoid pregnancy.[118] Absent legislative action, student health benefit plans would be required to reimburse women for expenses incurred in obtaining an abortion and related medical services.[119] The Amendment excepts from Title IX's sex-neutral mandate one particular method of terminating a pregnancy, without excepting disfavorable treatment of contraceptive drugs and devices as a method of avoiding pregnancy.[120]

Viewed in its historical context, the genesis of Title IX gives weight to the argument that the statute protects women who seek to avoid pregnancy, and therefore, requires that student health insurance plans provide equal coverage for prescription contraceptives. In 1971, Congress soundly defeated the Equal Rights Amendment which would have mandated sex equality in virtually every law, policy, or practice.[121] The resulting gap in existing civil rights legislation left exclusionary education policies intact, subjecting a wave of new female enrollees to institutionalized discrimination.[122] New legislation introduced shortly

117. Civil Rights Restoration Act of 1987, Pub. L. 100-259 § 8(b) (codified at 20 U.S.C. § 1688). For a discussion of a similar exclusion under Title VII for the costs of obtaining abortion services and the effect of the exclusion on employer-sponsored health plans, see Law, *supra* note 20, at 379-80.

118. 134 Cong. Rec. § 159, 162 (1988).

119. *See id.*

120. *See* North Haven v. Bell, 456 U.S. 512, 521-22 (1982) (refusing to infer additional exclusions from list of statutorily enumerated exceptions); Andrus v. Glover Constr. Co., 446 U.S. 608, 616-17 (1980).

121. The text of the proposed Equal Rights Amendment read, "Equality of rights under the law shall not be denied or abridged by the United States or by any State on account of sex." *See* H.R.C.J. Res. 208, 92d Cong. (1971); S. Res. 8, 92d Cong. (1971). First introduced in 1923, the ERA did not receive serious political consideration until the early 1970s. *See* Deborah Rhode, *Equal Rights in Retrospect*, 1 L. & EQUITY J. 1, 4-5 (1983); THE EQUAL RIGHTS PROJECT, THE EQUAL RIGHTS AMENDMENT: A BIBLIOGRAPHIC STUDY (Hazel Greenberg ed., 1977). Since its defeat in 1982, however, political stirrings among the states seems to point to a renewed interest in a federal ERA. In 1998, for example, Iowa and Florida passed amendments to expressly include women in their state constitutions. In that same year, Missouri's general assembly debated passage of a federal ERA, and legislation calling for the ratification of a federal ERA was introduced in Illinois and Virginia. *See* Debra Baker, *The Fight Ain't Over*, A.B.A. J., Aug. 1999, at 53.

122. As part of the Civil Rights Act of 1964, Congress enacted broad-based anti-discrimination legislation including Title VI and Title VII. Title VI prohibits discrimination "on the ground of race, color, religion or national origin . . . under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d (1994). Title VII prohibits discrimination on the basis of "race, color, religion, sex or national origin" in the terms or conditions of employment. 42 U.S.C. § 2000e-17 (1994). Noticeably absent from either statute is a prohibition on sex discrimination in federally funded educational institutions. Title IX was widely understood to "close[ ] loopholes in existing legislation relating to general education programs and employment resulting from those programs." *See* 118 Cong. Rec. 5803, 5807 (1972); 117 Cong. Rec. 30403, 30408 (1971). For a discussion of the politico-social controversies preceding the passage of the Civil Rights Act, see

thereafter took direct aim at discrimination in academia.[123] While not a panacea, this legislation expressly intended to hasten full scale female participation in the country's political, social, and economic power structure.[124]

Contemporaneous with the introduction of new anti-discrimination legislation came advancements in contraceptive technology. For the first time in history, the birth control pill afforded millions of women an opportunity to safely disaggregate intercourse from procreation.[125] Title IX supporters immediately recognized the interdependence of educational advancement and reproductive choice: "[i]f the only alternative to child-rearing is discrimination in education and a low paying job, then, despite the increase in birth control information and the dissemination of the pill and other devices, too many women will continue to choose to have too many babies."[126] In light of this history, university health plans that withhold coverage for birth control drugs and devices defeat the liberatory promise of Title IX.

No court to date has applied Title IX to a university sponsored health plan that excludes coverage for prescription contraceptives.[127] The proposition that Title IX protects only women who are already pregnant and not women whose actions might lead to or avoid pregnancy,

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generally CHARLES & BARBARA WHALEN, THE LONGEST DEBATE: A LEGISLATIVE HISTORY OF THE 1964 CIVIL RIGHTS ACT (1985).

123. *See* 119 Cong. Rec. 30399 (1971).

