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# Coverage of Reproductive Technologies Under Employer-Sponsored Health Care Plans

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# COVERAGE OF REPRODUCTIVE TECHNOLOGIES UNDER EMPLOYER-SPONSORED HEALTH CARE PLANS: PROCEEDINGS OF THE 2004 ANNUAL MEETING, ASSOCIATION OF AMERICAN LAW SCHOOLS, SECTIONS ON EMPLOYEE BENEFITS AND EMPLOYMENT DISCRIMINATION

**Professor Colleen E. Medill***: Good morning and welcome. This is the joint program of the Sections on Employee Benefits and Employment Discrimination. I'm Colleen Medill, Chair of the Section on Employee Benefits, and I'll be the moderator for today's program.

Our topic today is reproductive technologies under employer-sponsored health care plans. I will begin by introducing our speakers and by giving an indication of what they will discuss. They will each speak for about fifteen minutes, after which we are going to open up the discussion for comments from the floor. Today's program will be published by the *Employee Rights and Employment Policy Journal.*

Our first speaker today is Helen Norton. Helen has been a visiting professor at the University of Maryland since 2002. Prior to that, she was the E. George Rudolph Distinguished Visiting Chair in Law at the University of Wyoming. Before entering academia, Helen worked for almost ten years at the National Partnership for Woman and Families, where she began as a staff attorney and eventually became Director of Legal and Public Policy. Next, she worked at the U.S. Department of Justice in the Civil Rights Division where she managed the Civil Rights Division's employment litigation and coordinated policy. Helen teaches employment law and employment discrimination law, among other subjects, and publishes extensively in the field. She is a graduate of the University of California at Berkeley, Boalt Hall School of Law, and of Stanford University. She is going to cover the Title VII, ADA and FMLA aspects of our topic today.

Our second speaker is Eve Gartner. We are delighted Eve was able to take a break from her busy litigation schedule and speak to us today. She is the Senior Staff Attorney in the Public Policy Litigation

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and Law Department of the Planned Parenthood Federation of America in New York City. Prior to joining Planned Parenthood, she was the Senior Staff Attorney at the Center for Reproductive Law and Policy. In the ten years that she has worked in this field, she has been instrumental in litigating several key reproductive rights cases. She represented the class of plaintiffs in *Erickson v. Bartell Drug Company*,[1] which was the first case to establish that a private employer's failure to provide insurance coverage for prescription contraception constitutes sex discrimination under Title VII of the Civil Rights Act of 1964.[2] She is currently involved in litigation addressing First Amendment challenges to state insurance laws mandating coverage of reproductive technology in private employer-sponsored health care plans. Eve is going to speak to us about these cases and, in particular, about First Amendment challenges and trends in state insurance laws in this area. She is a graduate of the Columbia University School of Law and of St. John's College.

In case you are wondering what state law has to do with a field that seems to be dominated by ERISA, our third speaker, Elizabeth Pendo, will address that topic. Elizabeth is an associate professor of law at St. Thomas University School of Law. She is a graduate of the University of California at Berleley, Boalt Hall School of Law, and of the University of California at Los Angeles. Prior to entering academia, she was a pro se law clerk for the Second Circuit Court of Appeals. After her clerkship, she practiced law with a large commercial law firm, and then became an ERISA specialist in the litigation department of Met Life in New York. Elizabeth teaches and writes in the area of employee benefits law, health care law, and disability law. With that introduction, we will begin with Helen.

**Professor Helen L. Norton*:** Good morning. In beginning this discussion, I'm going to focus on two questions that I find particularly interesting. First, I want to look at the type of reproductive technology at issue. Are we talking about oral contraceptives? Are we talking about fertility-related drugs? Are we talking about surgical procedures to address infertility? I want to examine whether the type of technology involved affects the analysis and the outcome under the major federal anti-discrimination statutes and, for my purposes, I'm going to focus on Title VII and the Americans with Disabilities Act

1. 141 F. Supp. 2d 1266 (W.D. Wash. 2001).
2. 42 U.S.C. §§ 2000e to 2000e-16 (2000).

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("ADA").[3]

Second, I'd like to look at the type of employment decisions at issue. Are we talking about the exclusion of a particular treatment or condition from an employer's health plan, or are we talking about an employer's decision to hire, discipline or fire a particular employee? I want to examine whether, and how, the particular employment action under challenge affects the analysis and the outcome under these statutes.

Eve is going to talk in detail, I think, about the issues presented under Title VII with respect to health care plans and the exclusion of oral contraceptives, so I'm not going to spend a lot of time on that issue. Instead, let me turn to some other types of reproductive technologies and, specifically, to those addressing infertility issues.

Starting with Title VII, the key issue for our purposes is whether or not the employer is discriminating on the basis of sex. Infertility itself is a gender-neutral condition in that both men and woman can experience it and, in fact, they do experience it in roughly equal numbers.[4] So, an employer's even-handed treatment of male and female employees' infertility generally does not raise Title VII problems. Recall, for example, *United Auto Workers v. Johnson Controls, Inc.*,[5] a Title VII challenge to Johnson Controls' practice of excluding fertile women from jobs that involved exposure to lead because of the employer's concern that exposure posed unacceptable reproductive risks. Women could not work in those jobs unless they could present medical evidence that they had been sterilized, had gone through menopause, or otherwise were infertile, whereas men were free to take those jobs regardless of their fertility.

A unanimous Supreme Court held that the employer's exclusion of fertile women, but not fertile men, from these jobs violated Title VII, as amended by the Pregnancy Discrimination Act.[6] Certainly, we'd see a very different outcome if Johnson Controls had treated fertile and infertile men and women equally. If the company had excluded fertile men and women from those jobs, there would have been no Title VII problem. On the other hand, if an employer does not treat infertile men and women even-handedly, then we have Title VII problems and there have been a couple of lower court cases

3. 42 U.S.C. §§ 12101-12213 (2000).
4. *See* Saks v. Franklin Covey Co., 316 F.3d 344, 346 (2d Cir. 2003).
5. 499 U.S. 187 (1991).
6. *Id.* at 211.

where female plaintiffs seeking fertility treatments brought successful Title VII challenges when the circumstances indicated disparate treatment, such as disparate leave policies or disparate discipline compared to their male counterparts.[7] Those are relatively easy cases.

