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THE POLITICS OF INFERTILITY: RECOGNIZING COVERAGE EXCLUSIONS AS DISCRIMINATION

*Elizabeth A. Pendo**

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INTRODUCTION

Jane is infertile. When she sought treatment for her condition, she discovered that the health insurance provided through her work covered some treatments, but excluded surgical impregnation procedures such as the in vitro fertilization procedure recommended by her doctor. Jane’s infertility is recognized as a disability under federal law, and all of the excluded procedures are performed on women only.

Infertility affects approximately ten percent of the reproductive-age population in the United States, and strikes people of every race, ethnicity and socio-economic level.¹ It is recognized by the medical community as a

1. See generally American Society for Reproductive Medicine, *Frequently Asked Questions About Infertility*, at <http://www.asrm.org/Patients/faqs.html> (last visited Aug. 21, 2004) [hereinafter ASRM, *Frequently Asked Questions*]; See generally RESOLVE, The National Infertility Association, *Coverage for Infertility*, available at <http://www.resolve.org/main/national/advocacy/insurance/facts/coverage.jsp?name=advocacy&tag=insurance> (last visited Apr. 9, 2005) [hereinafter RESOLVE, *Coverage for Infertility*] (According to the National Center for Health Statistics, approximately 5.4 million couples experience infertility every year); Elizabeth Hervey Stephen & Anjani Chandra, *Use of Infertility Services in the United States: 1995*, 32 FAM. PLANNING PERSP. 132 (May/June 2000) (surveyed population of fertility-impaired women similar to general population of women in terms of education, income, race and ethnicity). *But see* U.S. CONG., OFFICE OF TECH. ASSESSMENT, *INFERTILITY: MEDICAL AND SOCIAL CHOICES*, OTA-BA-358 (Washington D.C. U.S. Government Printing Office, May 1988) available at <http://www.wws.princeton.edu/cgi-bin/byteserv.pr1/~ota/disk2/1988/8822/8822.PDF>

disease, one with devastating physical, psychological, and financial effects.² Nonetheless, comprehensive coverage of infertility treatments under employer-sponsored plans – where, like Jane, most Americans get health insurance³ – appears to be the exception rather than the rule.⁴ Can Jane sue for disability discrimination, sex discrimination, or both? While the answer – “it depends” – should not be surprising to anyone who has survived even a semester of law school, the facts upon which the answer depends are increasingly surprising. Why is Jane infertile? If she went ahead with the uncovered treatment, was it successful? Is Jane’s plan insured or funded by her employer? When was the exclusion established? Does the plan treat male infertility more frequently than female infertility? And is Jane married? Underlying these factual and doctrinal issues is the deeper question, should Jane be able to state a claim of discrimination? In other words, why should the exclusion of treatments for infertility such as in Jane’s plan be recognized as sex discrimination, disability discrimination, or both? This Article seeks to explore these questions.

In the last few years, the federal courts have issued important decisions under Title VII of the Civil Rights Act of 1964⁵ (“Title VII”) including the Pregnancy Discrimination Act,⁶ (“PDA”) and the Americans with Disabilities Act of 1990⁷ (“ADA”) regarding insurance coverage of treatments or conditions associated with sex and disability. Notably, the Supreme Court held in the 1998 case *Bragdon v. Abbott*⁸ that reproduction is a major life activity within the meaning of the ADA. Many lawyers, activists and scholars thought that coverage for infertility treatment would

(noting that one and one-half times more married African-American women are infertile than married white women) [hereinafter INFERTILITY].

2. See *infra* notes 14-33 and accompanying text.

3. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2001, available at www.census.gov/hhes/hlthins/hlthin01/hlth01asc.html (last visited Apr. 9, 2004) (In 2001 62.6% of workers and their families were covered by employer-sponsored health plans.); RUSSELL C. COILE, JR., FUTURES CAN, A FORECAST OF HEALTHCARE TRENDS 2002-2006 11 (2002) (“Employer-sponsored health insurance covers approximately 165 million, or 65 percent of working Americans.”).

4. Amicus Curiae Brief of the American Society for Reproductive Medicine at 11-12, *Saks v. Franklin Covey*, 316 F.3d 337 (2d Cir. 2003), available at 2001 WL 34113555 (C.A.2) [hereinafter ASRM Amicus Brief]; see also Shorge Sato, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL’Y 189, 197 (2001).

5. 42 U.S.C. § 2000e (1964).

6. 42 U.S.C. § 2000e(k) (1978).

7. 42 U.S.C. §§ 12101-12213 (Supp. V 1993).

8. 524 U.S. 624, 641-42 (1998)

follow soon after *Bragdon*.⁹ However, in 2003, in the first major case applying *Bragdon* to health benefits, *Saks v. Franklin Covey*,¹⁰ the Second Circuit held that an employer's health plan could exclude coverage for infertility procedures performed on women only without violating Title VII or the ADA.

The decision in *Saks* was a disappointment to many, particularly after the successful use of Title VII to challenge a health plan exclusion of prescription contraceptives in *Erickson v. Bartell Drug Company*¹¹ in 2001. But *Saks* did not shut the door on using Title VII or the ADA to challenge an employer's exclusion of infertility treatment from its plan. Although the ADA has received more scholarly attention in this context,¹² the decisions of the trial and appellate court illustrate the relative weakness of the ADA as a tool to challenge discrimination in the content of employer health plans because of its "equal access" test, which requires only facial neutrality, and its broad "safe harbor" provision. The decisions also illustrate that Title VII can offer significant advantages over the ADA for purposes of challenging the exclusion of infertility treatment because a facially neutral policy that simply permits equal access to the same set of benefits for male and female employees is not sufficient. Instead, employers providing coverage must provide equally comprehensive coverage for both sexes, and the additional cost of offering non-discriminatory benefits, if any, is not a defense. Although the court in *Saks* concluded that the employer's plan could lawfully exclude coverage for infertility procedures performed on women only without violating Title VII or the ADA, this Article explains how other courts could analyze claims under Title VII differently, and provides a roadmap of alternative legal and factual analyses for Title VII and ADA claims that could be successfully adopted in other cases.

9. See Jane Gross, *The Fight to Cover Infertility; Suit Says Employer's Refusal to Pay is Form of Bias*, N.Y. TIMES, Dec. 7, 1998, at B1 (reporting opinions of Mark G. Sokoloff, Ms. Saks's attorney, and an anonymous EEOC official regarding the impact of *Bragdon* on employer health plan exclusion of infertility treatment); Sato, *supra* note 4, at 189-90 ("Many thought mandatory insurance coverage for infertility was a "slam dunk" after *Bradgon* held that reproduction was a major life activity as defined by the ADA.")

10. 316 F.3d 337, 345-46 (2d Cir. 2003) [hereinafter *Saks* II].

11. 141 F. Supp. 1266, 1277 (W.D.Wash. 2001).

12. See, e.g., Kimberly Horvath, *Does Bragdon v. Abbott Provide the Missing Link for Infertile Couples Seeking Protection Under the ADA?*, 2 DEPAUL J. HEALTH CARE L. 819, 829 (1997-1999); John E. Estes, *Employee Benefits or Employer "Subterfuge": The Americans with Disabilities Act's Prohibition Against Discrimination in Health Plans*, 12 N.Y.L. SCH. J. HUM. RTS. 85 (1994); Dion A. Sullivan, *ERISA, the ADA, and AIDS: Fixing Self-Insured Health Plans with Carparts*, 7 MD. J. CONTEMP LEGAL ISSUES 423, 436 (1996); Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers Under the ADA and ERISA*, 35 TORT & INS. L.J. 117 (1999).

Of course, notwithstanding the ability of a plaintiff to state cognizable claims under civil rights laws, requiring plans to provide comprehensive (or at least non-discriminatory) coverage of treatments for infertility is a controversial issue. Opponents of legislative or judicially mandated infertility coverage commonly argue that reproduction is simply a “lifestyle choice,” and that increased coverage will further increase rising health care costs. When examined critically, however, these arguments fail to justify the pattern of exclusions. Indeed, infertility is still seen as a “woman’s issue,” it is not a “lifestyle choice,” and the costs of comprehensive coverage for treatment of infertility (in particular coverage of *in vitro* fertilization) appear overstated. Moreover, appropriately comprehensive coverage of treatment for infertility may lead to better, more humane and cost-effective treatment.

In support of these conclusions, Part I of this Article provides a brief overview of the disease of infertility, medical treatments of infertility, and the cost of such treatments. Part II provides an overview of the important but limited protections under federal and state law against discrimination in benefits focusing on Title VII, the ADA and the Employee Retirement Income Security Act of 1974¹³ (“ERISA”). Against this backdrop, Part III closely examines the decisions of the trial and appellate courts in *Saks*, and the rejection of plaintiff’s challenges to the exclusion of certain infertility treatments under the ADA, Title VII, PDA and state law. Part IV provides a roadmap of alternative legal and factual analyses for Title VII and ADA claims that could be successfully pursued by future plaintiffs. Finally, Part V critically examines the policy arguments commonly raised in opposition to coverage, including reproduction as a “lifestyle choice” and the fear of increased health care costs, and concludes that public policy strongly supports comprehensive coverage of infertility.

I. THE PROBLEM OF INFERTILITY

Infertility is defined by the medical community as “a disease or condition of the reproductive system often diagnosed after a couple has had one year of unprotected, well-timed intercourse, or if the woman has suffered from multiple miscarriages.”¹⁴ The American Society of

13. 29 U.S.C. §§ 1001-1461 (2002).

14. RESOLVE, The National Infertility Association, *Frequently Asked Questions About Infertility*, at <http://www.resolve.org/main/national/trying/whatis/faq.jsp?name=&tage=whatis> (last visited Apr. 9, 2005) [hereinafter RESOLVE, *Frequently Asked Questions*]. See also ASRM, *Frequently Asked Questions*, *supra* note 1 (“a disease of the reproductive system

Reproductive Medicine (“ASRM”) estimates that infertility affects approximately ten percent of the reproductive-age population in the United States, or over 6 million people.¹⁵ The disease of infertility strikes people of every race, ethnicity and socio-economic level,¹⁶ and more than one million Americans seek treatment for infertility every year.¹⁷

The devastating emotional effects of the disease of infertility are well documented.¹⁸ Facing the potential or actual loss of the ability to conceive or carry a child, people diagnosed with infertility experience grief, anguish, despair, and isolation. Many report that dealing with infertility is “the most upsetting experience of their lives.”¹⁹ Indeed, in one widely cited study, researchers found that women living with infertility experienced levels of depression comparable to patients living with terminal diseases like cancer.²⁰

A. MEDICAL TREATMENTS FOR INFERTILITY

that impairs the body’s ability to perform the basic function of reproduction”); MERCK RESEARCH LAB, MERCK MANUAL OF MEDICAL INFORMATION § 22, at ch. 254 (2d ed. 2003) available at <http://www.merck.com/mmhe/sec22/ch254/ch245a.html> (last visited Apr. 9, 2005) (“the inability of a couple to achieve a pregnancy after repeated intercourse without contraception for 1 year”). There is also secondary infertility, defined as the inability to become pregnant, or to carry a pregnancy to term after the birth of one or more biological children. RESOLVE reports that over three million Americans experience secondary infertility. RESOLVE: The National Infertility Association, *Secondary Infertility*, at <http://www.resolve.org/main/national/treatment/diagnosis> (last visited Apr. 4, 2005).

15. ASRM, *Frequently Asked Questions*, *supra* note 1. According to the National Center for Health Statistics, approximately 5.4 million couples experience infertility every year. RESOLVE, *Coverage for Infertility*, *supra* note 1.

16. See Horvath, *supra* note 12, at 820.

17. RESOLVE & DIANE ARONSON, RESOLVING INFERTILITY: UNDERSTANDING THE OPTIONS AND CHOOSING SOLUTIONS WHEN YOU WANT TO HAVE A BABY 3 (1999) [hereinafter RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS].

18. See generally ASRM, *Frequently Asked Questions*, *supra* note 1; Katherine T. Pratt, *Inconceivable? Deducing the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1126-30 (2004) (summarizing reports and research regarding the extreme emotional distress caused by infertility). Moreover, the negative effects of infertility may be long-lasting. See Ann Lalos et al., *The Psychosocial Impact of Infertility Two Years After Completed Surgical Treatment*, 64 ACTA OBSTET. GYNECOL. SCAND. 599, 599 (1985) (“The negative emotional and social effects of infertility were pronounced both before and 2 years after the surgical treatment.”); INFERTILITY *supra* note 1, at 119-35.

19. Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (1985) (noting that 49% of women and 15% of men being treated for infertility described the experience with this language).

20. Alice D. Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1161-62 (1992) (noting that the researchers were not surprised to find that the “infertile women had higher depression scores than control women”).