124. *See* 117 Cong. Rec. 39256-39258 (1971). From its inception, Title IX promised women more than formal educational opportunity. *See generally* 118 Cong. Rec. 5806 (1972) (describing unequal work and pay for women as a product of inequality in education). The statute was "an important first step in the effort to provide for the women of America something that is rightfully theirs - an equal chance to attend the school of their choice, to develop the skills they want, and to apply those skills with the knowledge that they will have a fair chance to secure the jobs of their choice with equal pay for equal work." 118 Cong. Rec. 5808 (1972). It was intended "to provide women with solid legal protection from the persistent, pernicious discrimination which is serving to perpetuate second-class citizenship for American women." 118 Cong. Rec. 5804 (1972). Thirty years after the enactment of Title IX, sex discrimination in contemporary form continues to perpetuate the myth of a subordinated female citizenry. *See* United States v. Virginia Military Inst., 518 U.S. 515, 534 (1996) (recognizing that military academy's male only admission policy perpetuates "the legal, social, and economic inferiority of women").

125. *See* KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 111-118 (1984) (discussing social changes induced by the mass availability of the birth control pill); LINDA GORDON, WOMAN'S BODY, WOMAN'S RIGHT: A SOCIAL HISTORY OF BIRTH CONTROL IN AMERICA 96-102 (1976).

126. 118 Cong. Rec. 5812 (1972).

127. The vast majority of impact claims arising under Title IX concern sex-based disparities in the allocation of financial resources and scholarships to female student athletic programs. *See generally* Trudy Saunders Bredthauer, *Twenty-Five Years Under Title IX: Have We Made Progress?*, 31 CREIGHTON L. REV. 1107 (1998); Crista D. Leahy, *The Title Bout: A Critical Review of the Regulation and Enforcement of Title IX in Intercollegiate Athletics*, 24 J.C. & U.L. 489 (1998); William Thro, *Still on the Sidelines: Developing the Non-Discrimination Paradigm under Title IX*, 3 DUKE J. GENDER L. POL'Y 25-28 (1996).

however, was rejected by one federal court in *Wort v. Vierling*.[128] In *Vierling*, a local chapter of the National Honor Society dismissed a high school honor student when school officials discovered that the student was pregnant.[129] The student challenged her dismissal pursuant to a Title IX regulation that prohibits the exclusion of students from extra-curricular activities on the grounds of "pregnancy, childbirth, false pregnancy, termination of pregnancy and recovery therefrom."[130] The high school countered that the student's dismissal was not premised on her "sex" per se, but rather on the fact that she had engaged in pre-marital sexual activity, conduct that The National Honor Society does not condone. In sustaining the student's challenge, the court declined to draw a factual distinction between Vierling's pregnancy and her underlying sexual conduct. Whether Vierling had been dismissed from the Honor Society "because of her pregnancy or the acts leading up to her pregnancy was irrelevant for purposes of determining whether her dismissal violated Title IX."[131] From the court's perspective, adverse treatment occasioned by a woman's potential to become pregnant and, by implication, her ability to avoid pregnancy constitutes discrimination on the basis of sex.

Applying the rationale from *Vierling* to a university sponsored student health plan demonstrates that the refusal to reimburse women for contraceptive costs violates Title IX. Neutrality, as required with respect to health policies affecting women whose actions might lead to pregnancy, is required with respect to policies affecting women whose actions might tend to avoid pregnancy. Those actions include the use of prescription contraceptive devices and services, which must be covered under comprehensive student benefit plans.

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128. Wort v. Vierling, No. 82-3169, slip. op. (C.D. Ill. Sept. 4, 1984), *aff'd on other grounds*, 778 F.2d 1233 (7th Cir. 1985).

129. *See id.*, slip op. at 2.

130. 34 C.F.R. § 106.40(b)(1) (1998).

131. *Vierling*, slip op. at 4. Some courts distinguish pre-marital sexual conduct from pregnancy as a legitimate basis for exclusion from high school activities. *See, e.g.*, Pfeiffer v. Marion Ctr. Area Sch. Dist., 917 F.2d 779, 784 (3d Cir. 1990) (excluding pregnant high school student from chapter of National Honor Society, not "for her pregnancy but because. . .she failed to uphold the standards. . ."). The legitimacy of adverse treatment accorded a student who engages in pre-marital sex, however, can be discriminatory against female students given that pregnancy provides per se evidence of sexual activity. Absent a voluntary disclosure, evidence of sexual activity engaged in by male students is virtually impossible to obtain. *See* ACLU, *ACLU Files Sex Discrimination Case For Pregnant Teens Denied Honor Society Membership* (Aug. 6, 1998) (discussing complaint filed by pregnant high school student dismissed from National Honor Society), *available in* <http://www.aclu.org/court/chipman_comp.html>. Furthermore, in the context of post-secondary education where the majority of students are adults, restrictions on student behavior, including sexual activity, might be entirely inappropriate. *See* Bethel Sch. Dist. No. 403 v. Fraser, 478 U.S. 675, 683 (1986) (emphasizing school's enhanced role in regulating student conduct at high school level).