The tricky issues arise under Title VII when we look at whether health plans' exclusions of infertility-related conditions and treatment run afoul of Title VII. As you probably recall, the Pregnancy Discrimination Act was a congressional response to the Supreme Court's 1976 decision in *General Electric Co. v. Gilbert*,[8] a Title VII challenge to an employer's disability insurance policy that basically provided wage replacement for time lost due to virtually any medical condition except for pregnancy. The plaintiffs argued that the exclusion of pregnancy, while covering all other medical conditions, was impermissible sex discrimination under Title VII. A divided Court held that the exclusion of pregnancy was not sex discrimination because not all women are or will become pregnant and because the plan covered the same set of conditions for both men and women.[9] In other words, there was no condition for which men received coverage that women didn't. Men received coverage for heart disease, and so did women. Men received coverage for diabetes, and so did women. Men and women had equal access to the same set of available benefits. This is often referred to as the equal access analysis.

Congress responded to *Gilbert* by enacting the Pregnancy Discrimination Act in 1978 ("PDA"),[10] which provides "the terms because of sex or on the basis of sex include, but are not limited to, because of or on the basis pregnancy, childbirth or related medical conditions, and women affected by pregnancy, childbirth or related medical conditions shall be treated the same for all employment related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work."[11] One may view this language in the PDA as simply a repudiation of *Gilbert's* holding that pregnancy discrimination is not a form of illegal discrimination. Under this approach, the PDA simply adds pregnancy, childbirth and related

7. *See* EEOC v. UPS, Inc., 141 F. Supp. 2d 1216 (D. Minn. 2001). Cleese v. Hewlett-Packard Co., 911 F. Supp. 1312 (D. Or. 1995); Pacourek v. Inland Steel Co., 858 F. Supp. 1393 (N.D. Ill. 1994).

8. 429 U.S. 125 (1976).

9. *Id.* at 135-36.

10. Pub. L. No. 95-555, 92 Stat. 2076 (*codified at* 42 U.S.C. § 2000e(k) (2000)).

11. 42 U.S.C. § 2000e(k) (2000).

medical conditions to the list of Title VII's protected characteristics.

The better view, in my opinion, and the one that has been adopted by most courts looking at these issues, understands the PDA as a rejection not only of *Gilbert's* specific holding, but also a rejection of the equal access analysis. The Supreme Court suggested this in *Newport News Shipbuilding & Dry Dock Co. v. EEOC*,[12] which was the first decision in which it addressed the Pregnancy Discrimination Act, and there's also legislative history indicating that the PDA was intended to adopt the *Gilbert* dissenters' view that Title VII is violated whenever a plan excludes or whenever an employer otherwise discriminates on the basis of a sex-specific decision and that pregnancy is the most prominent example of such a sex specific.[13] So, the key issue in determining whether there's a Title VII violation is to look to whether the health insurance plan addresses men's and women's health care needs in an equally comprehensive manner. I think Eve is going to discuss, in greater detail, this approach, taken by the district court in her case, *Erickson v. Bartell Drug Co.*,[14] where the court held that the employer's exclusion of oral contraceptives from its otherwise comprehensive prescription drug coverage was, in fact, a violation of Title VII, not necessarily because an interest in preventing pregnancy falls within the PDA's magic phrase "pregnancy, childbirth or related medical conditions," but because the plan did not provide equally comprehensive coverage of women's prescription drug needs compared to men's. In other words, it covered basically all of men's prescription drug needs but failed to cover a significant prescription drug need of women.

What does this mean for infertility? Infertility, of course, is a condition experienced by both men and women, in roughly equal numbers. An employer's truly even-handed exclusion of infertility from its health plan coverage is not disparate treatment because it does not exclude a sex-specific condition. There may be disparate impact issues, which I'll discuss in a minute, but there probably is no disparate treatment issue.

Even though infertility is experienced by both men and women, the treatments for male and female infertility are quite different. What if an employer chooses to cover some infertility-related treatments but not others? The Second Circuit struggled, I think

12. 462 U.S. 669 (1983).
13. *See id.* at 678.
14. 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

struggled is exactly the right verb, with this question last year in a case called *Saks v. Franklin Covey Co.*[15] Franklin Covey's health care plan covered many treatments for infertility including, for example, ovulation kits and fertility drugs like Clomid, both used by women, and prosthetic penile implants used by men. It also included coverage of many surgical treatments for infertility for men, surgery to correct blockages of the vas deferens, surgery to correct varicose veins in the testicles that limits sperm production, and surgery for women to address endometriosis, tubal inclusions, and things like that. The plan specifically excluded surgical impregnation treatments, artificial insemination, in vitro fertilization, and embryo and fetal implants, and these, obviously, are treatments that can be performed only on women.[16] So, the plaintiff Saks argued that this exclusion violated Title VII because the plan covered all treatments, including all surgical treatments, that are performed on men to address their infertility, but provided incomplete coverage of surgical treatments for women's infertility.

The Second Circuit disagreed. It said that there was no exclusion of a sex-specific condition because infertility is not a sex-specific condition.[17] It also held that, even though surgical impregnation is a treatment that can be performed only on women, it is not a sex-specific treatment because it is used to treat male and female infertility.[18] In other words, both men and women who are infertile can be treated with surgical impregnation. According to the court, treatment for an infertile woman includes surgically impregnating her. For an infertile man, the treatment can include surgically impregnating his partner, and for this reason the Second Circuit concluded that the exclusion disadvantaged male and female employees equally. In so holding, the court made clear that it was assuming that the plan would normally cover treatment of an employee's condition that requires some procedure to be performed on somebody other than the employee;[19] in other words, the court assumed that, absent a specific exclusion of this type, if an employee with a condition that for some reason requires that some procedure be performed on somebody else the plan will normally pay for the procedures that are performed on this other person. If that is so, and

15. 316 F.3d 337 (2d Cir. 2003).
16. *Id.* at 341.
17. *Id.* at 346.
18. *Id.* at 343.
19. *Id.* at 346.

the court said that the plaintiff had failed to offer any evidence to refute that assumption, then excluding surgical impregnation equally disadvantaged both men and women because it excluded both of them from coverage of expenses that otherwise would be covered under the plan.