The medical diagnosis “infertility” encompasses a wide range of causes and conditions. According to the ASRM, male factors and female factors each account for about a third of infertility cases, and a combination of male and female factors account for another ten percent of cases.²¹ In the remaining cases – around twenty percent – the infertility is unexplained.²² Male factors include no or low sperm production, blocked passage of sperm, problems with ejaculation, or immunological disorders that prevent the sperm from penetrating the egg.²³ Female factors include ovulation disorders, blocked fallopian tubes, or structural problems or disorders of the uterus or cervix.²⁴ In both cases, the causes may result from a variety of factors, including: congenital defects; hormonal imbalances; genetic disorders; environmental factors; or previous illness, infection or surgery. In addition, fertility rates for women gradually decline during the thirties, and sharply decline after the age of forty.²⁵ Male fertility rates also decline with age.²⁶

Given the range of factors that may contribute to a diagnosis of infertility, infertility can be treated in a variety of ways.²⁷ Treatment can include: advice and information regarding the reproductive cycle and process; drug therapies such as clomiphene and gonadotropins to regulate ovulation and to return female or male hormones to normal levels;²⁸ surgery for treatment of female structural problems, such as laparoscopy to repair or remove blockages from the fallopian tubes,²⁹ or male structural problems such as varicocele surgery to correct varicose veins;³⁰ intrauterine insemination (also called artificial insemination); and assisted reproductive technologies such as *in vitro* fertilization (IVF).³¹

21. ASRM, *Frequently Asked Questions*, *supra* note 1.

22. *Id.*

23. *Id.*

24. *Id.*

25. See Horvath, *supra* note 12, at 821.

26. *Id.*

27. For a more detailed discussion of causes of infertility and treatment options, see INFERTILITY *supra* note 1, at 117-32.

28. Bonny Gilbert, *Infertility and the ADA: Health Insurance Coverage for Infertility Treatment*, 63 DEF. COUNS. J. 42 (1996).

29. *Id.* Other surgically correctable female structural problems include endometriosis, tubal blockage, the presence of fibroid tumors, DES, Asherman’s Syndrome and Sdenomyosis. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

30. Gilbert, *supra* note 28. Other surgically correctable male structural problems and obstructions partially or totally block the flow of sperm, seminal fluid or both. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

31. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

The vast majority of cases of infertility – 85 to 90 percent – are resolved with conventional medical treatment such as drugs or surgery.³² For the small percentage of cases not resolved through these means, assisted reproductive technologies may be appropriate. Intrauterine insemination is a relatively simple, non-surgical procedure in which prepared sperm from a partner or donor is brought closer to the ova through insertion into the woman’s uterus during her ovulatory phase.³³ IVF is a more complicated process in which the ova are removed from the woman’s body by laparoscopy, fertilized with semen from her partner or a donor, incubated in a laboratory dish until an embryo develops, and then transferred to the woman’s uterus.³⁴

B. THE COSTS OF INFERTILITY TREATMENTS

Given the range of treatments, the cost of medical treatment for infertility varies greatly.³⁵ For example, advice and information costs no more than a general office visit. The cost of clomiphene, a drug commonly prescribed to women to induce regular ovulation, may be \$50 for one month.³⁶ Surgery to repair blocked fallopian tubes typically costs between \$10,000 and \$15,000, and surgery to repair varicocele typically costs \$5,000 to \$8,000.³⁷ Repeated surgeries may be required to resolve the infertility.³⁸

32. ASRM, *Frequently Asked Questions*, *supra* note 1. *See also* Stephen & Chandra, *supra* note 1, at 134 (Of the surveyed women who received treatment for infertility, the most common services provided were advice, diagnostic tests, medical help to prevent miscarriage, and drugs to induce ovulation. Fewer than 13% used intrauterine insemination, and fewer than 2% used assisted reproductive technologies such as IVF).

33. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

34. RESOLVE, The National Infertility Association, *Intrauterine Insemination*, available at <http://www.resolve.org/main/national/treatment/options>. Related assisted reproductive technologies include gamete intra fallopian transfer (GIFT), in which the retrieved ova are immediately combined with the sperm and inserted into the fallopian tube during the laparoscopy, and zygote intra fallopian transfer (ZIFT), in which the fertilized ova is transferred into the fallopian tubes at the zygote, rather than the embryonic, stage of development. *Id.* at *Assisted Reproductive Technology* (ART), available at <http://www.resolve.org/main/national/treatment/options>.

35. *See* Pratt, *supra* note 18, at 1135 (discussing costs of various treatments).

36. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 1 available at <http://www.resolve.org/main/national/treatment/options/medications> (based on estimate of \$10 per pill, taken for five consecutive days); INFERTILITY *supra* note 1, at 141 (based on 1986 data, average monthly cost of clomiphene is \$30).

37. Pratt, *supra* note 18; INFERTILITY *supra* note 1, at 142 (based on 1986 data, average total cost of tubal surgery is \$7,118).

38. *See* Pratt, *supra* note 18, at 1137 (“where insurance covers tubal surgeries but not IVF, a woman with blocked fallopian tubes may have several tubal ligation surgeries to

The assisted reproductive technologies used in the small percentage of cases not resolved through drug therapy or surgeries also vary widely in cost. Intrauterine insemination is relatively inexpensive, usually costing “a few hundred dollars.”³⁹ Estimates for IVF range from \$8,000 to \$10,000 per procedure,⁴⁰ and patients often undergo multiple procedures.⁴¹ As these figures show, although IVF is commonly thought to be the “big ticket item” in the treatment of infertility, surgery is often as expensive, and in some cases is more expensive.⁴² In fact, according to one widely-cited estimate, assisted reproductive technologies such as IVF “account for only three hundredths of one percent (0.03%) of U.S. healthcare costs.”⁴³

II. PROTECTIONS AGAINST DISCRIMINATION IN BENEFITS

If an employer⁴⁴ elects to offer a health care benefit plan to its employees, the content of coverage must comply with applicable federal laws, including Title VII and the ADA.⁴⁵ Although the protections offered

attempt to repair her tubes, instead of bypassing the tubes with IVF”); INFERTILITY *supra* note 1, at 143.

39. Pratt, *supra* note 18 at 1135; *See also* INFERTILITY *supra* note 1, at 141 (based on 1986 data, average cost of intrauterine insemination is \$50 to \$100).

40. P.J. Neuman et al., *The Cost of a Successful Delivery with In Vitro Fertilization*, 331 NEW ENG. J. OF MED. 239, 239-43 (1994) (calculating average cost of IVF as \$8,000 per cycle); Adam Sonfield, *Drive for Insurance Coverage of Infertility Raises Questions of Equity, Cost*, 2 THE GUTTMACHER REPORT (Oct. 1999) available at <http://www.guttmacher.org/pubs/tgr/02/5/gr020504.pdf> (last visited Apr. 9, 2005) (IVF costs \$10,000 per attempt); ASRM, *Frequently Asked Questions*, *supra* note 1 (the average cost of IVF in the U.S. is \$12,400).

41. According to a report published by the CDC and ASRM, 32.8% ART cycles reported in 2001 resulted in a clinical pregnancy, and 82.2% of those pregnancies resulted in a live birth. *See* CENTER FOR DISEASE CONTROL, *2001 Assisted Reproduction Technology Success Rates: National Summary and Fertility Clinic Reports* (Dec. 2003) available at <http://www.cdc.gov>. *See also* INFERTILITY *supra* note 1, at 293 (reporting that based on 1986 data, 15-20% of IVF treatments performed by expert clinics resulted in a live birth).

42. *See* Bradley J. Van Voohris et al., *Cost Effectiveness of Infertility Treatments: A Cohort Study*, 67 FERTILITY & STERILITY 830, 835 (May 1997) (comparing total cost per delivery, IVF is more cost effective than surgery for women with blocked fallopian tubes).

43. ASRM, *Frequently Asked Questions*, *supra* note 1.

44. This Article refers to plans as sponsored by a single employer, although a plan may also be sponsored by an employee organization, or jointly by multiple employers or employee organizations under ERISA. *See* 29 USCS § 1002(B) (2005).

45. *See, e.g.*, Equal Employment Opportunity Comm’n, DECISION ON COVERAGE OF CONTRACEPTION (Dec. 14, 2000), available at <http://www.eeoc.gov/policy/docs/decision-contraception.html> (“ERISA preempts certain state laws that regulate insurance but explicitly exempts federal law from preemption . . . [T]he fact that ERISA does not require health plans to ‘provide specific benefits’ does not mean that other statutes – namely Title

by civil rights law in this area are important, they are limited.⁴⁶ Nor, as scholars have noted,⁴⁷ are state law mandates requiring coverage of certain conditions or treatments likely to lead to uniform results because of the preemption provisions of ERISA.

A. TITLE VII AND SEX-BASED DISCRIMINATION

Title VII of the Civil Rights Act of 1964 prohibits employment practices that “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex or national origin.”⁴⁸ In 1978, the PDA amended Title VII to clarify that discrimination “because of sex” included discrimination “because of or on the basis of pregnancy, childbirth, or related medical conditions.”⁴⁹

VII – do not impose such requirements where necessary to avoid or correct discrimination.”).

46. Other civil rights laws also apply to employer health plans. See Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes’ Applicability to Health Insurance*, 23 *CARDOZO L. REV.* 1315, 1318 (2002) (characterizing the protections offered by federal law, including Title VII, the ADA, the Equal Pay Act, the ADEA and HIPAA, the area of health insurance as containing “significant gaps and loopholes”).

47. See, e.g., *id.*; Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 *TENN. L. REV.* 485, 491-92 (1998); John V. Jacobi, *The Ends of Health Insurance*, 30 *U.C. DAVIS L. REV.* 311, 352-61 (1997).

48. 42 U.S.C. § 2000e-2(a)(1) (2000).

49 Act of Oct. 31, 1978, Pub. L. 95-555, 92 Stat. 2076 (codified as amended at 42 U.S.C. § 2000e(k) (2000)).

Employment benefits include health care benefits.⁵⁰ If an employer elects to offer a health care benefit, it has a legal obligation to make sure that the plan does not discriminate based on sex-based characteristics and that it provides equally comprehensive coverage for both sexes.⁵¹ Under the PDA, an otherwise inclusive plan that singles out pregnancy-related benefits for exclusion is discriminatory.⁵² The additional cost of offering non-discriminatory benefits, if any, is not a defense.⁵³

A plaintiff may pursue a claim of discrimination under Title VII under either a theory of disparate treatment or of disparate impact.⁵⁴ A plaintiff alleging disparate treatment must show that her employer intentionally treated her differently than other employees because of her sex.⁵⁵ For example, an employee who alleges that her employer's plan paid infertility benefits for male employees, but not for female employees, states a claim of disparate treatment under Title VII.⁵⁶ The landmark case of *Erickson v. Bartell Drug Company*,⁵⁷ decided in 2001, provides another example. In that case, plaintiffs claimed that their employer's policy of excluding coverage for prescription contraception from an "otherwise comprehensive"⁵⁸ health plan constituted sex discrimination under Title

50. *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 682 (1983); *See also* 29 C.F.R. § 1604.9 (2004) (prohibiting discrimination with regard to fringe benefits, including medical, hospital, accident, life insurance and retirement benefits, as compensation).

51. *Erickson*, 141 F. Supp. 2d at 1272 (citation omitted).

52. *See Newport News*, 462 U.S. 669, 683-85.

53. *Los Angeles Dep't. of Water & Power v. Manhart*, 435 U.S. 702, 716-17 (1978).

54. *See Int'l Bhd. Of Teamsters v. U.S.*, 431 U.S. 324, 335-36 n.15 (1977). A plaintiff alleging disparate treatment must show that her employer intentionally treated her differently than other employees because of her sex. *See, e.g., McDonnell Douglas Corp. v. Green*, 411 U.S. 792 at 802-03 (1973) (discussing prima facie case of disparate treatment). A plaintiff alleging disparate treatment must show that a facially neutral employment practice "in fact fall[s] more harshly on one group than another and cannot be justified by business necessity," and need not prove discriminatory intent. *See Int'l Bhd. of Teamsters*, 431 U.S. at 335-36 n.15 (1977). There is also a third theory, sexual harassment, which includes both quid pro quo and hostile work environment sexual harassment. *See Meritor Sav. Bank, FSB v. Vinson*, 477 U.S. 57 (1986).

55. *See, e.g., McDonnell Douglas*, 411 U.S. at 792 (discussing prima facie case of disparate treatment).

56. Such a plaintiff may also state a claim under both the PDA and the ADA. *See Bielicki v. City of Chicago*, No. 97 C 1471, 1997 WL 260595, at *3 (N.D. Ill. May 8, 1977); *see also Cooley v. Daimler Chrysler*, 281 F. Supp. 2d 979, 988 (E.D. Mo. 2003) (denying motion to dismiss female plaintiff's action alleging that the exclusion of prescription contraceptives constituted disparate treatment under Title VII).

57. 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

58. The court noted that the plan excluded only a handful of products, including contraceptive devices, drugs prescribed for weight reduction, infertility drugs, smoking

VII. In granting plaintiffs' motion for summary judgment on their claim of disparate treatment, the Court held that Title VII requires employers to recognize the differences between the sexes and provide equally comprehensive health coverage, even if that means providing additional benefits to cover expenses incurred only by women.⁵⁹ Relying in part on the PDA,⁶⁰ the Court held that "[m]ale and female employees have different, sex-based disability and healthcare needs, and the law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception."⁶¹ Indeed, the special or increased health care needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other healthcare needs.⁶²

A plaintiff alleging disparate impact must show that a facially neutral employment practice "in fact fall[s] more harshly on one group than another and cannot be justified by business necessity," and need not prove discriminatory intent.⁶³ Some courts appear reluctant to rule on disparate impact claims in the context of health care coverage. For example, in *Erickson*, plaintiffs asserted claims of disparate treatment and disparate impact. The Court granted the employer's motion for summary judgment on the disparate treatment theory only, and did not address the disparate impact claim.⁶⁴

cessation drugs, dermatologicals for cosmetic purposes, growth hormones, and experimental drugs. *Id.* at 1268 n.1.