B. *Title IX Applies to the Specific Program or Activity Receiving Federal Funds*

In addition to claiming that Title IX prohibits only those educational policies that accord adverse treatment to pregnant women, and therefore, does not require coverage for prescription contraceptives under student health plans, institutional defendants could attempt to justify discriminatory health plans on a second ground. Defendants might argue that, by its terms, Title IX prohibits sex-discrimination only in the particular educational program or activity "receiving Federal financial assistance."[132] Therefore, even if student health plans singled out prescription contraceptives for disfavorable treatment, the university itself could not be held liable for sex-discrimination so long as federal funds are not allocated to defray the costs of administering those plans.

1. INSTITUTION WIDE LIABILITY: FROM *GROVE CITY* TO THE CRRA

A program-specific interpretation of Title IX was advanced by the plaintiffs in *Grove City College v. Bell.*[133] In that case, the federal government suspended the college's student financial aid program on account of its refusal to execute an Assurance of Compliance, a required condition to receiving federal educational funding.[134] Grove City challenged the government's decision, arguing that as a private institution that received no direct federal subsidy, it was under no obligation to comply with the statute. By its terms, Grove City contended, Title IX regulates only those specific programs receiving "Federal financial assistance,"[135] and Grove City could not be deemed in receipt of federal financial assistance "by virtue of the fact that some of its students receive 'financial aid grants.'"[136]

A majority of the Supreme Court agreed with Grove City that the receipt of federal funds by some of its students "does not trigger institution wide coverage under Title IX."[137] As an institution, Grove City would not be subject to Title IX "merely . . . because one of its departments received an earmarked federal grant."[138] At the same time, however, the Court identified the department administering student aid grants as the education program or activity "receiving" federal assistance. It concluded that that department may be properly regulated under

132. 20 U.S.C. § 1681(a) (1994).
133. 465 U.S. 555 (1984).
134. *See Grove City*, 465 U.S. at 559-60.
135. *Id.* at 561.
136. *Id.* at 562.
137. *Id.* at 574.
138. *Id.* at 572.

Title IX.[139]

Congress later rejected the "program-specific" aspect of *Grove City* by enacting the Civil Rights Restoration Act of 1987 [CRRA].[140] The CRRA amends Title IX by redefining the term "program or activity" to include "all of the operations of . . . a college, university, or other post-secondary institution . . . any part of which is extended federal financial assistance."[141] Where colleges or universities are concerned, the CRRA makes "the entire educational institution" the "program or activity" subject to Title IX's anti-discrimination mandate.[142]

The CRRA implicitly endorses the logic and reasoning of the two *Grove City* dissenters. According to the dissent in *Grove City*, because federal financial assistance is meant "to provide funds that will benefit colleges and universities as a whole . . . the entire undergraduate institution is subject to the antidiscrimination provisions included in Title IX."[143] A "program-specific" approach to Title IX liability would prohibit educational institutions from "discriminating on the basis of sex in [their] own 'financial aid program'," but leave colleges and universities "free to discriminate in other 'programs or activities operated by the institution.'"[144] Mimicking that concern, CRRA supporters in Congress warned that a compartmentalized approach to Title IX liability would have allowed educational institutions to discriminate with one hand as long as they do not discriminate with the other.[145] They recognized that the decision in *Grove City* essentially halted enforcement of the nation civil rights laws "by allowing schools [and] other institution to isolate discrimination, to cubbyhole it."[146] Evaluating particular programs or activities in isolation from the educational institution as a whole would run counter to the spirit and underlying purpose of Title IX.[147]

In sum, if one arm of a university receives federal financial assistance, the CRRA's institution-wide approach to liability prohibits discrimination throughout the "entire entity."[148] Accordingly, a university is liable under Title IX for offering discriminatory student health bene-

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139. *See id.* at 573-74.

140. *See* Pub. L. 100-259, 3 (a), § 908, 102 Stat. 28, 28-29 (1988) (codified at 20 U.S.C. § 1687).

141. *See id.*; 20 U.S.C. § 1687 (a).

142. *See* 134 Cong. Rec. E1049-01 (1988).

143. Grove City v. Bell, 465 U.S. 555, 599 (1984) (Brennan, Marshall, JJ., dissenting).

144. *Id.* at 601.

145. 134 Cong. Rec. H565, 579 (1987).

146. 134 Cong. Rec. H565-02 (March 2, 1988).

147. *See* 134 Cong. Rec. S159 (1987).