I'll defer to the benefits experts as to whether that's the way plans normally work, but it seems unusual to me. If the assumption is correct, then it may be that the result is correct, but it's hard to see how the plaintiff could have refuted that assumption, in large part because it's hard to imagine many other circumstances in which the treatment of an employee requires doing something to somebody else. Organ donation is the only other example I can think of, and Franklin Covey's plan specifically excluded the expenses of the organ donor. The court found that irrelevant because that exclusion was specific to organ donation and didn't tell us much about how other sorts of expenses would be covered.[20]

This seems to me to be a strange result. The better approach would recognize that exclusion of sex-specific treatments is sex discrimination, but maybe Franklin Covey's problem was that it covered some, but not all, infertility treatments. It covered all of those treatments that are performed on men, but not all of those treatments that are performed on women. What if it decided to save itself and exclude all infertility treatments across the board? If it did, it seems to me there would be no disparate treatment problem under Title VII, but there might be a disparate impact issue if the plaintiffs could show that women were adversely affected – if, for example, the plaintiffs could offer data showing that women were disproportionately requesting and being denied infertility related treatment, or women were incurring higher health care costs as a result of that exclusion. I have yet to see a case where the plaintiffs offered that data, but it seems to me a case could be made along those lines.

I want to switch briefly to the ADA and what, if any, protections for infertility it provides. Recall that, as a threshold matter, the plaintiff in an ADA case must show that he or she has a disability that's covered by the act, that is an impairment that substantially limits a major life activity. After the Court's decision in *Bragdon v. Abbott*,[21] many, if not most, infertility-related conditions are going to be considered disabilities under the ADA. *Bragdon* held that

20. *Id.* at 348.
21. 524 U.S. 624 (2000).

reproduction is a major life activity for ADA purposes.[22] *Bradgon* held that asymptomatic HIV-positive status is a covered disability because HIV-positive status is an impairment that substantially limits the major life activity of reproduction, and a woman who is HIV-positive is substantially limited in her ability to reproduce because doing so carries significant risk that she'll pass the virus on to her partner or to the child.[23] If reproduction is a major life activity, many, if not most, infertility-related conditions will qualify as covered disabilities. The exceptions will be infertility due to aging or menopause because these are not impairments. These are not disorders or dysfunctions; they're just part of natural life and the aging process. But other conditions like endometriosis, certain forms of cancer, blockages of the vas deferens, and the like, are covered disabilities.

Determining that an infertility-related condition is a covered disability isn't the end of the inquiry and this is one of those situations where I think the type of employment action being challenged is outcome-determinative. It seems pretty clear that an employee with an infertility-related disability can't be fired or denied a job because of that disability. It's also pretty clear that an employee with that sort of disability is entitled to leave or some other reasonable accommodation to get treatment, including fertility-related treatments. I'll note also that the Family and Medical Leave Act[24] provides some protection to employees seeking time for fertility-related treatments. The Family and Medical Leave Act provides job-guaranteed leave to workers to address their serious health conditions.[25] Serious health conditions are defined to include impairments or conditions that require either inpatient care or continuing treatment by a health care provider,[26] and many infertility-related conditions are going to fall within that definition, and that's the trigger for the leave entitlement.

But with respect to a health insurance plan, the ADA probably permits the exclusion of infertility-related conditions from plan coverage and this is because the ADA, unlike Title VII, explicitly treats the terms and conditions of health insurance plans differently,

22. *Id.* at 638.
23. *Id.* at 643.
24. 29 U.S.C. §§ 2601 - 54 (2000).
25. *Id.* § 2612(A).
26. *Id.* § 2611(11).

and more deferentially, than other employment actions like hiring and firing. The statute specifically provides a safe harbor for certain insurance plans that are based on "underwriting risks, classifying risks or administrating risks" that are based on or not inconsistent with state law,[27] and the legislative history suggests,[28] and the lower courts have pretty much uniformly held, that the ADA was not intended to dramatically change the business of insuring health risks, and that health insurance plans do not run afoul of the ADA when they discriminate among types of disabilities so long as all the employees, regardless of disability status, have equal access to the available range of benefits.[29] For example, it's generally permissible to provide more generous coverage of physical conditions, as opposed to mental conditions or visual impairments, so long as the employees with mental disabilities or visual disabilities have the same access to the same coverage. Similarly, it's been held that it's okay for a plan to cap AIDS-related coverage at lower levels than other conditions so long as folks with AIDS have access to the full range of available benefits.[30] In other words, there is no violation so long as the HIV-positive employee has the same access and same level of benefits for non-AIDS conditions as do other employees, and so long as that employee has the same access to AIDS-related coverage as do other employees. So, it seems clear, or at least likely, that the ADA permits the exclusion or differential treatment of infertility-related conditions, What you can't do, of course, is to say that somebody with an infertility-related disability or any other disability is excluded from the plan entirely, that a different set of rules applies to them because of their disability.

Returning to the questions that I started with, it seems clear that the type of reproductive technology at issue does matter. With respect to Title VII, one of the key inquiries is going to be whether the treatment is sex-specific. If so, we have a Title VII problem; if not, we don't. And it also seems clear that the type of employment action at issue matters, especially with respect to the ADA, under which employers' decisions with respect to insurance coverage are

27. 42 U.S.C. § 12201 (2000).

28. *See, e.g.*, H.R. REP. NO. 101-485(II), at 59 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 341; H. R. REP. NO. 101-485(III), at 438 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 460-61.