59. Of course, it has not been established that coverage of prescription contraceptives would represent a significant additional cost. Indeed, one widely cited figure states that it only costs an employer \$1.43 per employee per month to add full contraceptive benefits to a health plan. See, e.g., James Trussell, *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH, 494 (Apr. 1995).

60. The Court did not base its holding solely on the PDA, however. It also held that "regardless of whether the prevention of pregnancy falls within the phrase 'pregnancy, childbirth, or related medical conditions,' Congress' decisive overruling of *General Electric Co. v. Gilbert* [in the PDA] . . . evidences an interpretation of Title VII which necessarily precludes the choices Bartell has made in this case." *Erickson*, 141 F. Supp. 2d at 1274.

61. *Id.* at 1271.

62. *Id.*

63. See *Int'l Bhd. of Teamsters*, 431 U.S. at 335-36 n.15.

64. *Erickson*, 141 F. Supp. 2d at 1277. Similarly, the Court in *Saks* acknowledged that Ms. Saks's allegation of disparate impact was properly raised, but that it failed on the facts as she did not show that female employees were more adversely affected by the exclusion of fertility treatments than male employees. *Saks II*, 316 F.3d at 347 n.5 (plaintiff's disparate impact claim fails because she did not show that female participants were more adversely affected by the exclusion of fertility treatments than male participants); see also Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 680 (8th Cir. 1996), *abrogated on other grounds by* Bragdon v. Abbott, 524 U.S. at 644.

B. THE ADA AND DISABILITY-BASED DISCRIMINATION

Over 25 years after the enactment of Title VII, the ADA was enacted to “provide clear, strong, consistent, [and] enforceable standards [for] ending discrimination against individuals with disabilities,” and to bring such individuals into the economic and social mainstream of American life.⁶⁵ The ADA prohibits an employer from discriminating on the basis of disability against a qualified individual with a disability⁶⁶ in regard to fringe benefits including participation in an employer-sponsored health insurance plan.⁶⁷ Employers can be liable for disability-based discriminatory benefits they provide themselves, as well as benefits that they contract with third-parties (such as plan administrators and insurance companies) to provide.⁶⁸

As with Title VII, an ADA plaintiff can pursue a claim of employment discrimination based on disparate treatment or disparate impact.⁶⁹ In the context of cases alleging discrimination in benefits, disparate treatment theory is more commonly used.⁷⁰ A plaintiff alleging disparate treatment in

65. 42 U.S.C. §§ 12101(b) (2000). The ADA reaches beyond employment, and into public services, public transportation, public accommodations and telecommunications. *See* 42 U.S.C. § 2000e (2000).

66. *See infra*, notes 104-107 and accompanying text for a definition of “disability” within the meaning of the ADA; *see also* 42 U.S.C. § 12102(2) (2000).

67. *See* 29 C.F.R. § 1630.4(f) (stating that an employer may not discriminate on the basis of disability with respect to “[f]ringe benefits available by virtue of employment, whether or not administered by the ‘employer[.]’”); EQUAL EMPLOYMENT OPPORTUNITY COMM’N, EEOC INTERIM GUIDANCE ON APPLICATION OF ADA TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (June 8, 1993), *available at* <http://www.eeoc.gov/policy/docs/health.html> [hereinafter EEOC Interim Guidance] (“[e]mployee benefit plans, including health insurance plans provided by an employer to its employees, are a fringe benefit available by virtue of employment. Generally speaking, therefore, the ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees”); *Parker v. Metro Life Ins. Co.*, 121 F.3d 1006, 1014-15 (6th Cir. 1997) (citing these sources and collecting cases).

68. *See* 42 U.S.C. § 12112(b) (2000). *See also* *Anderson v. Gus Mayer Boston Store*, 924 F. Supp. 763, 781 (E.D. Tex. 1996); EEOC Interim Guidance, *supra* note 67.

69. *See* *Raytheon Co. v. Hernandez*, 540 U.S. 44, 55 (2003) (recognizing disparate treatment and disparate impact claims under the ADA). Disability-based harassment is also a cognizable claim. *Flowers v. S. Reg’l Physicians Servs., Inc.*, 286 F.3d 798 (5th Cir. 2002) (recognizing disability-based harassment claim under the ADA).

70. Bonnie Poitras Tucker, *Health Care and the Americans with Disabilities Act: Access to Health Care for Individuals with Hearing Impairments*, 37 HOUS. L. REV. 1101 (2000) (“In the context of insurance coverage, however, disparate impact analysis cannot be utilized.”); Daniel A. Engel, *The ADA and Life, Health, and Disability Insurance: Where is the Liability?*, 33 TORT & INS. L. J. 227, 236 (1997) (“The ADA prohibits under a disparate impact analysis conduct that, although facially neutral, has an adverse discriminatory effect

this context must show that she, a qualified individual with a disability, did not have equal access to benefits.⁷¹

“Equal access” is measured in two ways. First, the challenged distinction must be based on a disability as defined by 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.⁷² However, courts have generally recognized that the ADA does not require an employer to offer health plan benefits that provide the same level of benefits for all disabilities.⁷³ For example, several courts have held that an employer may offer a disability insurance policy that caps benefits for mental, but not physical, disabilities without running afoul of the ADA.⁷⁴

Second, even if the distinction is disability-based, it may still be permissible if it falls within the ADA’s “safe harbor” clause. Specifically, this clause provides that the ADA shall not be construed to prohibit or restrict “establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law . . . or that [are] not subject to State laws that regulate insurance.”⁷⁵ As this language suggests and the regulations make clear:

on employment. However, Section 501(c) eliminated to a large degree the disparate impact analysis as it relates to the setting of coverage under ERISA plans.”)

71. *Saks II*, 316 F.3d at 343; *See also* EQUAL EMPLOYMENT OPPORTUNITY COMM’N, A TECHNICAL ASSISTANCE MANUAL ON THE EMPLOYMENT PROVISIONS (TITLE I) OF THE AMERICANS WITH DISABILITY ACT, § 7.9-7.12 (1992).

72. EEOC Interim Guidance, *supra* note 67.

73. Although an employer may draw disability-based distinctions in coverage, it may not simply deny coverage based on a disability. *Anderson*, 924 F. Supp. at 781. An employee of a small business was diagnosed with AIDS, a disability within the meaning of the ADA. When his condition was revealed to his employer’s group health insurer, the premiums were raised and the employer sought a different group insurer. The new insurer excluded individuals with AIDS from participation in their plans. The court found “that if an employer switches to a group health insurer that categorically denies coverage to an employee with a disability because of that disability (here, AIDS), the employer has violated the ADA because it has not provided equal access to insurance for disabled and non-disabled employees.

74. *See Parker*, 121 F.3d at 1008; *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3rd Cir. 1998); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101 (10th Cir. 1999); *Lewis v. Kmart*, 180 F.3d 166 (4th Cir. 1999); *but see Johnson v. K-Mart*, 273 F.3d 1056 (11th Cir. 2001).

75 Specifically, the statute provides that the ADA shall not be construed to prohibit or restrict the following:

- (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

the ADA is not intended to disrupt the current regulatory structure for self-insured employers or disrupt the current nature of insurance underwriting, or current insurance industry practices in sales underwriting, pricing, administrative and other services, claims and similar insurance-related activities based on classifications of risks as regulated by the states.⁷⁶

As this section suggests, the funding of the plan makes a difference. Bona fide,⁷⁷ ERISA-regulated insured plans with disability-based distinctions will be protected by the safe harbor if the plan's sponsor can show that the distinction is actuarially justified, and is based on permissible classification of risks. Plans can also be self-funded, meaning that the employer assumes all or part of the risk of paying for the benefits instead of purchasing a health care coverage policy from an insurance company.⁷⁸ In contrast to insured plans, self-funded plans will be upheld—whether or not they are based on sound actuarial analyses—unless the distinctions can be shown to be subterfuge for discrimination.⁷⁹

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- (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
 - (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

42 U.S.C. § 12201(c) (2000); 29 C.F.R. § 1630.16(f) (2004).

76. 29 C.F.R. 1630.16(f).

77. Under the Age Discrimination in Employee Act ("ADEA"), a "bona fide" plan has been defined as one that exists and pays benefits. *See, e.g.,* *United Air Lines v. McMann*, 434 U.S. 192, 194 (1977); *Pub. Employees Ret. Sys. v. Betts*, 492 U.S. 158, 161 (1989). Several courts have adopted that definition for purposes of the ADA, as well. *See, e.g.* *Fitts v. Fed. Nat'l Mortg. Ass'n*, 236 F.3d 1, 3 (D.C.C. 2001); *EEOC v. Aramark Corp.*, 208 F.3d 266, 269 (D.C.C. 2000); *Piquard v. City of East Peoria*, 887 F. Supp. 1106 (C.D.Ill. 1995).

78. *See* 27 AM. JUR. 2d *Employment Relationship* § 109 (2002); The Kaiser Family Foundation, *Employer Health Benefits 2003 Annual Survey*, 127 available at http://www.kff.org/insurance/upload/20672_1.pdf (last visited Apr. 9, 2005); Employee Benefits Research Institute, *EBRI Health Benefits Databook* 91 (1999) (comparing self-funded and insured plans). Self-funded plans are sometimes referred to as "self-insured" plans, although there is no insurance policy involved. A plan can also be partially self-funded, meaning that the employer bears the risk up to some stop-loss threshold, after which an insurer bears or shares the risk for additional claims. Gail A. Jensen & Jon R. Gabel, *The Erosion of Purchased Insurance*, 25 INQUIRY 328, 329 (1988) ("Jensen & Gabel, *The Erosion of Purchased Insurance*").

79. 42 U.S.C. § 12201(c) ("Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter."); Jensen & Gabel,

C. ERISA PREEMPTION AND STATE LAW MANDATES

ERISA was intended to encourage the formation of pension and welfare benefits plans, and to protect employees' rights within such plans by "establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts."⁸⁰ Although aimed primarily at pension benefits, ERISA also regulates employer-sponsored welfare benefit plans, such as health benefits.⁸¹

In recent terms, the Supreme Court has repeatedly turned its attention toward ERISA and the scope of its preemption provisions.⁸² Although, generally, 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,⁸³ the structure and interpretation

The Erosion of Purchased Insurance at 329; *see also Saks II*, 316 F.3d at 341; *Leonard v. Israel Discount Bank of N.Y.*, 199 F.3d 99, 104 (2d Cir. 1999); *Henzel v. Del. Otsego Corp.*, 285 F. Supp. 2d 271, 279 (N.D.N.Y. 2003).

80. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987) (quoting 29 U.S.C. § 1001(b)); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (quoting 29 U.S.C. § 1001(b)).

81. 29 U.S.C. § 1002 (2000); 29 U.S.C. § 1001.

82. *See, e.g., Davila*, 542 U.S. 200 (Plaintiffs' causes of action under Texas Health Care Liability Act completely preempted by ERISA § 502); *Kentucky Ass'n of Health Plans Inc. v. Miller*, 538 U.S. 329 (2003) (Kentucky's "any willing provider law" not preempted by ERISA); *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 335 (2002) (Illinois law requiring independent medical review of benefit denials based on medical necessity considerations not preempted by ERISA); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (Washington law automatically revoking designation of spouse of beneficiary upon divorce preempted by ERISA); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (California's notice-prejudice rule not preempted by ERISA). The Court also decided *Pegram v. Herdrich*, 530 U.S. 211 (2000), in which it held that mixed eligibility-treatment decisions by HMOS are not fiduciary acts within the meaning of ERISA. *Pegram* has been cited for its distinction between eligibility and treatment decisions in preemption cases involving medical malpractice and negligence claims against managed care organizations. *See, e.g. Cicio v. Vytra Healthcare*, 321 F.3d 83, 100-05 (2d Cir. 2003); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 272 (3d Cir. 2001).

83. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995) (noting that ERISA does not require employer to provide any given set of minimum benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (noting that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits."). There have been specific amendments to ERISA aimed at requiring coverage for specific conditions or treatments. For example, ERISA has been amended to require that health care benefit plans include coverage for post-delivery hospital stays, *see* 29 U.S.C. § 1185 (2000), and to require coverage for certain post-mastectomy treatment and care, including reconstruction, *see* 29 U.S.C. § 1185b (2000). Similarly, ERISA could be amended to provide coverage for

of ERISA's express preemption provisions⁸⁴ created increasingly inconsistent results for the content of ERISA-regulated health care plans.