148. *See* Horner v. Kentucky High Sch. Athletic Ass'n, 43 F.3d 265, 271 (6th Cir. 1994); Cohen v. Brown Univ., 991 F.2d 888, 894 (1st Cir. 1993).

fits whenever any part of the institution receives federal financial assistance.

C. *The "Operation" Must Be Educational In Nature*

A third defense to acclaim that a student health plan discriminates against women by excluding coverage for prescription contraceptives is the argument that the statute applies expressly to the academic functions of covered entities but not to the administrative functions, such as the provision of student health benefits. This defense would emphasize that in redefining the phrase "program or activity" to include "all of the operations of" a covered institution, the CRRA left the modifier "education" intact. Congress thereby indicated its intent to regulate only those operations that are part and parcel of the institution's academic mission. Accordingly, the administration of student health benefit plans falls outside the ambit of Title IX.

Besides contradicting Congress' directive under the CRRA that the "education program or activity is the entire college, university or system of higher education,"[149] this defense overstates the relevance of the term "education." That term is meant to characterize the type of entity regulated by Title IX, rather than the nature of the operation subject to the statute's anti-discrimination mandate. This becomes clear when the statute is read in its entirety.[150]

In addition to "institutions of higher education," Title IX regulates the operations of hospitals, private corporations, and instrumentalities of state and local government that are allotted federal financial assistance.[151] As the Second Circuit explained, the phrase "education program or activity" serves to delineate the scope of the statute as applied to the latter group of entities. "[T]aken together, the phrase 'education program or activity' indicates that in order to implicate Title IX in the first instance, an entity must have features such that one could reasonably consider its mission to be, at least in part, educational."[152] In other words, as a predicate to scrutinizing the operations of a hospital, corporation or instrumentality of government under Title IX, it must be established that the entity itself functions in some educational capacity. The phrase does not adjust the standard of liability applicable to colleges or universities, for which the entire institution is the "education program or

149. *See* 134 Cong. Rec. E1049 (1988).

150. *See* Connecticut Dep't of Income Maintenance v. Heckler, 471 U.S. 524, 530 n.15 (1985) (giving content to entire phrase selected by Congress pursuant to ordinary rules of statutory construction).

151. *See* 20 U.S.C.A. § 1687(1), (2) (1994).

152. O'Connor v. Davis, 126 F.3d 112, 117 (2d Cir. 1997), *cert. denied*, ___ U.S. ___, 118 S.Ct. 1048 (1998).

activity" subject to Title IX.[153]

The pre-enactment history of the CRRA confirms the Second Circuit's proper interpretation of the statute. Included in the Senate Report accompanying the Act's passage are Senator Kennedy's remarks explaining the materiality of the phrase "education program or activity":

> If a private hospital corporation is extended federal assistance for its emergency room, all the operations of the hospital, including for example, the operating rooms, the pediatrics department, admissions, discharge offices, etc., are covered under Title VI, section 504, and the Age Discrimination Act. Since Title IX is limited to educational programs or activities, it would apply only to the students and employees of educational programs operated by the hospital, if any.[154]

The legislative history of the CRRA, as well as case law interpreting the statute, both indicate that the phrase "education program or activity" limits the application of Title IX with respect to those hospitals, corporations or government entities that operate an educational program,[155] but do nothing to alter the breadth of Title IX's coverage with respect to institutions of higher education. As concerns the latter, the relevant "program or activity" for Title IX purposes is "the entire institution."[156]

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153. *See id.* One district court has reached the opposite conclusion. In *Preyer v. Dartmouth College*, 968 F. Supp. 20, 25 (D. N.H. 1997), the court dismissed a sexual harassment claim brought by a college dining services employee on the ground that Title IX applied only to those operations that have "an inherently educational goal." In addition to contradicting Title IX's legislative history, the court in *Preyer* invoked anomalous authority that was effectively overruled by the CRRA. Specifically, the court cites to *Walters v. President & Fellows of Harvard College*, 601 F.Supp. 867, 869 (D.Mass. 1985), for the proposition that "the [CRRA] did not alter the requirement that the program or activity in which the complaining party is involved be educational in nature." *Preyer*, 968 F. Supp. at 25. In *Walters*, the court refused to hold Harvard liable under Title IX for sexual harassment by a grounds crew worker because the University was without notice that discrimination was taking place in the buildings and grounds department. *See Walters*, 601 F. Supp. at 868-69. *Walters* however, turned on the inapplicability of agency principles to a suit brought under Title IX, not on the theory that Title IX applies only to those institutional operations that are "educational in nature." *See id.* Moreover, *Walters* was decided in 1985, before the CRRA created federal jurisdiction over "all departments, buildings, colleges, and graduate schools of th[e] university." Civil Rights Restoration Act, 20 U.S.C. § 1688.