29. *See, e.g.*, Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1116 (9th Cir. 2000); Ford v. Schering-Plough Corp., 145 F.3d 601, 608 (3d Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1015 (6th Cir. 1997).

30. *See* Owen v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993).

going to be given considerably greater latitude than other types of decisions, such as hiring, firing and discipline.

**Eve Gartner*:** Thank you for inviting me to be here today. I'd like to offer some views from the field about the practical ramifications of the Title VII issues, specifically with respect to contraceptive coverage. As Colleen said, I litigated the *Erickson v. Bartell* case which was the first case that established that the exclusion of contraception from an employee health plan is a violation of Title VII,[31] and I think Helen described that case in a fair amount of detail. I'll just mention, from the practical side, that in that case we asserted two specific claims. One was a disparate treatment claim under the Pregnancy Discrimination Act, and in that claim we argued that the capacity to become pregnant is itself a pregnancy-related medical condition under the Pregnancy Discrimination Act. We relied for that proposition on *UAW v. Johnson Controls,* where the Supreme Court found that the capacity to become pregnant is a medical condition related to pregnancy.[32] The disparate treatment claim based on the PDA was a purely legal claim. If an employer's health plan discriminates on the basis of the capacity to become pregnant, in this case by excluding medication that women need to help them control their capacity to become pregnant, then that is a *per se* violation of the Pregnancy Discrimination Act. Ultimately, that was the claim on which the court granted us summary judgment.

The second claim that was asserted in that case, and that the court never actually reached as a final matter, was not a Pregnancy Discrimination Act claim, but a pure Title VII sex discrimination claim alleging disparate impact. Our theory was that the exclusion of contraceptives from an employer's health plan has a disparate impact on women, because only women can become pregnant and only women bear the physical, emotional and other consequences of an unintended pregnancy if they can't afford to use contraception and become pregnant and in many cases women bear the financial burden of paying out of pocket for contraceptives if their insurance doesn't cover it. So far no court has reached the disparate impact claim.

In addition to the *Erickson* decision, there have been a couple of other published rulings on this matter, but none of them was a final

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31. 141 F. Supp. 2d 1266, 1277 (W.D. Wash. 2001).

32. 499 U.S. 187 (1991).

ruling. There's a case now pending against Wal-Mart in which the court granted a motion for class certification. There's a published opinion, but it doesn't go into the merits of the contraceptive coverage question.[33] There's also a case pending against Daimler-Chrysler. In that case, Daimler-Chrysler moved to dismiss the complaint, and the court denied the motion to dismiss. I believe there is a published opinion denying the motion to dismiss, but again, without a lot of detail about the legal theories.[34] Daimler-Chrysler sought permissive interlocutory appeal of the denial of the motion to dismiss. The Eighth Circuit refused to allow the interlocutory appeal in that case, so it's back before the district court. There also are cases pending against several other large employers: Union Pacific, for example, and we have a case now pending against the Albertson supermarket chain, but that's about to be settled. It's pending in the District of Arizona. Helen asked me at breakfast today, why there are not more cases out there, and the fact is that so many employers, when we threaten to bring litigation against them, immediately change their policy, and I think there are a lot of reasons for that. One is that it's a good policy in terms of employees, a fairly inexpensive way to keep employees happy. The cost data show that there's virtually no increase in cost for adding contraceptive coverage.[35] It's very inexpensive, and is cost efficient even if you avoid only a handful of unintended pregnancies in the course of a year. There's a significant cost benefit to that. So, what we're seeing around the country is that when employees ask for the coverage, the employers in many cases simply agree to provide it. We've represented a handful of plaintiffs who've made the requests, where the employer said no we won't provide it, but when we file EEOC charges the employer concedes almost immediately and changes its health plan. So, that seems to be the trend: employers are voluntarily complying with this requirement.

I think one of the important reasons for that is that the EEOC issued a Commission decision in December of 2000 which is an interpretative guidance. It's not binding on employers, but the EEOC's interpretation of Title VII is that Title VII is violated by any

33. Mauldin v. Wal-Mart Stores, Inc., No. 1-01-CV-2755-JEC, 2002 U.S.Dist. LEXIS 21024, at *1 (N.D. Ga. Aug. 23, 2002).

34. Cooley v. Daimler-Chrysler Corp., 281 F. Supp. 2d 979 (E.D. Mo. 2003).

35. CYNTHIA DAILARD, ALAN GUTTMACHER INSTITUTE, THE COST OF CONTRACEPTIVE INSURANCE COVERAGE, *at* <http://www.agi-usa.org/pubs/ib_4-03.html> (last viewed Oct. 16, 2003).

employer's health plan that does not provide FDA approved prescription contraceptive methods for employees.[36] This is very important because many employers now offer a range of health plans. For example, one of the employers that we brought EEOC charges against was the Dow Jones Corporation, which provided employees with a choice of three health plans: one was an HMO type plan; one was a PPO type plan; and one was an "old fashioned" fee for service plan. The PPO and the HMO provided contraceptive coverage, and the fee for service plan did not, but the fee for service plan in many other respects was clearly a better plan, so many of the employees opted for it. We had a series of meetings and letter exchanges with Dow Jones saying, "you need to add contraceptives to the fee for service plan," and they kept saying, "no we don't, we provide contraceptive coverage in the other health plans, that's good enough, if women want that coverage they can switch plans." We filed EEOC charges saying the EEOC has already said every health plan has to cover contraceptives. You can't force women to change to an otherwise less desirable plan in order to accommodate their need for contraceptives, and almost immediately Dow Jones settled.

I should mention there have been settlements with several other major employers, including CVS, Publix Supermarket chain, and American Mobile Nursing, which is a large chain that supplies home nurses. There's been a fair amount of litigation, or at least EEOC charges, but it's not clear how many cases we now will see because the trend has been toward fairly quick settlement of cases and charges.