1. State Laws that "Relate to" a Plan are Preempted

In an attempt to create uniform administration of employee benefit plans,⁸⁵ 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.⁸⁶ Although initially given an expansive interpretation,⁸⁷ the Supreme Court narrowed the reach of the preemption clause in a 1995 case, *New York*

infertility treatments to some degree, or to treat such coverage equitably in light of other covered treatments and conditions. Indeed, The Family Building Act of 2003 introduced in the House of Representatives in September of last year, would require all health plans – including ERISA-regulated plans – that cover obstetrical benefits to cover infertility treatments as well. H.R. 3014, 108th Cong. (2003). The Act would also amend ERISA so that it would not preempt state laws that provide greater infertility-related benefits, thus ensuring that self-funded plans would be required to provide the coverage under either state or federal law. H.R. 3014 (2003) (proposed amendment at Sec. Sec 714(a), incorporating amendment to Public Health Service Act, including preemption section, by reference)). To date, attempts to enact the Act into law have failed. For an analysis of these and other similar targeted reforms of ERISA in health care reform, see Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 506 (1998).

84. This article focuses on ERISA's express preemption provisions in Section 514. ERISA also provides for complete preemption under Section 502(a) with respect to claims for benefits due under a plan, to enforce rights under a plan, or to clarify future rights under the terms of a plan, 29 U.S.C. § 1132(a)(1)(B) (2000). See *Travelers*, 514 U.S. at 654. For examples of conflict preemption analysis under ERISA, see *Davila*, 542 U.S. 200 (Plaintiffs' causes of action under Texas Health Care Liability Act completely preempted because they duplicate, supplement or supplant ERISA's list of exclusive remedies); *Boggs v. Boggs*, 520 U.S. 833, 874 (1997) (Louisiana community property law that allowed the spouse of a participant to designate a beneficiary of ERISA-regulated survivor annuity preempted under traditional conflict preemption analysis because it directly conflicted with ERISA's anti-alienation protections).

85. See, e.g., *Aetna*, 542 U.S. 200 (2004) ("the purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Travelers*, 514 U.S. at 657 ("the basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans").

86. ERISA § 502; 29 U.S.C. § 1132 (2000). Specifically, the "preemption clause" provides "[e]xcept as provided in [the savings clause]. . . [ERISA shall] supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514; 29 U.S.C. § 1144 (2000).

87. See, e.g., *Pilot Life Ins. Co.*, 481 U.S. 41, 47 (1987) (a state law relates to an employee benefit plan for purposes of ERISA preemption if it has a connection with or reference to such a plan).

State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., in which it held that a state law relates to an ERISA plan if it specifically refers to ERISA plans, mandates employee benefits structures or their administration, or provides alternative enforcement mechanisms for ERISA rights.⁸⁸

At least fifteen states have enacted some type of infertility insurance coverage law requiring insurers to offer or to cover certain infertility treatments.⁸⁹ In the context of an action for health plan benefits, such state law mandates would be preempted (at least initially) by ERISA's broad preemption clause because they "relate to" a benefit plan.

2. State Laws that "Regulate Insurance" are Saved

The second part of ERISA's preemption analysis, the "savings clause," saves specific state laws regulating insurance, banking and securities law from preemption.⁹⁰ In order to escape preemption, the state law must be "specifically directed toward" insurance, and not simply a law of general application that has some bearing upon insurers.⁹¹ In defining the regulation of insurance for the purpose of this clause, courts traditionally applied a "common sense view," and then looked to three factors developed under the McCarran-Ferguson Act:⁹² (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer

88. 514 U.S. 645, 668 (1995) (holding that a New York law requiring hospitals to collect surcharge from patients covered by a commercial insurer but not from patients covered by a Blue Cross/Blue Shield plan was not preempted by ERISA because the law did not "relate to" employee benefit plans within the meaning of ERISA's preemption clause).

89. A state law mandating offer of coverage requires insurance companies to offer a policy with infertility coverage, but does not require employers to select or pay for such coverage. A state law mandating coverage requires insurance companies to include infertility coverage in every policy offered. Compare CONN. GEN. STAT. § 38a-536 (1989) (requires health insurance organizations to offer coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including IVF) with ARK. CODE. ANN. §§ 23-85-137, 23-86-118 (1987) (requires health insurance companies to cover the expenses of IVF procedures). See National Conference of State Legislatures, *50 States Summary of Legislation Related To Insurance Coverage for Infertility Therapy*, June 2004 (summarizes state infertility insurance coverage laws) available at <http://www.ncsl.org/programs/health/50infert.htm>.

90. Employee Retirement Income Security Act, 29 U.S.C. § 1144(b)(2)(A) (2002).

91. *Miller*, 538 U.S. at 334 (collected case law).

92. 15 U.S.C. § 1012(b). As noted in *Rush Prudential*, "The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation, and, subject to certain exceptions mandates that "[n]o Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . ." 536 U.S. 355, 366 n.4 (2002).

and the insured; and (3) whether the practice is limited to entities within the insurance industry.⁹³ For example, in the 1986 case *Metropolitan Life v. Massachusetts*, the Supreme Court held that a Massachusetts statute mandating minimum mental health care benefits in health insurance policies was a statute regulating insurance, and therefore was saved from preemption.⁹⁴

In a 2003 case, *Kentucky Association of Health Plans v. Miller*,⁹⁵ a unanimous Supreme Court made a “clean break” from the McCarran-Ferguson Act factors, and held that a state law “regulates insurance” for purposes of ERISA if it: (1) is “specifically directed toward entities engaged in insurance”; and (2) substantially affects the risk pooling arrangement between the insurer and the insured.⁹⁶ This new test broadened the reach of the savings clause, and will likely save more state laws directed at insurance and insurance practices from preemption.⁹⁷ Although the results of the Court’s holding in *Miller* in this respect remain to be seen, in the context of an ERISA benefits-due action, state laws mandating benefits will continue to be saved from preemption under this clause as state laws regulating insurance.⁹⁸

93. See, e.g., *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985) (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)); *Rush Prudential*, 536 U.S. 365, 373.

94. 471 U.S. 724, 758 (1985).

95. 538 U.S. at 324.

96. *Id.* at 343.

97. The Supreme Court in *Miller* broadened the reach of the savings clause, and may save more state laws directed at insurance and insurance practices from preemption. Specifically, the Court held that “entities engaged in insurance” includes insurers, self-funded plans, and parties providing administrative services to self-funded plans. *Id.* at 337 n.1. The Court explained, “ERISA’s savings clause does not require that a state law regulate ‘insurance companies’ or even ‘the business of insurance’ to be saved from preemption; it need only be a ‘law . . . which regulates insurance,’ and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan.” *Id.* With regard to the second requirement, the Court found that the state law merely had to substantially affect the risk pooling arrangement, and did not have to actually spread risk or change the terms of the insurance policy. *Id.* at 338. On the facts, the Court found that Kentucky’s law met the first requirement because it was directed at HMOs in their capacities as both insurers and administrative service providers. *Id.* at 337 n.1. The Court found that the second requirement was met because Kentucky’s law “substantially affected the bargain between insurers and insureds . . . [b]y expanding the number of providers from whom an insured may receive health services.” *Id.* at 338.

98. See, e.g., *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (Massachusetts law mandating coverage of certain mental health benefits saved from ERISA preemption under savings clause); see also *Macro v. Indep. Health Ass’n*, 180 F. Supp.2d 427, 436 (W.D.N.Y. 2001) (New York law prohibiting insurers from denying

3. The Exception for Self-Funded Plans

The third and final part of ERISA's preemption analysis is the "deemer clause," which provides that self-funded employee welfare plans cannot be deemed insurance plans for purposes of preemption analysis.⁹⁹ Because self-funded plans cannot be deemed insurance plans, specific state laws directed at insurance generally are not saved with respect to self-funded plans, and self-funded plans have not been considered subject to specific state regulation.¹⁰⁰

In the context of state laws mandating coverage of a certain treatment or condition, it is well documented that this exemption leads to dramatically different results because such laws apply to insured plans, but not to self-funded plans.¹⁰¹

III. THE FIRST APPLICATION OF *BRAGDON* TO BENEFITS

In the last few years, the federal courts have issued important civil rights decisions regarding insurance coverage of treatments or conditions associated with sex and disability.¹⁰² The lower court's decision in *Saks* garnered attention because it was the first to apply the Supreme Court's

coverage for correctable medical conditions resulting in infertility or based on infertility saved from ERISA preemption under savings clause).

99. ERISA § 514(b)(2)(B); 29 U.S.C. § 1144(b)(2)(B).

100. *See id.*; *FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990) (interpreting deemer clause broadly to exempt self-funded plan ERISA-regulated plans from state regulation and state law claims).

101. Of course, this effect is not limited to state laws mandating benefits. As authors have noted, the deemer clause exempts self-funded plans from a variety of other state laws, as well. Jon R. Gabel et al., *Marketwatch: Self-Insurance in Times of Growing and Retreating Managed Care*, HEALTH AFF. (Mar./Apr. 2003) [hereinafter *Self-Insurance*] (noting that the deemer clause exempts self-funded plans from a range of state law regulations including "state financial reserve requirements to minimize the risk of insolvency; state imposed premium taxes to finance state guaranty funds to pay claims of insolvent plans; state charges to finance high risk pools that provide coverage of uninsurable people; various consumer protection laws, or state insurance reforms intended to minimize harsh medical underwriting.") For a discussion of the regulation of self-insured plans, including stop-loss plans, *see generally* Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615 (1995); Kenneth M. Coughlin, *Filling the Gaps in Stop-Loss Insurance*, BUS. & HEALTH, Sept. 1992; Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 275-77 (1997); Dennis K. Schaeffer, *Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Federal Government's Duty To Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085, 1108 (1999).

102. *See, e.g., Saks II*, 316 F.3d 337 (2003); *Erickson*, 141 F. Supp. 2d 1266 (2001).

decision in *Bragdon* recognizing reproduction as a major life activity under the ADA to infertility.¹⁰³ However, in *Saks* the Second Circuit held that an employer's health plan could lawfully exclude coverage for infertility procedures that were only performed on women without violating Title VII or the ADA. What happened?

A. THE *BRAGDON* DECISION

In contrast to Title VII's prohibition against discrimination "because of [...] sex" which protects both men and women,¹⁰⁴ the ADA protects only a narrowly defined group of individuals who meet the statutory definition of "disabled." "Disability" is defined as having: "a physical or mental impairment that substantially limits one or more major life activities"; or "a record of such impairment"; or "being regarded as having such an impairment regardless of whether the individual actually has the impairment."¹⁰⁵ A major life activity is "substantially limit[ed]" if the individual is unable to perform a major life activity that the average person in the general population can perform, or is significantly restricted as to the condition, manner, or duration under which he or she can perform the activity, as compared to the general population.¹⁰⁶ Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.¹⁰⁷

In 1996 the Eight Circuit held in *Krauel v. Iowa Methodist Medical Center* that the ADA's list of major life activities should not be expanded.¹⁰⁸ In *Krauel*, an employee brought an action against her employer under both the ADA and the PDA challenging the exclusion of coverage for infertility treatment under the employer's health plan.¹⁰⁹ On appeal from summary judgment for the employer, the employee argued that her undisputed impairment of infertility affected the major life activities of reproduction and caring for others.¹¹⁰ The Eighth Circuit agreed that the employee's infertility was a physical impairment that prevented her from

103. 524 U.S. 624 (1998).

104. *Newport News*, 462 U.S. at 682.

105. 42 U.S.C. § 12102(2).

106. 29 C.F.R. § 1630.2(j).

107. 29 C.F.R. § 1630.2(i).

108. 95 F.3d 674, 677 (8th Cir. 1996).

109. *Id.* at 675.

110. *Id.* at 676-77.

becoming pregnant naturally.¹¹¹ It declined, however, to expand the non-exclusive list of major life activities, and thus held that the impairment did not substantially affect any recognized major life activity.¹¹²

Prior to *Krauel*, at least two district courts had found that reproduction was a major life activity within the meaning of the ADA.¹¹³ Two years later and in a different context, the Supreme Court in *Bradon v. Abbott*¹¹⁴ settled the question and held that reproduction is major life activity. In *Bradon*, an HIV-positive patient sued her dentist under the ADA for his refusal to treat her in his office. The Supreme Court first established that her HIV-positive status was an impairment that substantially limited her ability to reproduce because of the risk to her partner and child.¹¹⁵ Rejecting the petitioner's arguments that medication may significantly lower the risk of transmission at birth, the Court noted, "[i]t cannot be said as a matter of law that an 8% risk of transmission a dread and fatal disease to one's child does not represent a substantial limitation on reproduction [...] The Act addresses substantial limitations on major life activities, not utter inabilities."¹¹⁶ The Court then held that reproduction is a major life activity within the meaning of the ADA, because "[r]eproduction and the sexual dynamics surrounding it are central to the life process itself."¹¹⁷

B. APPLYING *BRADON* TO BENEFITS: THE *SAKS* DECISION

Many lawyers, activists and scholars thought that coverage for infertility treatment would follow soon after the Supreme Court's decision in *Bradon* recognizing reproduction as a major life activity within the meaning of the ADA.¹¹⁸ However, in the first major case applying *Bradon* to health benefits, *Saks*, the Second Circuit held that an

111. *Id.* at 677.

112. *Id.* ("Although *Krauel* is unable to conceive without medical intervention, she has the ability to care for herself, perform manual tasks, walk, see, hear, speak, breathe, learn, and work. It is undisputed that her infertility in no way prevented her from performing her full job duties as a respiratory therapist.")

113. *Erickson v. Bd. of Governors*, 911 F. Supp. 316, 323 (N.D. Ill. 1995); *Pacourek v. Inland Steel Co.*, 916 F. Supp. 797 (N.D. Ill. 1996); *but see Zatarain v. WDSU-Television Inc.*, 881 F. Supp. 240, 243 (E.D.La. 1995).