154. S. Rep. No. 100-64, at 18 (1988), *reprinted in* 1988 U.S.C.C.A.N. 3, 20.

155. Although Title IX's legislative history indicates Congress' intent to regulate, at minimum, the educational operations of hospitals, corporations, and government entities, whether Title IX attaches to the non-educational operations of covered entities other than institutions of higher education remains an open question. *See, e.g.*, Women's Prisoners of the D.C. Dep't of Corrections v. D.C., 93 F.3d 910, 927 (D.C. Cir. 1996) (leaving open whether Title IX applies to recreation, counseling, religious services and work details of prison facilities); Jeldness v. Pearce, 30 F.3d 1220, 1225-26 (9th Cir. 1994) (remanding for factual determination of whether farm annex, forest work camp, or prison industries are "educational" programs within the meaning of Title IX).

156. *O'Connor*, 126 F.3d at 117-18.

The statute's nine enumerated exceptions[157] lend textual support to the conclusion that Title IX prohibits sex discrimination in the non-academic operations of higher educational institutions, including the provision of student health benefits. That some of these exclusions logically fall into the category of administrative or non-educational operations is indicative of the statute's application to non-educational operations generally. The absence of additional non-educational exclusions supports the inference that none were intended.[158]

The legislative history of the CRRA underscores that sex discrimination in the non-educational operations of a covered educational institution, such as the administration of student health insurance plans, is prohibited by Title IX. The sponsors of Senate Bill 557, the precursor to the CRRA, drafted the language "all of the operations" to capture a host of institutional functions within the ambit of Title IX. The bill provided that services relating to "faculty and student housing, campus shuttle bus service, campus restaurants, the bookstore, and other commercial activities," when offered or provided by educational institutions, must be offered on sex-neutral terms.[159] The reach of Senate Bill 557 became clear when an analysis authored by the Department of Justice was read into the Congressional Record to explain the sweep of the phrase "all of the operations".

> [I]f an entity conducting one or more educational programs receives Federal financial assistance to any part of the entity, whether or not that part is educational, then . . . Title IX's ban on sex-discrimination, appl[ies] to the entire entity, including non-educational activities . . . [t]he commercial and non-educational activities of a school, college or university, including rental of commercial office space and housing to those other than students or faculty, and other commercial ventures will be covered.[160]

Rather than rebutting the Department's conclusion,[161] proponents of the CRRA accepted that the Amendment would extend federal control over operations "absolutely unrelated to educational activities."[162]

Added support for the application of the CRRA to non-educational operations such as university sponsored health insurance plans echoed in

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157. *See supra* note 95.

158. *See* North Haven v. Bell, 456 U.S. 512, 521 (1982) (citing the absence of a specific exclusion for the conclusion that none was intended); Andrus v. Glover Constr. Co., 446 U.S. 608, 616-17 (1980).

159. 134 Cong. Rec. S159 (1988).

160. 134 Cong. Rec. S2399-02 (1988).

161. *See* 134 Cong. Rec. S2399-02 (1988) ("The charge that the bill could extend federal control over colleges and other public and private agencies to unreasonable, perhaps dangerous, lengths has never been effectively rebutted.") (statement of Senator Karnes).

162. *See* 134 Cong. Rec. 2409-01 (1988); 134 Cong. Rec. S2399-02 (March 17, 1988).

the statements of Senator Packwood, who saw no distinction between sex-discrimination in the "whole school or the French department versus the health department."[163] Other CRRA supporters specifically urged that the Amendment be drafted in broad language, in part to prohibit college sponsored insurance programs that discriminate on the basis of sex.[164] Moreover, throughout the debates surrounding the abortion Amendment, legislators made specific reference to the applicability of Title IX to student health insurance plans.[165] Even the Office of Civil Rights, prior to the passage of the CRRA, entertained suits against educational institutions challenging student health policies that discriminated on the basis of sex.[166] This history indicates that Congress fully intended for the provision of student health insurance plans to constitute an "operation" of an educational institution that, when offered, must be offered on non-discriminatory terms.

With respect to educational institutions, the United States Supreme Court has verified that Title IX's sex-neutral mandate pertains to purely administrative operations. In *North Haven v. Bell*,[167] the Court resolved that "employment discrimination falls within the prohibition of Title IX".[168] According to the Court, Title IX's broad directive that "no person" may be discriminated against on the basis of sex "neither expressly nor impliedly excludes employees from its reach."[169] Absent a contrary indication in the statute's legislative history, Title IX must be accorded "a sweep as broad as its language."[170] After all, the Court concluded, "Congress easily could have substituted 'student' or 'beneficiary' for the word 'person' if it had wished to restrict the scope of [the statute]."[171]