I did want to mention one legal issue which I think is very interesting in this area, and that's the Eleventh Amendment question concerning Title VII cases involving contraceptive coverage for state employers: specifically the question of whether states can be sued by state employees under Title VII for a PDA violation. As I read the Supreme Court's recent cases, a state can be sued under a federal statute despite the Eleventh Amendment if there's a congruence and nexus between the federal statute and historical violations of a constitutional right.[37] The tricky thing here is that the PDA was passed in direct response to the *Gilbert* decision and the *Gilbert*

36. UNITED STATES EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, DECISION ON COVERAGE OF CONTRACEPTION, *at* <http://www.eeoc.gov/policy/docs/decision-contraception.html> (Dec. 14, 2001).

37. *E.g.* Tenn. v. Lane, ___ U.S. ___, 124 S. Ct. 1978 (2004); Nev. Dep't Human Res. v. Hibbs, 538 U.S. 721 (2003).

decision relied on a constitutional ruling in *Geduldig v. Aiello*,[38] which found that the Constitution is not violated when a state disability plan excludes pregnancy coverage. In *Geduldig*, the Court found that pregnancy exclusions were not a violation of the Constitution because they didn't discriminate between men and women; they discriminated between pregnant women and all other people. This seems like an absurd and indefensible ruling, but it is a standing ruling of the Supreme Court. So, given the *Geduldig* decision, which held that pregnancy discrimination is not a violation of the United States Constitution, is there a congruence and nexus between the PDA and the Constitution sufficient to override the Eleventh Amendment immunity of states from suit under this federal statute? I haven't seen any real scholarship on that point and I think it is an important question because we do know that there are some states that do not provide contraceptive coverage to their employees. There is a lawsuit now pending against the State of Illinois because it didn't provide this coverage. At the same time, there is a new state law in Illinois that mandates this coverage, and the state will be subject to that law. I think the lawsuit will continue because there are claims for retrospective damages for the plaintiff class, and therefore the legal issue still remains about the Eleventh Amendment.

In addition to the Title VII remedies for exclusion of contraceptives from health plans, we've also been looking at using state laws themselves, and the real reason to do that is that some state laws are actually broader than Title VII in terms of the scope of entities that would be subject to the anti-discrimination provisions. For example, the District of Columbia Human Rights Act has a mirror provision to the PDA in terms of the language about pregnancy, childbirth and related medical conditions, and it applies not only to employers, but also to educational institutions within the District of Columbia.[39] We've worked extensively with groups of students at universities in D.C., whose student health insurance did not cover contraceptives, and have talked to the administration at the universities to change the insurance policy to cover contraceptives under this Human Rights Act provision. I think the most important case that we worked on involved George Washington University (GWU). Whereas in most universities students have access to contraceptives through the student health center, so that even if the

38. 417 U.S. 484 (1974).
39. D.C. Code §§ 2-1401.5, 2-1402.41 (2004).

insurance plan doesn't cover it they still have access to low cost contraceptives, at George Washington for some reason the student health center didn't offer contraceptives and the insurance plan didn't cover it, so the students at that university were really in a very bad position. We threatened to sue under the D.C. Human Rights Act. We also alleged that there would be a Title IX violation for failure to cover the contraceptives which, by the way, would be another interesting topic to pursue in terms of research. I think there's a colorable but maybe difficult claim, but I think it's something worth pursuing. After a few letters and a few meetings the administration at GWU agreed to add the coverage to the student health insurance.[40]

There's one benefit to some of these state laws in Wisconsin. The Attorney General of Wisconsin, within the last two or three months, issued an attorney general opinion interpreting the Wisconsin state employment discrimination law to say that it prohibited contraceptive exclusions.[41] Even though there was no language in the Wisconsin law that specifically said that the law applied to educational institutions, the attorney general interpreted it as applying to educational institutions vis-a-vis students and said that student health plans that didn't include contraceptive coverage would violate their state law. I expect that we'll see litigation under that shortly, but none has been filed yet.

I had somebody pass around a list of states in which state laws have been passed that mandate contraceptive coverage. I think Elizabeth is going to talk to you a little bit about the significant limitations in these laws, but I did want to point out that there are now twenty or twenty-one states in which laws and regulations are in effect that mandate contraceptive coverage, and I think the main issue that we have seen in passing these laws, the main legislative issue, the main stumbling block to passage, has been the issue of exemptions for religious employers. Specifically, if there's going to be a mandate that employers have to provide contraceptive coverage or that insurers need to offer plans that include contraceptive coverage, what about the employer that has a sincerely held religious belief that

40. Amy Argetsinger & Avram Goldstein, *GWU to Cover Birth Control in Student Health Plan: Change Follows Complaint Alleging Sex Discrimination*, WASH POST, Aug. 29, 2002, at B1.

41. (attorney general opinion) OAG-01-04, Aug. 16, 2004 (to Wis. Dep't of Health & Fam. Servs.), available at <http://www.doj.state.wi.us/ag/opinions/2004_08_16.asp> (last viewed Feb. 2, 2005).

they should not have to subsidize their employees' use of contraceptives? This has been a huge stumbling block in several state legislatures. In New York and California in particular, states you would think would have no objection to passing this kind of a mandate, the laws were held up in the legislature for years, and in California provisions that didn't have a religious exemption were twice vetoed by then-governor Pete Wilson because of the absence of an exemption.