114. 524 U.S. 624 (1998).

115. *Id.* at 639-40.

116. *Id.* at 641.

117. *Id.* at 638.

118. *See Gross, supra* note 9 (reporting opinions of Mark G. Sokoloff, Ms. Saks's attorney, and an anonymous EEOC official regarding the impact of *Bradon* on employer health plan exclusion of infertility treatment); *Sato, supra* note 4 at 220 ("Many thought mandatory insurance coverage for infertility was a "slam dunk" after *Bradon* held that reproduction was a major life activity as defined by the ADA.").

employer's health plan could lawfully exclude coverage for infertility procedures performed solely on women without violating Title VII or the ADA.

1. The District Court Decision

Rochelle Saks's self-funded ERISA-regulated health plan (the "Plan") denied coverage for surgical impregnation procedures for infertility. The plan covered a variety of infertility products and procedures including "ovulation kits, oral fertility drugs, penile prosthetic implants (when certified by a physician to be medically necessary), and nearly all surgical infertility treatments."¹¹⁹ The Plan excluded "surgical impregnation procedures, including artificial insemination, IVF or embryo and fetal implants," regardless of medical necessity.¹²⁰

In the course of her treatment, Saks used several covered products and processes, and also underwent intrauterine insemination procedures and two cycles of IVF. She became pregnant three times during the course of treatment, but all three pregnancies ended in miscarriage. Her employer refused coverage of the intrauterine insemination and IVF procedures, as well as the related office visits and drug and monitoring expenses, on the basis that they were expressly excluded from coverage as surgical impregnation procedures.¹²¹ After receiving a probable cause determination from the EEOC,¹²² Saks filed an action against her employer in the United States District Court for the Southern District of New York, alleging that the Plan's exclusion of infertility treatments that can only be performed on women – artificial insemination, IVF, and *in utero*

119. *Saks II*, 316 F.3d at 341.

120. *Id.*

121. *Saks II*, 117 F. Supp. 2d at 322-23. Her employer, through a third-party administrator, initially also refused coverage for pregnancy and miscarriage-related expenses after her first miscarriage. Ms. Saks's internal appeal of that denial was successful. *Id.*

122. An employee alleging employment discrimination under the ADA must pursue an administrative claim with the EEOC prior to filing suit. 42 U.S.C. § 2000e-5(e). The EEOC may investigate the claim to determine whether there is "reasonable cause to believe that an unlawful employment practice has occurred or is occurring." 29 C.F.R. § 1601.24 (2003). If it finds reasonable cause and the matter cannot be resolved with the employer, the EEOC may issue a "determination that reasonable cause exists to believe that an unlawful employment practice has occurred or is occurring," which allows plaintiff to proceed with a lawsuit. *Id.* § 1601.21; *see also* § 1601.19.

insemination – violated Title VII, the PDA, the ADA and New York law.¹²³ The district court granted the employer’s motion for summary judgment on all claims.

a. *The Title VII Claim*

The district court held that the Plan did not violate Title VII because men and women receive the same benefits and are subject to the same exclusions under the plan -- both men and women have “equal access” to certain types of infertility treatments, and neither men nor women may receive benefits for other types of infertility treatment. The district court explained, “[i]t is no answer to say that the excluded treatments can only be performed on women, because male employees can claim infertility-related benefits for treatment performed on their wives – and are, conversely, precluded from obtaining benefits for surgical impregnation of their wives.”¹²⁴

Similarly, the district court held that infertility is a “pregnancy related condition” covered by the PDA under *Int’l Union, UAW v. Johnson Controls*,¹²⁵ but that the Plan did not violate the PDA because it provides equal coverage for male and female employees who suffer from infertility.¹²⁶

b. *The ADA Claim*

The district court held that although infertility is a disability within the meaning of the ADA under *Bragdon*, 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.

The court also found that the Plan was not covered by the ADA because it was a bona fide, ERISA-regulated and self-funded plan within the ADA’s “safe harbor” provision described above. Finding that “[t]he only self-insured plans that fall outside the ADA’s safe harbor are those that are used as a subterfuge to evade the purposes of the statute,” the court held that because the exclusion for surgical impregnation procedures pre-

123. *Saks II*, 117 F. Supp.2d at 320. Ms. Saks’s state law claims were for breach of contract and violation of New York Executive Law § 296 prohibiting discrimination in employment. *Id.*

124. *Saks II*, 117 F. Supp. 2d at 328.

125. 499 U.S. 187 (1991).

126. *Saks II*, 117 F. Supp. 2d at 329.

dated the effective date of the ADA, it could not be considered a subterfuge as a matter of law.¹²⁷

c. ERISA and the State Law Claims

Ms. Saks also raised claims of breach of contract and violation of New York Human Rights law. The district court granted summary judgment on these state law claims as preempted by ERISA, notwithstanding the employer's failure to timely raise ERISA preemption as a defense in its answer.¹²⁸

2. The Appellate Court Opinion

Ms. Saks appealed from the grant of summary judgment on all but the ADA claim. On appeal, the Second Circuit affirmed the decision of the district court, but on different grounds.

a. The Title VII Claim

The appellate court first clarified that the district court's use of the "equal access" standard under Title VII was incorrect. The issue was not equal access to a single set of benefits, but whether the set of benefits provided equitable coverage to women and men. In the words of the court, 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 those conditions results in a plan that provides inferior coverage to one sex."¹²⁹

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."¹³⁰ Thus, the court reasoned,

127. *Id.* at 327-38.

128. *Id.* at 330.

129. *Saks v. Franklin Covey Co.*, 316 F.3d 344 (2nd Cir. 2003) (citing *Newport News*, 462 U.S. at 676). Although it found that the district court did not rely on it, the appellate court also rejected the "couple analysis" (a female-specific exclusion does not constitute sex discrimination so long as male and female employees and their respective partners received the same health benefits when considered as a couple), noting the court must focus on the male and female employees, not the benefits offered to the "couple." *Saks*, 316 F.3d at 344-45.

130. *Id.* at 347.

because exclusion of surgical implantation procedures disadvantages male and female employees equally, the plan does not discriminate on the basis of sex.

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”¹³¹ 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. Thus, an infertility-based distinction is not a sex-based distinction prohibited by Title VII.

b. *ERISA and the State Law Claims*

The Second Circuit held that ERISA preemption in a benefits-due action is a waivable affirmative defense, and must be timely raised in the answer.¹³² Notwithstanding the employer’s failure to raise ERISA preemption in its answer, the court remanded the case to the district court to determine whether the defendant’s motion for summary judgment should be construed as a motion to amend the answer, and, if so, to rule on that motion.¹³³

IV. FUTURE CHALLENGES TO THE EXCLUSION OF INFERTILITY TREATMENT

The decision in *Saks II* was a disappointment to many, particularly after the successful use of Title VII to challenge a health plan exclusion in *Erickson*.¹³⁴ But *Saks II* did not shut the door on using Title VII to

131. *Id.* at 345-46.

132. *Id.* at 349-50.

133. *Id.* at 350-51. The court held that although the defendant failed to raise the affirmative defense of ERISA preemption in its answer, “a district court may still entertain affirmative defenses at the summary judgment stage in the absence of undue prejudice to the plaintiff, bad faith or dilatory motive on the part of the defendant, futility, or undue delay of the proceedings,” and that under “such circumstances, the district court may construe the motion for summary judgment as a motion to amend the defendant’s answer.” *Id.* It seems likely that if the district court construes the employer’s motion for summary judgment as a request to amend its answer to raise ERISA preemption, then the remaining state law contract claim will be preempted. As of the time this Article was completed, no further action had been reported on the remanded case.

134. *Erickson*, 141 F. Supp. 2d at 1266.

challenge an employer's exclusion of infertility treatment from its plan, as other courts could analyze claims under Title VII differently. In addition, *Saks* and other cases suggest that seemingly small changes in the facts could lead to different results under Title VII and the ADA. Returning to the example of Jane introduced at the beginning of this Article, this section outlines the types of challenges to the exclusion of infertility treatment that plaintiffs may pursue with success in the wake of *Saks II*.

A. TITLE VII CLAIMS

Title VII offers significant advantages over the ADA for purposes of challenging the exclusion of infertility treatment. As discussed in Section II.A. above, a facially neutral policy that simply permits equal access to the same set of benefits for male and female employees will not pass muster under Title VII. Instead, employers providing coverage must provide equally comprehensive coverage for both sexes, and the additional cost of offering non-discriminatory benefits, if any, is not a defense.¹³⁵

1. Disparate Impact: Gender Patterns in Coverage

After receiving the insurance plan's decision to deny coverage, Jane spoke to some of her coworkers about the situation, and learned that several others had requested and received coverage of infertility treatments. The stories that she heard suggest that the plan covered treatment of infertility attributable to male factors more frequently than infertility attributable to female factors.

If true, does this matter? The Second Circuit's opinion in *Saks II* suggests that Jane could state a disparate impact claim based on her plan's claim history. It held that "the Plan's exclusion of surgical impregnation procedures does not provide male employees with more comprehensive coverage of infertility treatments than female employees because the surgical procedures in question are used to treat both male and female infertility."¹³⁶ However, it also noted:

Saks has not offered any evidence from which a reasonable jury could conclude that the surgical impregnation procedures required for the treatment of male infertility

135. See *supra* notes 48 to 64 and accompanying text.

136. *Saks II*, 316 F.3d at 347.

differ from those required for the treatment of female infertility, or, more importantly, that male infertility is more frequently treated by other (Plan-approved) means than is female infertility.¹³⁷

Accordingly, a plaintiff who can show that her plan has covered treatment of male infertility more frequently than female infertility may state a claim under Title VII. Specifically, she may be able to show that her plan more frequently treats male factors such as no or low sperm production, blocked passage of sperm, problems with ejaculation, or immunological disorders that prevent the sperm from penetrating the egg, than female factors such as ovulation disorders, blocked fallopian tubes, or structural problems or disorders of the uterus or cervix.¹³⁸

2. Disparate Impact: Women and Infertility

After receiving the insurance plan's decision to deny coverage, Jane's feelings of rage, grief and depression at the perceived loss of a chance to conceive, deliver and raise a child intensify. She joins a support group for people struggling with the disease of infertility. Of the fifteen members of the support group, only two are men.

Although the Second Circuit recognized that gender patterns in a plan's claim history could support a claim of disparate impact on women, it failed to recognize how a plan's failure to provide comprehensive coverage for treatment of infertility disparately impacts women.

As discussed in the first section of this Article, infertility is recognized by the medical community as a disease with devastating emotional effects. The Second Circuit found that the specific cause of infertility could be "traced to male, female, or couple infertility with equal frequency," and thus exclusion of surgical impregnation procedures performed on women disadvantaged male and female employees equally. What the Second Circuit did not consider is the significant evidence suggesting that the

137. *Id.* at 347 n.5.

138. *See supra* notes 21 to 31 and accompanying text. *See also* Coverage of Reproductive Technologies Under Employer-Sponsored Health Care Plans: Proceedings of the 2004 Annual Meeting, Association of American Law Schools, Joint Program of Sections on Employee Benefits and Employment Discrimination, 8 EMPLOYEE RIGHTS & EMP. POL'Y J. 2, 8 (2004) (comments of Professor Helen L. Norton, noting the potential for this type of claim). Conversely, a male plaintiff may also state a claim if he can show his plan has covered treatment of female infertility more frequently than male infertility.

emotional and physical toll of infertility disproportionately affects women.¹³⁹

One recent survey of the literature on gender differences in psychological reactions to infertility concluded that in comparison to infertile men, infertile women report: a higher degree of anxiety, depression, and loss of self-esteem; lower sexual and marital adjustment;

139. See, e.g., SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL AND ETHICAL CONSIDERATIONS 18 (1998) (“The observation that women and men experience infertility in different ways is something that has long been known by infertile couples and their caregivers. . . [In studies] [w]omen have been found to experience significantly more psychological distress than do their partners, especially in the areas of depression, anxiety, cognitive disturbance and hostility.”); Anna Hjelmstedt et al., *Gender Differences in Psychological Reactions to Infertility Among Couples Seeking IVF- and ICSI-Treatment*, 78 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 42, 44-46 (1999) (noting the different psychological impact infertility has on women and men); John Wright et al., *Psychosocial Distress and Infertility: Men and Women Respond Differently*, 55 FERTILITY & STERILITY 100 (1991) (“Consistent with previous research, infertile women showed higher distress than their partners on a global measure of psychiatric symptoms and subscales of anxiety, depression, hostility, and cognitive disturbances, as well as on measured of stress and self-esteem.”); Frank M. Andrews et al., *Stress from Infertility, Marriage Factors, and Subjective Well-Being of Wives and Husbands*, 32 J.HEALTH & SOC. BEHAV., 238, 238 (1991) (finding that “negative effects on life quality are stronger for wives than for husbands”); Christopher R. Newton et al., *Psychological Assessment and Follow-Up After In Vitro Fertilization: Assessing the Impact of Failure*, 54 FERTILITY & STERILITY 879, 879 (1990) (after a failed cycle of IVF, women and men showed significant increases in anxiety and depressive symptoms, and prevalence of mild and moderate depression increased substantially, particularly among women); Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (1985) (noting that 49% of women and 15% of men being treatment for infertility described the experience as the “most upsetting experience in their lives”); Ann Lalos et al., *A Psychosocial Characterization of Infertile Couples for Surgical Treatment of the Female*, 4 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 83, 83 (1985) (a Swedish study finding that infertility has severe emotional and social effects, and that women openly admitted more symptoms such as grief, depression guilt, feelings of inferiority and isolation than their male partners). But see Robert D. Nachtigall et al., *The Effects of Gender-Specific Diagnosis on Men’s and Women’s Response to Infertility*, 57 FERTILITY & STERILITY 113, 113 (1992) (finding significant differences in the emotional response to infertility between women and men, and noting that men’s response more closely approximates that of women if the infertility has been attributed to a male factor); Aila Collins et al., *Perceptions of Infertility and Treatment Stress in Females as Compared with Males entering In Vitro Fertilization Treatment*, 92 FERTILITY & STERILITY 350, 350 (1992) (although women reported more stress entering into IVF treatment, the men appeared to be as psychologically affected by infertility as women).

and more feelings of guilt, inferiority and isolation.¹⁴⁰ The authors also noted that “[t]he negative effects of infertility on quality of life have been shown to be stronger for infertile women compared to infertile men.”¹⁴¹ While there could be many reasons for the disparity in reactions to infertility between women and men,¹⁴² the evidence certainly suggests that the disease of infertility, in particular its psychological effects, disproportionately affects women.