The rationale in *North Haven* directly supports the application of Title IX, as amended by the CRRA, to the terms of student health benefit plans. First, the phrase "all of the operations" neither expressly nor impliedly excludes administrative operations from the Amendment's reach. Second, the bulk of Congressional testimony specifically contemplates Title IX's application to student health plans.[172] Third, as the Court stated in *North Haven*, Title IX should be given "a sweep as broad as its language."[173] Had Congress intended otherwise, it easily could

163. 34 Cong. Rec. S159-02 (1988).
164. 134 Cong. Rec. H565 (1988).
165. *See* 134 Cong. Rec. S159 (1988).
166. *See* 134 Cong. Rec. H565 (1988).
167. 456 U.S. 512 (1982).
168. *See North Haven*, 456 U.S. at 520, 530-31.
169. *Id.* at 520-21.
170. *Id.*
171. *Id.* at 521.
172. *See supra* text accompanying notes 139-141, 153-165.
173. *See North Haven*, 456 U.S. at 521.

have restricted the scope of the statute by inserting the word "educational" or "academic" within the CRRA phrase "all of the operations."[174]

Following *North Haven*, however, it nevertheless remains plausible that the application of Title IX to institutional employment decisions does not ipso facto require the statute's application to policies unrelated to the institution's educational mission. For instance, to the extent that the composition of a college or university faculty impacts the learning environment,[175] administrative hiring decisions could be characterized as "educational" in nature. Therefore, *North Haven's* holding that a college or university is liable under Title IX for discrimination against academic employees does not necessarily extend the statute's application beyond those operations designed solely to further educational objectives.

This argument is easily addressed. First, *North Haven* does not compel such a literal reading of Title IX. Nowhere in the opinion does the majority ground its decision on the educational nature of the institution's faculty hiring decision. Instead, the majority cited extensively to both pre and post-enactment history which references the statute's application to non-educational operations generally.[176] Even the dissenting Justices understood Title IX to apply to non-educational decisions. It was the very extension of Title IX to administrative operations that kept the three Justices from joining the majority opinion.[177]

Second, since *North Haven*, the Office of Civil Rights has implemented regulations prohibiting discrimination in expressly non-academic aspects of employment, including advertising, pay rates, fringe benefits or any other term, condition or privilege of employment.[178] Even if an initial hiring, placement or discharge decision might be considered educational by nature, the provision of employee fringe benefits could not be said to affect a university's academic mission.

In light of the foregoing analysis, *North Haven* supports the application of Title IX to the institutional operations of covered entities, regardless of whether those operations are educational in nature. Following *North Haven*, the defense that an educational institution could

174. *Cf. id.* at 520.

175. *See* Wygant v. Jackson Bd. of Educ., 476 U.S. 267, 288 (1986) (O'Connor, J., concurring); *see id.* at 315 (Stevens, J., dissenting); Taxman v. Piscataway, 91 F.3d 1547, 1563, (3d Cir. 1996).

176. *See generally North Haven*, 456 U.S. at 523-535.

177. *See id.* at 541 (Powell, J., dissenting) (criticizing the majority's "tortured" conclusion that Title IX protects "not only teachers and administrators, but also secretaries and janitors, who are discriminated against on the basis of sex in employment . . .").

178. *See, e.g.*, 34 C.F.R. § 106.51 (b)(1); (b)(3); (b)(10) (1998).

not be held liable for discriminating against women in the provision of health benefits fails.

D. *Third Party Operations are Not Covered*

A fourth justification could be offered in defense of a student insurance plan that discriminates against women by excluding coverage for prescription contraceptives. Even if Title IX applies to the non-educational operations of educational institutions, the defense would proceed, the institution itself should only be held liable when it is directly responsible for the discrimination. That is to say, to the extent that a university serves in a capacity to market the product of a third party underwriter, a discriminatory health insurance plan would not constitute an "operation of" the educational institution. As such, the university should not be deemed to have violated Title IX.

The response to this defense is threefold. First, federal funding recipients are responsible for discrimination in any health benefit plan "which such recipient administers, operates, offers, or participates in."[179] Thus, for liability purposes, whether an educational institution serves as a marketing or processing agent is irrelevant. Second, given that employers cannot escape liability for third party discrimination under parallel civil rights laws,[180] a less expansive interpretation of Title IX would expose the very loophole the statute was intended to close.[181] Finally, in enacting the CRRA, Congress reaffirmed that the federal government "absolutely will not tolerate tax-supported discrimination."[182] To sanction the inadvertent funding of discriminatory third party programs would undermine the spirit and purpose of Title IX.[183]

Similarly, courts should not accept as a defense to a discriminatory

179. 34 C.F.R. § 106.40(b)(4) (1998).