So, in some states this has been a huge issue. In other states, such as the state we're in, Georgia, it wasn't an issue at all. Contraceptive coverage mandates were passed in six states with no religious exemption whatsoever. That seems to be no big deal in those states, but in other states it's been a major hurdle. In the two states where it was the largest issue, New York and California, both adopted similar religious exemptions after many years of debate, and in both states the religious exemption said an employer does not have to provide contraceptive coverage if it meets a four part test. The test is (1) the purpose of the organization is to inculcate religious values, (2) the employer primarily employs persons of the same faith, (3) the employer primarily serves persons of the same faith, and (4) the employer is a non-profit corporation under the IRS provision that exempts the religious employer from having to file tax returns.[42] The point of this exemption was to say if you truly are a church, if you truly are all about religion, if what you do is inculcate values, if you serve people of the same religion, if you employ people of the same religion so you're not going to burden people who don't share your values, then you don't have to do this, but if you employ people of many faiths, you can't impose your values on them. And in those two states, New York and California, immediately before the law was supposed to go into effect, Catholic Charities, which is a charitable organization that primarily does social services work, sued the states challenging the mandate under the various provisions of the first amendment. The claim was that they would not fall within the scope of the religious exemption because they really serve people of all faiths, they employ people of all faiths, and their mission is not to inculcate values but to provide social services. They admitted that they wouldn't fall within the exemption but they said that to require them to provide this coverage would violate their right to freely

42. Cal. Health & Safety Code § 1367.25 (2004); N.Y. Ins. Law § 4303 (cc)(1) (2004).

exercise their religion under both the state constitution and the U.S. Constitution. They said that the laws constituted an establishment of religion in two primary respects. They said that these laws were an establishment clause violation because they targeted Catholics and constituted a denominational preference for religions that were not Catholic. They also said that a state determination as to whether or not an entity that claimed to be a religious employer really was a religious employer would result in an excessive entanglement with the church. In the California case, as I recall, they also argued that for the state to define what a religious employer is interfered with church business by attempting to define what is or is not a church, and they also had a handful of other claims like first amendment speech and freedom of association claims, and various preemption claims under other state law provisions.

So far, both cases are still pending. Catholic Charities has not won at any level of the courts so far. In California, the case was brought with a preliminary injunction motion. The preliminary injunction was denied by the lower court, and this was affirmed by the Court of Appeals,[43] and the case now is pending before the California Supreme Court.[44] Apparently, one of the major issues in the California case is more a question of California constitutional law and the question is what level of scrutiny should be applied to free exercise claims under the California Constitution. As I'm sure you all know, under the U. S. Constitution, and under *Employment Division v. Smith*,[45] the standard of review for a free exercise claim no longer is strict scrutiny. If there is a generally applicable law that doesn't target a particular religion, then rational basis review is applied. All of the courts have said this is a generally applicable law that doesn't target religion, and under the U.S. Constitution it's been upheld.

In California, there's apparently a long standing debate about whether the California Constitution is more protective of free exercise claims, and it may well be that the California Supreme Court will decide that strict scrutiny applies to the free exercise claim under

43. Catholic Charities of Sacramento, Inc. v. Super. Ct. of Sacramento County, 90 Cal. App. 4th 425 (2001).

44. Since the date of this presentation, the California Supreme Court affirmed the lower court's decision. Catholic Charities of Sacramento, Inc. v. Super. Ct. of Sacramento County, 32 Cal. 4th 527 (2004), *cert. denied* Catholic Charities of Sacramento, Inc. v. Cal., 2004 U.S. LEXIS 5609.

45. 494 U.S. 872 (1990).

the California Constitution. The case was fully briefed before the California Supreme Court for over a year before they held argument, just a month ago. So far, we only have the lower court rulings in the California case and the one ruling in New York, which is from the lowest New York court, and which dismissed the Catholic Charities petition.[46]

The courts have said, even if you apply strict scrutiny to these constitutional claims, the state interests in enacting these laws are so strong and compelling that they would override the free exercise and the establishment clause claims of Catholic Charities. The two state interests that the courts have cited have been the interest in eliminating gender discrimination and the public health interest in ensuring that women have access to basic health care that helps them prevent unintended pregnancy, to maintain their health, and to improve the health of their existing family.

The court rulings, especially the California Court of Appeals ruling, have been very detailed in discussing the discrimination claims and in finding that contraceptive exclusions do in fact constitute gender discrimination and, therefore, that the state has a compelling interest in these contraceptive coverage mandates regardless of whether or not the laws burden free exercise and establishment clause rights of Catholic Charities,[47] but ultimately the hope is that the courts will find that there isn't a burden on religious rights. So far, both the New York and the California courts have said really there is no burden here because if an employer doesn't provide prescription coverage at all for anything, they don't have to provide coverage for contraceptives, so religious employers always have the out of simply eliminating any prescription coverage.[48]

Now, I don't think that would be a desirable result and it isn't something we would urge religious employers to do, but I think it really does undercut their burden argument, that this burdens their religious beliefs, because they do have another way around that. I think I should probably stop talking now but I look forward to your questions.

46. The California case was decided after this presentation. Catholic Charities of Sacramento, Inc., 32 Cal. 4th at 527. The New York case was Catholic Charities of the Diocese of Albany v. Serio, Case No. 8229-02 (N.Y Sup. Ct. Albany Cty. Nov. 25, 2003), *appeal argued*, No. 96621 (3d Dep't Feb. 23, 2005).

47. *Catholic Charities of Sacramento, Inc.*, 90 Cal. App. 4th at 442, 459, 458.

48. *Id.* at 441.

**Professor Elizabeth A. Pendo*:** Thank you very much. As you have just heard, the federal courts have issued two important decisions regarding non-discriminatory insurance coverage of conditions and treatments associated with sex, disability or both, such as prescription contraception and infertility treatment. Cases like *Erickson*[49] and *Saks*[50] are important because, as ERISA scholars know, state law mandates regarding coverage are unlikely to lead to uniform results due to the structure of ERISA's preemption provisions, and none of the federal proposals addressing infertility treatment or prescription contraception have been enacted to date.

What I would like to do is outline the impact of ERISA in this area, and offer some thoughts on one of the recent decisions, *Saks v. Franklin Covey*, decided by the Second Circuit in 2003, which addresses the application to Title VII and the ADA to a plan's exclusion of infertility treatments (and, to a lesser extent, prescription contraceptives), and outline the types of judicial challenges ERISA-regulated plans can expect in its wake.