Women may also experience distinct and disparate health effects as a result of infertility. For example, according to the National Cancer Institute, women who have never been pregnant have a greater risk of developing endometrial¹⁴³ or ovarian cancer,¹⁴⁴ while women who have more than one child have a decreased risk of developing breast cancer.¹⁴⁵ Another recent study suggests that breast-feeding after childbirth may reduce a woman’s risk of developing rheumatoid arthritis.¹⁴⁶

Accordingly, if a plaintiff musters the literature to support her claim that infertility disproportionately affects women in terms of emotional health, physical health, or both, she could then argue that the exclusion of certain treatments for infertility has a disparate impact on female employees that should be recognized under Title VII.

3. Employee’s Marital Status

140. See generally Hjelmstedt et al., *supra* note 139 (reviewing the literature); See also Domar et al., *supra* note 20 (reporting that infertile women being treated by an infertility specialist experience twice the prevalence of depression than healthy women).

141. Hjelmstedt et al., *supra* note 139, at 42.

142. *Id.* (women may be more likely to report greater feelings of anxiety, men may have different coping mechanisms, etc.). See also Nachtigall et al., *supra* note 139 (finding significant differences in the emotional response to infertility between women and men, and noting that men’s response more closely approximates that of women if the infertility has been attributed to a male factor).

143. National Cancer Institute, U.S. National Institutes of Health, *Ovarian Cancer (PDQ®): Prevention*, available at <http://www.cancer.gov/cancertopics/pdq/prevention/ovarian/Patient/page2> (last visited Apr. 9, 2005).

144. National Cancer Institute, U.S. National Institutes of Health, *Endometrial Cancer (PDQ®): Prevention*, available at <http://www.cancer.gov/cancertopics/pdq/prevention/ovarian/Patient/page2> (last visited Apr. 9, 2005).

145. National Cancer Institute, U.S. National Institutes of Health, *Pregnancy and Breast Cancer Risk*, at http://cis.nci.nih.gov/fact/3_77.htm (last visited Apr. 9, 2005).

146. Elizabeth W. Karlson et al., *Do Breast-feeding and other Reproductive Factors Influence Future Risk of Rheumatoid Arthritis?: Results from the Nurses’ Health Study*, 50 ARTHRITIS & RHEUMATISM 3458, 3458-67 (2004) (finding that women who breastfeed have a lower risk of developing rheumatoid arthritis).

Jane is seeking treatment for infertility because she and her partner, Julia, wish to raise a child together. In the alternative, Jane is single and heterosexual, and wishes to have a child.

Regardless of her sexual orientation, does Jane's marital status affect the scope of her protection under Title VII? Jane may be able to state a disparate impact claim based on the lingering "couple analysis." The appellate court in *Saks II* found that because exclusion of surgical implantation procedures disadvantages male and female employees equally, the plan does not discriminate on the basis of sex.¹⁴⁷ In so holding, it explicitly rejected the lower court's "couple analysis," under which a female-specific exclusion would not constitute sex discrimination so long as male and female employees and their respective partners received the same health benefits when considered as a couple.¹⁴⁸ The appellate court explained that the lower court had misapplied the Supreme Court's holding in *Newport News*:

The [Supreme Court], therefore, focused on whether male and female employees received equal coverage under their health benefits packages. It did not hold, as Franklin Covey seems to suggest, that an across-the-board female-specific exclusion would pass muster under Title VII or the ADA, so long as all couples received the same benefits.¹⁴⁹

However, the appellate court appeared to endorse another form of "couple analysis" in evaluating the level of coverage for male and female employees: "in the instant case, we engaged in a couple analysis to the extent that we evaluate whether the exclusion of surgical impregnation procedures results in less comprehensive benefits for female employees."¹⁵⁰

147. *Saks II*, 316 F.3d at 347.

148. *Id.* at 344. As an illustration of the district court's analysis, imagine that the Jane introduced at the beginning of the Article has a coworker, John, who is married and seeking coverage of infertility treatment for himself, his wife, or both. Jane and John's plan excludes infertility treatments performed on women only. Under the district court's analysis, the plan is not discriminatory because both Jane and John are denied coverage of the same treatments performed on women -- Jane is denied coverage for treatments performed on herself, and John is denied coverage for treatments performed on his wife.

149. *Id.* at 344-45 (citations omitted).

150. *Id.* at 345 n.2 (citations omitted). As the focus is on the employee, the spouse-beneficiary may not have standing to raise a Title VII claim. See generally *Nicol v. Imagematrix, Inc.*, 773 F. Supp. 802 (E.D.Va. 1991); *Niemeier v. Tri-State Fire Prot. Dist.*,

The appellate court went on to hold that Franklin Covey's plan did not violate Title VII because it did not result in a less comprehensive benefit package for female employees.¹⁵¹

The problem with the Second Circuit's analysis is that it still assumes a couple. Indeed, the court even suggested how this "couple analysis" might be exploited:

With respect to unmarried employees, the Plan would appear to cover only those infertility treatments that are required to treat the infertility of the employee, not the employee's partner, and that are performed directly on the employee himself or herself. Hence, in these circumstances, by excluding certain infertility treatments that are performed on women only, an argument can be made that the Plan denies coverage for a subset of infertility treatments available to unmarried female employees while covering all infertility treatments available to unmarried male employees.¹⁵²

Therefore, it appears that an unmarried infertile female employee may 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 employee could access the unrestricted benefits available without any such exclusion.¹⁵³ This is a notable inversion of the heterosexual and marriage-based norms traditionally reflected in diagnosis, treatment and legal criteria for infertility treatment.¹⁵⁴

The Second Circuit's analysis also appears to assume that the employee and his or her spouse are both covered under the employee's health care plan. This may not be a sound assumption, as according to recent news

No. 99C7391, 2000 U.S. Dist. LEXIS 12621 (N.D. Ill. Aug. 24, 2000). At least one court has allowed the employee to seek reimbursement for costs associated with treating the spouse-beneficiary. *Cwiak v. Flint Ink Corp.*, 186 F.R.D. 494, 496 (N.D. Ill. 1999) (male employee has standing to pursue claims under the ADA and the PDA for employer health plans failure to cover expenses incurred in treatment of his wife's infertility).

151. *Saks II*, 316 F.3d at 349.

152. *Id.* at 347-48 n.6.

153. *Id.*; see ASRM Amicus Brief, *supra* note 4, at 11-12.

154. See, e.g., Lisa C. Ikemoto, *The Infertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1027-33 (1996) (discussing heterosexual and marriage-based norms in diagnosis and treatment criteria). There have been news reports that couples are marrying in order to secure health insurance benefits. See Daniel Costello, *Saying "I Do" for a Health Plan: With Medical Costs Rising, Gaining Access to Benefits is Becoming a Factor in Some Couples' Decisions to Wed*, L.A. TIMES, June 28, 2004, at F1. If unmarried female employees do in fact have a relatively stronger Title VII or PDA claim as suggested above, this could lead to the opposite result—divorcing to secure coverage for infertility treatment.

reports, a few large employers are eliminating health care benefits for employees' spouses, or using financial penalties to discourage such coverage in order to lower overall health costs.¹⁵⁵

B. ADA CLAIMS

The ADA appears to be less helpful than Title VII for purposes of challenging the exclusion of infertility treatment due to the less demanding “equal access” standard, the broad safe harbor provision, and a narrow definition of subterfuge.¹⁵⁶ Notwithstanding these issues, what if Saks appealed the ADA claim? At first blush, it appears that the result would be the same, as the district court used the accepted “equal access” standard to evaluate non-discriminatory benefits under the ADA.¹⁵⁷ However, comparison of *Saks* with other cases suggests that seemingly small changes in the facts could lead to different results under the ADA.

1. Standing and the Origin of the Condition

155. Kris Hundley, *Companies Squeeze Spouses Out to Save Health Care Costs*, ST. PETERSBURG TIMES, Sept. 30, 2004, at 1A (reporting that employers such as Gannett, Verizon and Knight-Ridder recently have implemented such policies).

156. *See supra* notes 65 to 79 and accompanying text.

157. Ms. Saks could have brought a claim under Title III of the ADA, challenging the exclusion as discrimination in the public accommodation of health insurance. Title III of the ADA prohibits disability-based discrimination by private entities “in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.” 42 U.S.C. § 12182(a) (2004). A few Circuits have held that a provider of health insurance coverage can be liable as a “public accommodation” under this Title. *See* Castellano v. City of New York, 142 F.3d 58 (2d Cir. 1998); Conners v. Me. Med. Ctr., 42 F. Supp. 2d 34, 46 (D. Me. 1999); Rogers v. Dep’t of Health and Envtl. Control, 985 F. Supp. 635, 637-38 (D.S.C. 1997). However, other circuits have found that Title III does not reach the content of privately-offered health insurance coverage. *See* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1115 (9th Cir. 2000); Ford v. Schering-Plough Corp., 145 F.3d 601, 612 (3d Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1012 (6th Cir. 1997). Analysis of health insurance as a public accommodation is beyond the scope of this Article.

When Jane sought treatment for her condition, her doctor opined that her infertility was due to her age, rather than a specific illness or disease.

Does the cause of Jane's condition matter? In the *Krauel* case discussed above, the Eighth Circuit held that an exclusion of infertility treatment was not a disability-based distinction under the ADA because it applied to infertility due to all causes, and not just ADA-recognized impairments.¹⁵⁸ The court reasoned:

[T]he Plan's infertility exclusion applies equally to all individuals, in that no one participating in the Plan receives coverage for treatment of infertility problems. For example, the Plan exclusion bars coverage for infertility caused by age, a condition which is not recognized as a disability under the ADA, and for infertility caused by ovarian cancer, which is defined as a disability under the ADA. Therefore, the District Court properly held that the Plan is not a disability-based distinction in violation of the ADA.¹⁵⁹

Although *Krauel's* rejection of reproduction as a major life activity was abrogated by the Supreme Court's ruling in *Bragdon*, it is not clear that *Krauel's* emphasis on the origin of the infertility was similarly abrogated. Indeed, the lower court in *Saks I* noted that infertility arising from "natural aging process, rather than from some disease or defect, is not a 'disability' within the meaning of the ADA."¹⁶⁰

Given the numerous and often interacting causes of infertility—including the fact that in approximately twenty percent of the cases the cause is never known¹⁶¹—proving a medical cause or origin may be a significant factual hurdle for the plaintiff.¹⁶² For example, in the course of treatment of her infertility, Ms. Saks's doctors attributed the inability of Ms. Saks and her husband to conceive first to polycystic ovarian syndrome, then unknown causes, and finally a hormonal imbalance and ovulatory

158. *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677-78 (8th Cir. 1996).

159. *Id.* at 678.

160. *Saks I*, 117 F. Supp. 2d. at 326.

161. ASRM, *Frequently Asked Questions*, *supra* note 1.

162. Plaintiff has the burden of establishing standing under the ADA as an essential element of her claim. *See, e.g., Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 494 (1999) (dismissing petitioner's complaint for failure to state a claim because they did not establish that they are actually disabled or "regarded as" disabled).

disorder.¹⁶³ Although the medical origin of Ms. Saks's infertility was not challenged,¹⁶⁴ it is unclear if Ms. Saks could have marshaled the medical evidence to demonstrate that her infertility arose from a disease or physical defect if she had been required to do so.