180. *See Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1089 (1983) (finding liability where employer offered discriminatory retirement package underwritten by a third party); *see generally* Paul K. Sonn, *Fighting Minority Under-representation in Publicly Funded Construction Projects After Croson: A Title VI Litigation Strategy*, 101 YALE L.J. 1577, 1582-83 (1992) (demonstrating sponsoring state agency's liability under Title VI for discriminatory policies of sub-contractor). As to whether insurance companies themselves can be liable for discrimination under Title VII, the circuit courts have reached differing conclusions. *Compare* Spirt v. Teachers Ins. & Annuity Asso'n, 691 F.2d 1054 (2d Cir. 1982), *vacated and remanded*, 463 U.S. 1223 (1983) (holding insurer liable for offering discriminatory fringe benefits policy through employer); *and* Colorado Civil Rights Comm'n v. Travelers Ins. Co., 759 P.2d 1358 (Colo. 1988) (finding insurer liable for restricting employer choice to discriminatory policies), *with* Peters v. Wayne State Univ. 691 F.2d 235 (6th Cir. 1982) (refusing to find insurer liable where insured's representative had no control over use of sex-specific mortality tables), *vacated and remanded*, 463 U.S. 1223 (1983). *See generally*, Andrew O. Schiff, Note, *The Liability of Third Parties Under Title VII*, 18 U. MICH. J. L. REFORM 167, 180-85 (1985).

181. *See supra* text accompanying note 121.

182. 133 Cong. Rec. S2400-02 (1987); 134 Cong. Rec. H565 (1988).

183. *See* Gebser v. Lago Vista Indep. Sch. Dist., 524 U.S. 274, 286 (1998) (acknowledging

student health insurance plan that policies available in the commercial market typically exclude contraception.[184] In the employment context, an employer who offers a discriminatory fringe benefit plan is not shielded from Title VII liability simply because sex-neutral insurance policy is commercially unavailable. As the Supreme Court made clear in *Arizona Governing Committee v. Norris*:[185]

> It would be 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. An employer who confronts such a situation must either supply the fringe benefit himself without the assistance of any third party, or not provide it at all.[186]

Given the similarity of purpose between Title VII and Title IX,[187] *Norris* stands as strong persuasive authority that educational institutions do not escape liability under the latter simply because policies offered in the public domain discriminate against women. The commercial unavailability of sex-neutral plans "is simply irrelevant" when it comes to institutional liability under Title IX.

E. *Available Options: Foregoing Membership and Alternative Packages*

Finally, educational institutions could not defend the provision of otherwise comprehensive health benefits that exclude coverage for prescription contraceptives on the grounds that students may waive out of university sponsored insurance coverage upon proof of individual coverage.[188] In *Norris,* the Court grounded employer liability on the fact that employees were presented with discriminatory alternatives, despite that employees enjoyed the liberty to forego enrollment in any particular plan.[189] "Once the State selected these companies . . . [it] cannot disclaim responsibility for the discriminatory features of the insurers' options."[190] Likewise, educational institutions cannot disclaim responsi-

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that principal purpose of Title IX is "to avoid the use of federal resources to support discriminatory practices") (quoting Cannon v. Univ. of Chicago, 441 U.S. 677, 704 (1979)).

184. *See* Law, *supra* note 20, at 383.

185. 463 U.S. 1073 (1983).

186. *Norris*, 463 U.S. at 1090-91. The excerpt from *Norris* is cited verbatim to preserve authenticity, and to demonstrate that despite its holding, the court's reliance on the pronouns "he" and "his" as a pseudogeneric referent manifests a discriminatory subtext. *See* Deborah Schweikart, *The Gender Neutral Pronoun Redefined*, 20 WOMEN'S RTS. L. RPT. 1 (1998).

187. *See* Yusuf v. Vassar College, 35 F.3d 709, 714-15 (2d Cir. 1994).

188. *See, e.g.*, PENN, *supra* note 84, at 4; NEW YORK, *supra* note 84, at 3.

189. *See generally Norris*, 463 U.S. 1073.

190. *Id.* at 1089.

bility for the discriminatory features of a student health insurance policy simply because students have the option of obtaining their own coverage. It is the prerogative of educational institutions not to offer insurance coverage in any form.[191] Institutions that offer such a service must do so on a non-discriminatory basis.

IV. PROPOSAL FOR A MODEL STUDENT HEALTH PLAN

Concluding that the exclusion of contraceptive coverage from otherwise comprehensive student health insurance plans is illegally discriminatory, the task remains to designate the terms on which coverage should be provided for prescription contraceptives. In designing such coverage, two related goals should take priority: (1) redressing the sex-based inequity inherent in the exclusion of reversible prescription contraceptives so that educational institutions that offer student health insurance plans come into compliance with Title IX; and (2) ensuring that in selecting a contraceptive method, a woman's choice is both informed and individualized.[192]

The following are provisions which, at minimum, must be included in a student health plan to ensure that birth control drugs and devices are provided on a non-discriminatory basis, in a manner that facilitates access to and financing for prescription contraceptives by middle-income college-age women.