## I. WHAT DOES ERISA HAVE TO DO WITH THIS?

ERISA was enacted to encourage employer formation of and to protect employees' rights to pension plans and welfare benefits plans by requiring uniformity in the administration of benefits plans. "Welfare benefits" includes life, accident, disability, and health benefits.[51] Today, workers consider health care benefits to be the most important type of welfare benefit, and most Americans get their health insurance through their employment. According to the Census Bureau, approximately 177 million workers and their family members get coverage through work – 62.6 percent of the population as of 2001.[52] In general, ERISA does not require that any employer provide a health care benefit plan, nor does it govern the content of a health care benefit plan in the event an employer elects to offer one.

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49. Erickson v. The Bartell Drug Company, 141 F. Supp. 1266, 1270 (W.D. Wash. 2001).

50. Saks v. Franklin Covey, 316 F.3d 337 (2d Cir. 2003).

51. 29 U.S.C. § 1002(1) (2004).

52. U. S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2001, *at* <http://www.census.gov/hhes/hlthins/hlthin01/hlth01asc.html> (last viewed Feb. 2, 2005); *see also* THE KAISER FAMILY FOUNDATION, 2001 HEALTH BENEFITS SURVEY: REPORT 44, *available at* <http://www.kff.org/insurance/3138-index.cfm> (Aug. 8, 2001) (reporting that 63 percent of all employees have health insurance coverage through and employer-sponsored plan).

## II. ERISA PREEMPTION AND SELF-FUNDED PLANS

ERISA contains a broad preemption clause that preempts state law insofar as it "relates to" employee benefit plans, and ERISA provides the exclusive remedial scheme for claims relating to employee benefit plans. ERISA preemption has three parts. First, the "preemption clause" provides that ERISA supercedes any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.[53] Second, the "savings clause" exempts specific state laws regulating insurance, banking and securities law from preemption.[54] Third, under the "deemer clause," self-funded employee welfare plans cannot be deemed insurance plans, and therefore will not be subject to specific state regulation.[55]

## III. WHAT IS A SELF-FUNDED PLAN?

A self-funded plan is one in which the plan sponsor, rather than a health insurer, assumes the risk of covering the costs of the health care benefits provided by the terms of the plan. The plan may be administered by an insurance company or other third party.

The types of state laws mandating coverage discussed earlier do apply to non-ERISA plans and ERISA plans that are insured – they are "saved" from preemption because they directly regulate insurance. But they do not apply to self-funded plans. The exception for state laws relating to insurance is significant. The number of self-funded plans has increased dramatically since ERISA's passage in 1974. As of 2003, the majority of covered workers are in a plan that is completely or partially self-insured.[56]

Perhaps because of the potential for uneven application of specific state laws to ERISA-regulated plans, there have been a few specific amendments to ERISA aimed at requiring coverage for specific conditions of treatments, such as coverage for post-delivery hospital stays,[57] and certain post-mastectomy treatment and care,

53. 29 U.S.C. § 1144(a) (2004).

54. 29 U.S.C. § 1144(b)(2)(A) (2004).

55. 29 U.S.C. § 1144(b)(2)(B) (2004).

56. THE KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 123-29, *available at* <http://www.kff.org/insurance/ehbs2003-1-set.cfm> (last viewed Oct. 20, 2004) (reporting that 52% of covered workers are in a plan that is completely or partially self-insured).

57. 29 U.S.C. § 1185 (2004) (requiring ERISA plans to offer forty-eight hours of coverage for mothers and newborns undergoing a normal vaginal delivery, and ninety-six hours where delivery is by Cesarean section).

including reconstruction.[58] ERISA's preemption provisions do not apply to federal law, of course, and federal laws mandating coverage of specific treatments have also been proposed.

## IV. THE ADA AND HEALTH PLAN BENEFITS

Civil rights claims are important in this area because state law mandates regarding coverage are unlikely to lead to uniform results due to the structure of ERISA's preemption provisions, and because none of the federal proposals addressing infertility treatment or prescription contraception have been enacted to date. Professor Norton and Ms. Gartner have already discussed the application of Title VII and the PDA, so I will focus on the ADA.

The ADA prohibits an employer from discriminating on the basis of disability with respect to fringe benefits, including health plans. In general, all employees, including qualified individuals with a disability, should have equal access to benefits, which is evaluated using a two-step analysis. *First*, the distinction must be based on disability to be actionable under the ADA. According to the EEOC, a distinction is disability-based if it singles out a particular disability, a discrete group of disabilities or disability in general for different treatment.[59] *Second*, even if the distinction is disability-based; it may still be permissible if it falls within the ADA's "safe harbor" clause. This clause clarifies that the ADA was not intended to interfere with traditional practices of underwriting, classifying, or administering risks as long as they do not violate state law and are not intended as a subterfuge for discrimination. It also provides a safe harbor for bona fide benefit plans that are not subject to state laws that regulate insurance.[60] This means that disability-based distinctions in bona fide, ERISA-regulated, self-funded plans will be upheld unless the distinctions can be shown to be subterfuge for discrimination. Interestingly, courts have found that distinctions in plans adopted before the enactment of the ADA cannot be a subterfuge, because

58. 29 U.S.C. § 1185(b) (2004) (the Women's Health and Cancer Rights Act of 1998, requiring ERISA plans providing medical and surgical benefits for a mastectomy to also provide coverage for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to provide a symmetrical appearance prostheses; and physical complications at all stages of a mastectomy, including lymph edemas).

59. EEOC, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, *available at* <http://www.eeoc.gov/policy/docs/health.html> (June 8, 1993).

60. 42 U.S.C. § 12201(c) (2004).

there could be no intent to evade the act prior to its enactment.

## V. IMPACT OF NEW CASE LAW IN 2003 – *SAKS*

In *Saks v. Franklin Covey,*[61] a unanimous court held that an employer's health plan could lawfully exclude coverage for infertility procedures performed on women only. Rochelle Saks's self-insured ERISA-regulated health plan (the "plan") denied coverage for surgical impregnation procedures for infertility. The plan covered a variety of infertility products and procedures, but excluded "surgical impregnation procedures," including artificial insemination, *in vitro* fertilization or embryo and fetal implants," even if medically necessary.[62] Saks filed an action against her employer in federal district court in New York, alleging that the plan's exclusion of infertility treatments that can only be performed on women – artificial insemination, *in vitro* fertilization, and *in utero* insemination – violated Title VII, the PDA, and the ADA and New York law.