A pair of pre-*Bragdon* cases provides some guidance on this issue. In *Zatarain v. WDSU-Television Inc.*,¹⁶⁵ an employee brought suit under the ADA claiming that her employer rejected reasonable accommodations to her work schedule to allow her to pursue infertility treatment. No specific medical cause for her infertility was established. Her employer argued, among other things, that her infertility was not an impairment because it was likely caused by her age (she was approaching 40) or job stress.¹⁶⁶ The court denied the summary judgment for the employer on that basis because the employee had offered expert testimony sufficient to support a finding that she suffered from a disorder of the reproductive system apart from age and stress.¹⁶⁷ In addition, in *Pacourek v. Inland Steel Company*,¹⁶⁸ the court outright rejected the requirement of medical cause. In that case, an employee brought suit under the ADA claiming that she was fired for taking time off for infertility treatment. The cause of her infertility was medically unexplained.¹⁶⁹ Her employer argued, among other things, that she lacked standing because unexplained infertility is not an impairment covered by the ADA. The district court rejected that argument and held that “it does not matter whether the infertility is explained or not. The ADA and regulations under it are simply devoid of any requirement that a physiological disorder or condition have a scientific name or known etiology.”¹⁷⁰ Courts have also rejected the requirement of specific medical cause or impairment post-*Bragdon*. For example, in *LaPorta v. Wal-Mart Stores Inc.*,¹⁷¹ the employee’s physician stated that she was infertile, but could not identify a specific cause for her infertility. Her employer suggested that because it might arise from “a physiological problem of the

163. *Saks I*, 117 F. Supp. 2d at 321-22.

164. *Id.* at 320 n.1. Although for the purposes of its motion for summary judgment her employer did not dispute that her infertility was an impairment that substantially limited her ability to reproduce, the court noted, “it appears that certain issues regarding Saks’ infertility and her need for chemical and/or surgical intervention to become pregnant would be disputed if this case were going to trial.” *Id.*

165. *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240 (E.D. La. 1995).

166. *Id.* at 243.

167. *Id.*

168. 916 F. Supp. 797 (N.D. Ill. 1996).

169. *Id.* at 799.

170. *Id.* at 801.

171. 163 F. Supp.2d 758 (W.D.Mich. 2001).

[husband]” or “environmental factors and lifestyle habits,” she had not demonstrated that she was disabled within the meaning of the ADA.¹⁷² The district court rejected this argument, finding that a reasonable jury could find that the plaintiff was infertile based on the doctor’s affidavit.

Therefore, a plaintiff may need to be prepared to demonstrate the origin or medical cause of the infertility in order to establish that it arises from an impairment recognized under the ADA, although lack of a medical basis to do so should not bar her claim.

2. Standing and Mitigation of the Condition

After Jane discovered that the health insurance provided through her work covered some treatments, but excluded surgical impregnation procedures, she went ahead with IVF and was able to conceive. She then sought reimbursement from the health plan.

Do successful results affect Jane’s ability to seek reimbursement for infertility treatment? The defendants in *Saks* argued—albeit in a footnote—that infertility cannot be a disability within the meaning of the ADA because it is a correctable condition,¹⁷³ relying upon *Murphy v. United Parcel Service*¹⁷⁴ and *Sutton v. United Airlines*.¹⁷⁵

Together with *Albertsons v. Kirkenburg*,¹⁷⁶ *Murphy* and *Sutton* comprise the Supreme Court’s 1999 “*Sutton* trilogy” on standing. In each of these cases, the Court held that the ADA requires an individualized consideration of the plaintiff’s undisputed impairment, taking into account any medical treatment, corrective devices and other mitigating measures.¹⁷⁷ Following these cases, courts have found impairments such as diabetes,¹⁷⁸

172. *Id.* at 764 (quotations omitted). Although not reached in *LaPorta*, the question of whether an employee can state a claim if the source of the infertility is her partner (and therefore she has no identifiable impairment herself) is an interesting one. At least one court has allowed the employee to seek reimbursement for costs associated with treating the spouse-beneficiary. See *Cwiak v. Flint Ink Corp.*, 186 F.R.D. 494, 496 (male employee has standing to pursue claims under the ADA and the PDA for employer health plan’s failure to cover expenses incurred in treatment of his wife’s infertility).

173. 117 F. Supp. 2d at 325.

174. 527 U.S. 516 (1999).

175. 527 U.S. 471 (1999).

176. 527 U.S. 555 (1999).

177. For a critique of the *Sutton* Trilogy see Elizabeth A. Pendo, *Substantially Limited Justice?: The Possibilities and Limits of a New Rawlsian Analysis of Disability-Based Discrimination*, 77 ST. JOHN’S L. REV. 225 (2003).

178. *Orr v. Wal-Mart Stores, Inc.*, 297 F.3d 720, *reh’g en banc denied* (8th Cir. 2002) (employee with diabetes not disabled -- and therefore could not prevail on his claim that he

asthma¹⁷⁹ and depression¹⁸⁰ to be correctable or amenable to mitigation, and therefore not disabilities within the meaning of the ADA in those cases.

The district court in *Saks*, however, rejected this argument as ill-advised as applied to infertility:

[I]n the opinion of this Court, the Supreme Court did not intend to rule that no disease or organic defect can qualify as an ADA disability as long as some treatment can ameliorate its impact in some percentage of persons afflicted, however small that percentage may be. Indeed, I think it highly likely that courts will, over time, develop a spectrum of “disability” along which various diseases will fall, depending on some case-by-case analysis of their seriousness, their susceptibility to treatment, the rate at which treatment succeeds in curing them altogether or lessening their impact, and the impact of available treatments on the plaintiff at bar Whether the availability of draconian regimens that avoid the consequences of infertility in a small percentage of individuals places this particular impairment closer to the Murphy/Sutton end of the spectrum or the diabetes/cancer/kidney failure end could not possibly be determined on the present record. But the position espoused by defendants is not so self-evident (as demonstrated by the fact that they relegate this argument to a footnote) that I would dismiss on Murphy/Sutton grounds at this juncture.¹⁸¹

One year later, the Michigan district court in *LaPorta* reached a similar conclusion. In that case, plaintiff brought an action under the ADA, Title VII and state laws challenging her termination after her employer failed to

was unlawfully terminated for closing pharmacy to take lunch breaks for maintaining his health -- because diabetes currently corrected with medication).

179. *Tangires v. Johns Hopkins Hosp.*, 79 F. Supp. 2d 587 (D. Md. 2000), *aff'd*, 230 F.3d 1354 (4th Cir. 2000) (Plaintiff's asthma found not substantially limiting because it was correctable by medication, even though plaintiff refused to take the medication. Plaintiff's doctor testified that her asthma was slow to clear because she refused to comply with his recommendations and was reluctant to take steroid drugs).

180. *Krocka v. Chicago*, 203 F.3d 507 (7th Cir. 2000) (upholding jury's finding that employee's depression was not substantially limiting because he exhibited no symptoms when taking medication and was able to perform his job adequately); *Spades v. City of Walnut Ridge*, 186 F.3d 897 (8th Cir. 1999) (employee's depression was being treated with medication that allowed him to function “without limitation”).

181. *Saks I*, 117 F. Supp.2d at 325-26.

accommodate her request for medical leave to receive treatment for infertility.¹⁸² Her employer argued, among other things, that plaintiff lacked standing to bring the action because her infertility was not a disability within the meaning of the ADA. Relying upon the *Sutton* trilogy, defendant argued, “[P]laintiff’s eventual success in becoming pregnant through artificial insemination in 1998 renders it ‘impossible’ to find that her condition of infertility substantially limited her in the major life activity of reproduction.”¹⁸³ The court rejected defendant’s argument: “[u]nlike the plaintiffs in *Sutton* and *Albertsons*, Ms. LaPorta is not asking the court to consider her situation in an uncorrected state. To the contrary, she points to the need for accommodation arising from the corrective measures themselves.”¹⁸⁴ Thus, the court recognized that defendant’s argument would create a painful “Catch-22” for the plaintiff—her infertility is an impairment that was ultimately correctable through expensive and intrusive treatment, but her employer can refuse to accommodate her requests for medical leave to pursue such treatment because the treatments were ultimately successful.¹⁸⁵

The courts in both *La Porta* and *Saks* also recognized that a rule under which an impairment that is subject to any amelioration—no matter how onerous—would not qualify as a disability under the ADA was unwise, and in the case of infertility conflates the distinct concepts of infertility and sterility.¹⁸⁶ Such an approach is also directly contrary to the Supreme Court’s decision in *Bragdon*, which notes that the ADA “addresses substantial limitation on major life activities, not utter inabilities.”¹⁸⁷ Indeed, other courts have found that impairments such as hearing loss,¹⁸⁸

182. 163 F. Supp. 2d at 760. As the *LaPorta* case illustrates, courts have found that infertile employees enjoy more ADA protection for requests for changes to work schedules, time off for treatment, and other “reasonable accommodations” in the workplace than for coverage of infertility treatments under their employer’s health plan. See, e.g. *Pacourek v. Inland Steel Co., Inc.*, 916 F. Supp. 797 (N.D. Ill 1996).

183. *LaPorta*, 163 F. Supp. 2d at 765.

184. *Id.* at 766.

185. *Id.*; see also Pendo, *supra* note 177, at 261-62 (discussing the “Catch 22” created by the *Sutton* trilogy).

186. *LaPorta*, 163 F. Supp. 2d at 764 (recognizing that infertility as “a diminished ability to become pregnant by natural means,” not the “complete inability to produce offspring.”)

187. 524 U.S. at 639. The Court also explicitly noted, “[W]hen significant limitations result from the impairment, the definition is met even if the difficulties are not insurmountable.” *Id.* at 639.

188. See *Wilson v. Aetna Life & Cas. Co.*, 195 F. Supp. 2d 419, 428-29 (W.D.N.Y. 2002) (denying defendant’s motion for summary judgment because plaintiff’s hearing loss, although mitigated by hearing aids, was permanent and significantly below the average person’s hearing, and plaintiff had difficulties using the hearing aids).

epilepsy,¹⁸⁹ depression¹⁹⁰ and asthma¹⁹¹ that can be corrected or mitigated may still constitute disabilities within the meaning of the ADA where the mitigation was not complete, or itself resulted in substantial limitation of a major life activity.

Accordingly, although it may continue to be raised by defendants, the fact that infertility can be treated, sometimes successfully, should not bar a plaintiff's challenge to the exclusion of infertility treatment under the ADA.

3. Self-Funded versus Insured Plans

Although Jane's insurance card bears the name of a well-known insurance company, she recently discovered that her health plan is self-funded. A Human Resources representative told her that this means her employer assumes all or part of the risk of paying for the benefits instead of purchasing a health care coverage policy from an insurance company.

Does the funding of her plan affect her protections under the ADA? As discussed in Section I.B. above, self-insured plans are exempted from state regulation as a result of ERISA's preemption analysis, and therefore are subject to only the most minimal antidiscrimination requirements under the ADA.¹⁹²

A number of scholars analyzed the scope of ADA protection for participants in self-funded health plans in the early 1990s, particularly after the decision in *McGann v. H & H Music Co.*,¹⁹³ upholding under ERISA an employer's cap on health insurance benefits for the treatment of persons with AIDS.¹⁹⁴ Based on two early cases,¹⁹⁵ some scholars anticipated a more protective role for the ADA in the context of employer-sponsored health insurance, even for self-funded plans.¹⁹⁶ Despite the relative optimism of these predictions, courts subsequently held that disability-based distinctions in bona fide, ERISA-regulated, self-funded plans will be

189. *Otting v. J.C. Penney Co.*, 223 F.3d 704, 711 (8th Cir. 2000) (denying defendant's motion for summary judgment because despite mitigating effects of plaintiff's medication, plaintiff's epilepsy was not fully under control).

190. *Maxwell v. GTE Wireless Serv. Corp.*, 121 F. Supp. 2d 649, 654 (N.D. Ohio 2000) (denying motion for summary judgment in part because of genuine issues of material fact as to whether employee's depression, even when treated with medication and counseling, interfered with the major life activities of working).

191. *Saunders v. Baltimore County*, 163 F. Supp. 2d 564, 568 (D. Md. 2001) (finding that employee's asthma was an impairment because he experiences severe asthma attacks despite medications and other treatments).

192. *See supra* notes 75-79 and accompanying text.

upheld—whether or not they are based on sound actuarial analysis—unless the distinctions can be shown to be subterfuge for discrimination.¹⁹⁷

Although it is not clear that employers choose self-funding solely to avoid state law mandates or the protections of the ADA,¹⁹⁸ it remains true

193. 946 F.2d 401 (5th Cir. 1991).

194. See John A. English, *Self-insured Group Medical Plans: A Search for Protection of Benefits*, 22 CAP. U. L. REV. 749 (1993); Patrick Morgan, *Applicability of ADA Non-Discrimination Principles to Self-Insured Health Plans: Do “AIDS Caps” Violate the Law?*, 11 J. CONTEMP. HEALTH L. & POL’Y 221 (1994); Dion A. Sullivan, *ERISA, the ADA, and AIDS: Fixing Self-Insured Health Plans with Carparts*, 7 MD. J. CONTEMP. LEGAL ISSUES 423 (1996); Nancy R. Mansfield et al., *Insurance Caps on AIDS-Related Healthcare Costs: Will the ADA Fill the Gap Created by ERISA?*, 14 GA. ST. U. L. REV. 601 (1998).