First, the plan must make clear the breadth of coverage provided for prescription contraceptives. In plain, nontechnical language, the policy must spell out the full range and extent of reimbursement that is provided for contraceptive drugs, devices and services. In a similar vein, each plan should make plain its commitment to abide by state and federal anti-discrimination requirements. Further, implementation is crucial. "Women need to know about contraceptive coverage, insurers need to comply, and authorities need to enforce the law."[193]

Second, contraceptive coverage must be compulsory. Coverage for birth control drugs, devices, and supplies must be provided under student health plans whenever the plan provides reimbursement for other prescription medications. It is not enough for insurance companies merely to offer educational institutions the option of purchasing benefit plans that include coverage for contraceptives.[194] Coverage for contra-

191. 134 Cong. Rec. S159 (1988).

192. *See* LISA KAESER, *What Methods Should Be Included In a Contraceptive Coverage Insurance Mandate*, 1998 ALAN GUTTMACHER REPORT ON PUBLIC POLICY, No. 5, 1.

193. *See* ACOG, *supra* note 10.

194. *See* V. CODE ANN. § 38.2-3407.5:1 (Michie 1997); HAW. REV. STAT. § 432:1-604.5, 431:10A-116.6 (1994).

ceptives must be provided under each plan that provides coverage for other prescribed drugs and devices.

Third, contraceptive coverage must be complete. University sponsored health plans must reimburse beneficiaries fully for the costs of birth control drugs, devices, and supplies. Providers must not single out prescription contraceptives for enhanced deductibles, co-payments, co-insurance, or contribution caps.[195] Where students are forced to obtain an appropriate birth control method off campus because the full range of birth control options are not available at student health centers, providers must waive services charges that would otherwise accrue.[196]

Fourth, contraceptive coverage must be comprehensive. University sponsored health plans must provide coverage for the full range of commonly prescribed birth control drugs, devices and supplies or their generic equivalents.[197] Absent comprehensive coverage, women without significant disposable income would be forced to choose among less suitable alternatives, which in turn would increase the risk of unintended pregnancy.[198] The insurance industry would not tolerate a "one-size-fits-all" mentality with respect to other prescription drugs, and should not do so with respect to prescription contraceptives.[199]

A comprehensive reimbursement scheme also would include coverage for consultations, examinations, procedures, education, and counseling related to the use of contraceptives.[200] A woman's contraceptive choice cannot be meaningful absent a full understanding of the range of contraceptive options available, and the risks and benefits associated with each option. Moreover, educational counseling with respect to proper and consistent contraceptive use will maximize the effectiveness of the chosen method.[201]

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195. *See, e.g.*, H.B. 630, 90th Legis., 1st Sess. (Mo. 1999); S.B. 222, 47th Legis., 1st Sess. (Okla. 1999).

196. *See* UNIVERSITY OF MICHIGAN, *supra* note 84, at 10.

197. *See, e.g.*, A.B. 6168, 222d Legis., 1st Sess. (N.Y. 1999).

198. For example, the IUD, Depo-provera and Norplant are among the most cost-effective birth control methods available, but least accessible due to up front costs. *See* James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 494, 494 (1995). In 1993, a five year supply of birth control pills and related examinations cost $1500; a five year supply of Norplant cost $700.00. *See* Law, *supra* note 20, at n.13. In comparison, the cost of and IUD, which remains effective for eight years, was about $500.00 *See id.*

199. *See* ACOG, *supra* note 10.

200. *See, e.g.*, S.B. 82, 21st Leg., 1st Sess. (Alaska 1999).

201. Statistics regarding rates of unintended pregnancy reveal the need for enhanced contraceptive counseling; almost half of the unintended pregnancies that occur are among women who are using contraception incorrectly or inconsistently. *See Coverage for Contraception*, *supra* note 9, at 6.

V. CONCLUSION

The family planning needs of middle-income college-age women are not being met. The system of health care financing operating in the United States provides benefits primarily through employer-sponsored health plans on the one hand, and publicly subsidized health care initiatives on the other. These programs target services toward women who are either older and more affluent, or younger and poor. Middle-income college-age women, however, seldom meet the eligibility requirements necessary to receive health care services under either type of program. While student health insurance plans offer these women an alternative health care financing option, such plans typically fail to cover the costs of prescription contraceptives. As demonstrated by the foregoing analysis, this exclusion of birth control drugs and devices from student health insurance plans constitutes sex-discrimination. As such, this exclusion is prohibited under Title IX.