The lower court opinion granting summary judgment for the employer is interesting for several reasons. I won't go over it in detail except with respect to the decision on the ADA claim, which was not appealed. The district court held that although infertility is a disability within the meaning of the ADA under 1998 Supreme Court decision *Bragdon v. Abbott,*[63] the plan's exclusion of certain infertility treatments performed on women only did not violate the ADA because the plan offered the same insurance coverage to fertile and infertile employees.[64] This is an interesting contrast with the Title VII analysis. Also, the plan falls within the ADA's safe harbor provision because it is a bona fide, ERISA-regulated and self-insured plan AND the exclusion predated the adoption of the ADA (so could not be a subterfuge).[65]

On appeal, the Second Circuit affirmed the decision of the district court on different grounds, as follows. The appellate court found that the district court's use of the "equal access" standard was incorrect. Instead, the "proper inquiry in reviewing a sex discrimination challenge to a health benefits plan is whether sex-specific conditions exist, and if so, whether exclusion of benefits for

61. 316 F.3d 337 (2d Cir. 2003).
62. *Id.* at 341.
63. 524 U.S. 624 (1998).
64. Saks v. Franklin Covey, Co., 117 F. Supp. 318, 326 (S.D.N.Y. 2000).
65. *Id.* at 327-28.

those conditions results in a plan that provides inferior coverage to one sex."[66] Applying this standard, the appellate court found that "[a]lthough the surgical procedures are performed only on women, the need for the procedures may be traced to male, female, or couple infertility with equal frequency. Thus, surgical impregnation procedures may be recommended regardless of the gender of the ill patient."[67] In other words, because exclusion of surgical implantation procedures disadvantages male and female employees equally, the plan does not discriminate on the basis of sex.

As to the PDA claim, in contrast to the district court, the appellate court held that infertility is not a "pregnancy related condition" under the plain meaning of Title VII as modified by the PDA and *Johnson Controls*, which addresses "childbearing capacity," but not "fertility alone." It reasoned that for a condition to fall within the PDA's inclusion of "pregnancy . . . and related medical conditions" as a sex-based characteristic, it must be unique to women. Infertility is a medical condition that afflicts men and women with equal frequency, and the exclusion of surgical implantation procedures disadvantages male and female employees equally.[68]

## VI. AFTER *SAKS*, WHAT TYPES OF CIVIL RIGHTS CLAIMS MAY PLANS EXPECT?

With respect to a challenge under Title VII to the exclusion of infertility treatment, the *Saks* case suggests that the following types of claims may be worth exploring.

What if a plaintiff could show that male infertility is more frequently treated by other plan provisions than is female infertility? A lack of "evenhanded" treatment of male infertility and female infertility could be the basis of a disparate treatment claim.

What about employees outside the implicit "pair" analysis? If it is permissible under Title VII to exclude the treatment because, although performed exclusively on women, the procedures are used to treat male and female infertility equally, would an unmarried infertile female employee have a viable PDA or Title VII claim because she could not access certain infertility treatments that are performed on women only, while an unmarried infertile male

66. *Saks*, 316 F.3d 337, 344 (2d Cir. 2003) (citation omitted).
67. *Id.* at 347.
68. *Id.* at 346.

employee could access the unrestricted benefits available without any such exclusion? Similarly, what if the employee is a member of a same-sex couple?

Are third-party expenses covered? As Professor Norton explained, the plan will cover expenses of treating someone else, as this appears to be an assumption of marriage. But other forms of third-party care, such as organ transplant, are excluded.

With respect to a challenge under the ADA to the exclusion of infertility treatment, what if the plan at issue did not fall within the ADA's "safe harbor" provision? For example, if the plan was insured, rather than self-funded, or because the disability-based distinction was adopted post-ADA and could be considered a "subterfuge" for discrimination? As to the latter, would it be relevant if the disability-based distinction was not supported by actuarial data?

In *Saks*, the defendants argued in a footnote that infertility cannot be a disability within the meaning of the ADA because it is a correctable condition, relying upon *Murphy* and *Sutton*.[69] The district court rejected this argument without a lot of analysis. How will other courts apply *Bragdon* to the exclusion of treatment for infertility under the ADA? Factual issues surrounding the origin of the infertility may also be important. Some case law, both pre- and post-*Bragdon*, suggest that infertility due to something other than an impairment (for example, advanced age) is not a "disability" within the meaning of the ADA.[70]

With respect to a challenge under Title VII to the exclusion of prescription contraceptives, the *Saks* court invited a Title VII challenge to exclusion of prescription contraceptives in dicta by pointedly distinguishing prescription contraceptives from infertility treatments. The Saks court also noted that "the exclusion of oral contraceptives *disadvantages women only*." This lends support to existing case law, notably the landmark case *Erickson*. There are several post-*Erickson* cases pending in the federal district courts. One author has suggested that a claim for exclusion of prescription contraceptives could be raised under the ADA if a female employee or covered family member could show that the risk of pregnancy to her or her child was "disabling" within the meaning of the ADA.[71] As

69. Murphy v. United Parcel Serv., 527 U.S. 516 (1999); Sutton v. United Airlines, 527 U.S. 471 (1991).

70. *Saks*, 117 F. Supp. at 326; McGraw v. Sears Roebuck & Co., 21 F. Supp. 2d 1017, 1021 (D. Minn. 1998).

71. *See, e.g.*, Melissa Cole, *Beyond Sex Discrimination: Why Employers Discriminate*

mentioned by Ms. Gartner, there may be Title IX claims worth exploring, as well.

*Against Women With Disabilities When Their Employee Health Plans Exclude Contraceptive From Prescription Coverage*, 43 ARIZ. L. REV. 501 (2001).