195. *Mason Tenders Dist. Council Welfare Fund v. Donahey*, No. 93 CIV. 1154, 1993 WL 944580, at *7 (S.D.N.Y. Nov. 19, 1993) (opining that a self-funded plan’s benefit cap for a specific disability would violate the ADA unless actuarially justified); *Carparts Distribution Ctr. v. Auto. Wholesaler’s Asso. of New England*, 37 F.3d 12 (1st Cir. 1994) (trade association and trust administering health plan can be considered a public accommodation under Title III of ADA for purposes of challenging a cap on benefits for illnesses relating to AIDS). The EEOC’s Interim Guidance also lent support to a broader interpretation of the ADA’s protections with respect to employer health plans. EEOC Interim Guidance, *supra* note 67.

196. See Kevin Caster, *The Future of Self-Funded Health Plans*, 79 IOWA L. REV. 413 (1994) (ADA could provide meaningful protection for participants in self-funded plans if the courts reject the ADEA’s definition of subterfuge); John E. Estes, *Employee Benefits or Employer “Subterfuge”: The Americans with Disabilities Act’s Prohibition Against Discrimination in Health Plans*, 12 N.Y.L. SCH. J. HUM. RTS. 85, 100 (1994) (employers should be required to show that cost justification itself is not a subterfuge for discrimination); Sullivan, *supra* note 195, at 423; Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers Under the ADA and ERISA*, 35 TORT & INS. L. J. 117 n.85 (1999) (cases such as *Mason Tenders* and *Carparts* suggests that the ADA may eliminate ERISA’s loophole for self-funded plans, so that insured and self-funded plans may have to provide sound actual support when singling out a disability for a post-claim cap.). Other early analyses were less optimistic. See English, *supra* note 195, at 764-66 (1993) (Because of safe harbor, the only ADA limit on self-funded plans is “subterfuge” which is not defined by the statute. If ADEA definition is used (*McMann*), this protection will be quite limited.); Morgan, *supra* note 195, at 251 (1994) (predicting the courts would reject the EEOC’s assertion that the ADA’s anti-discrimination and provision and risk classification principles apply to self-funded plans).

197. See, e.g., *Saks I*, 117 F. Supp. 2d 318, *aff’d* 316 F.3d 337, 341 (2d Cir. 2003); *Leonard*, 199 F.3d at 104; *Henzel*, 285 F. Supp. 2d at 279.

198. One survey indicates that employers choose self-funded health insurance benefits in order to avoid conflicts in insurance laws across the states. LeAnne DeFrancesco, *State Variation in Insurance Laws a Major Driver of Employers’ Self-Insurance Decisions*, Findings Brief (Academy Health / Changes in Health Care Financing & Organization), Vol. VII, No. 1 Feb. 2004, available at <http://www.hcfo.net/pdf/findings0204.pdf>; see also MARTHA PRIDDY PATTERSON & DEREK LISTON, ANALYSIS OF THE NUMBER OF WORKERS COVERED BY SELF-INSURED HEALTH PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974–1993 AND 1995 (1996) (noting one advantage to a self-funded plan is health plan designs can be applied on a nation-wide basis; the employee does not have to

that employees who participate in self-funded plans will continue to enjoy significantly less protection under the ADA than those who participate in insured plans. The same is not true for employees pursuing a claim under Title VII, in which case the funding status of the health plan is not relevant. Indeed, the plan at issue in *Erickson* was self-funded.¹⁹⁹

The exception for self-funded plans is increasingly significant. The number of self-funded plans has increased dramatically since ERISA's passage in 1974.²⁰⁰ As of 2003, the majority of covered workers are in a plan that is completely or partially self-funded.²⁰¹ While large employers have always been the most likely to self-fund health benefit plans,²⁰² news reports indicate that the trend toward self-funding will spread to small and mid-size employers as the cost of health care continues to rise.²⁰³ Moreover, like Jane, many employees may not be aware that their health plans are self-funded, as employers may contract with a traditional insurance carrier or other third-party administrator to administer the plan on a day-to-day basis.²⁰⁴

Accordingly, a plaintiff using the ADA to challenge exclusions in her employer-sponsored plan will be in a significantly better position if her plan is insured, rather than self-funded.

4. Subterfuge and the Timing of the Exclusion

change benefits when he or she changes job locations with the employer). In addition, there is some evidence that self-funded and insured plans cost similar amounts and provide similar benefits. Gabel et al., *supra* note 101.

199. 141 F. Supp. 2d. at 1268 n.1.

200. *See, e.g.*, Jensen & Gabel, *supra* note 78 (reporting that between 1981 and 1985, the percentage of employees in mid- to large-size firms covered by self-insurance grew from 25% to 42%). *See also* PATTERSON & LISTON, *supra* note 198, at 6 (noting that the percentage of workers enrolled in a fully or partially self-funded plan dropped from 60 to 51% between 1993 and 1995, due in part to the shift toward insured managed care plans, particularly by smaller employers. However “[a]s various types of managed care plans begin moving toward shifting financial risk to the employer, the trend toward increasing self-insurance, and the ERISA preemption of state laws afforded by self-insurance, may begin growing again.”).

201. Kaiser Family Foundation, *supra* note 78, at 121-29 (reporting that in 2003, 52% of covered workers were in a plan that is completely or partially self-insured) *available at* http://www.kff.org/insurance/upload/20672_1.pdf (last visited Apr. 9, 2005).

202. *See id.* at 123-29. “The likelihood that an employer self-insures is highly related to the size of the firm. Ten percent of covered workers in all small firms (3-199 workers) are in self-insured plans, compared to 50% of workers in mid-size firms (200-999 workers) and 79% of workers in jumbo firms (5,000 or more workers).” *Id.* at 124.

203. *See* Christopher Windham, *Self-Insurance Plans Gain as Premiums Jump*, WALL ST. J., Dec. 30, 2003, at B2.

204. Jensen & Gabel, *supra* note 78.

Jane looks through her old health insurance booklets, and discovers that her employer instituted the exclusion of surgical impregnation procedures in 1995. In the alternative, she discovers that her employer instituted the exclusion in 1985.

As discussed above, disability-based distinctions in bona fide, ERISA-regulated, self-funded plans will be upheld—whether or not they are based on sound actuarial analysis—unless the distinctions can be shown to be subterfuge for discrimination. What is a “subterfuge” for discrimination in this context, and does the date of the exclusion determine whether or not the exclusion is a subterfuge for discrimination?

In its 1993 Interim Guidance, the EEOC defined subterfuge as disability-based disparate treatment in an employee benefit plan that is not justified by “sound actuarial principles or related to actual or reasonably anticipated experience.”²⁰⁵ It specifically rejected the definition of subterfuge developed by the Supreme Court in *Public Employees Retirement System v. Betts*²⁰⁶ under the Age Discrimination in Employment Act of 1967 (“ADEA”),²⁰⁷ which held that a plan adopted prior to the enactment of the statute could not be a subterfuge to avoid the purposes of the statute.²⁰⁸ It also rejected *Betts*’s requirement that an ADEA plaintiff show the employer’s specific intent to discriminate in a non-fringe aspect of the employment relationship as inapplicable to the ADA.²⁰⁹

205. EEOC Interim Guidance, *supra* note 67.

206. 492 U.S. 158 (1989), *superseded by statute as stated in*, Gen. Dynamics Land Sys., Inc. v. Cline, 540 U.S. 581 (2004).

207. 29 U.S.C. § 621.

208. EEOC Interim Guidance, *supra* note 67, at 10.

209. *Id.* at 10. Indeed, several scholars argued that the courts would or should adopt the EEOC’s definition of subterfuge. Caster, *supra* note 196 (ADA could provide meaningful protection for participants in self-funded plans if the courts reject the ADEA’s definition of subterfuge); Estes, *supra* note 196 (the ADEA’s narrow, intent-based definition of subterfuge should not apply to the ADA. Moreover, employers should be required to show that cost justification itself is not a subterfuge for discrimination); Sullivan, *supra* note 195; Mansfield, *supra* note 196 (although the Circuits are not in agreement, cases such as *Mason Tenders & Carparts* suggests that the ADA may eliminate ERISA’s loophole for self-funded plans, so that insured and self-funded plans may have to provide sound actual support when singling out a disability for a post-claim cap.). Other early analyses were less optimistic. See English, *supra* note 195 (Because of safe harbor, the only ADA limit on self-funded plans is “subterfuge” which is not defined by the statute. If ADEA definition is used (*McMann*), this protection will be quite limited); Morgan, *supra* note 195, at 251 (predicting the courts would reject the EEOC’s assertion that the ADA’s anti-discrimination and provision and risk classification principles apply to self-funded plans).

However, beginning in 1996, courts began to reject the EEOC's definition, and to adopt the *Betts* definition of subterfuge in ADA cases.²¹⁰ These cases define subterfuge as "a scheme, plan, stratagem, or artifice of evasion," that includes "a specific intent to circumvent or evade a statutory purpose."²¹¹ Under this analysis, it does matter when the challenged exclusion was adopted, because exclusions adopted prior to 1992, the date Title I of the ADA became effective for employers with 25 or more employees,²¹² cannot be considered a subterfuge to avoid the ADA's prohibition of disability-based discrimination.

Accordingly, it appears that only plaintiffs who can establish that at some point after 1992, their employers planned to exclude treatments for infertility with the specific intent to evade the ADA can demonstrate that the exclusion is a subterfuge for discrimination.

V. RECOGNIZING THE EXCLUSIONS AS DISCRIMINATION: THE POLICY CONTEXT

*There is an old saw in political science that difficult conditions become problems only when people come to see them as amenable to human action. Until then, difficulties remain embedded in the realm of nature, accident, and fate – a realm where there is no choice about what happens to us. The conversion of difficulties into problems is said to be the sine qua non of political rebellion, legal disputes, interest-group mobilization, and of moving policy problems onto the public agenda.*²¹³

Currently, comprehensive coverage of treatments for infertility appears to be the exception rather than the rule in employer plans,²¹⁴ and voluntary expansion of benefits in this area seem unlikely in the face of continued

210. See, e.g., *Aramark Corp.*, 208 F.3d 266 (D.C. Cir. 2000); *Ford*, 145 F.3d 601 (3d Cir. 1998); *cert. denied*, 525 U.S. 1093 (1999); *Moderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996), *cert. denied*, 519 U.S. 1094 (1997); *Leonard F.*, 199 F.3d 99 (2d Cir. 1999); *Conner v. Colony Lake Lure*, No. 4:97CV01, 1997 WL 816511 (W.D.N.C. Sept. 4, 1997).

211. *Aramark Corp.*, 208 F.3d at 269 (citing *Betts*, 492 U.S. at 167 (quoting *McMann*, 434 U.S. at 203)).

212. The ADA was signed by President George Bush in 1990, but Title I did not become effective until July 26, 1992 for employers with 25 or more employees. 42 U.S.C.A. § 12101, S. Rep. No. 101-116, at 2 (1989).

213. Deborah Stone, *Causal Stories and the Formation of Policy Agendas*, 104 POL. SCI. Q. 281, 281 (1989).

214. ASRM Amicus Brief, *supra* note 4, at 11-12; see also Sato, *supra* note 4, at 197-2000.

increases in group health insurance premiums.²¹⁵ The analysis above shows that some plaintiffs may be able to use claims of sex discrimination, disability discrimination, or both to secure equitable treatment of infertility. Equitable coverage is of course distinct from comprehensive coverage – under the former, an employer could lawfully exclude all treatment of infertility, or place limitations on coverage based on factors other than sex or disability. The deeper question is whether employers should be required to provide comprehensive infertility treatments. This section examines the public policy arguments for and against the comprehensive coverage of infertility treatment, and argues for the transformation of the “difficulty” of infertility exclusions into a “problem” that should be recognized under the law.

A. INFERTILITY IS STILL A “WOMAN’S PROBLEM”

Jane and her husband, John, finally revealed their shared struggle to have a child with their family. Although they explained that the infertility was due to low sperm production, both Jane and John's family members offered support, sympathy and treatment advice primarily to Jane, and saw the issue as one primarily affecting Jane.

As discussed above, the available evidence suggests that women experiencing the disease of infertility are disproportionately affected by its devastating psychological impact. Although infertility is medically defined

215. Vernon Smith et al., Kaiser Commission on Medicaid and the Uninsured, Medicaid Spending Growth, Results from 2002 Survey, at 3, 9 (Sept. 2002) *available at* http://www.kff.org/insurance/upload/13512_1.pdf (rates rose by 12.7% in 2002 -- the largest increase since 1990); Bradley C. Strunk et al., *Tracking Health Care Costs: Growth Accelerates Again in 2001*, *available at* <http://content.healthaffairs.org/cgi/content/full/hltaff.w2.299v1/DCI> (“premiums for employment-based insurance increased 12.7 percent from 2001 to 2002...the largest increase in premiums since 1990.”). See Hewitt Association at <http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2003/06-23-03.htm> (forecasting average rate increases of 17.7% for 2004); Aon Spring 2003 Health Care Trend Survey, *at* http://www.aon.com/about/publications/pdf/issues/healthcaresurvey_29may03.pdf (forecasting average health plan rate increases of 15.7% to 17.2% for 2004); Press Release, Hewitt Health Assocs., HMO Rates Continue Double-Digit Increases, But Begin to Moderate (June 3, 2004), *available at* <http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2004/06-03-04.htm> (health insurers will seek premium increases for large employers averaging 13.7 percent in 2005); Aon Consulting, Aon Spring 2003 Health Care Trend Survey, *available at* http://www.aon.com/about/publications/pdf/issues/healthcaresurvey_29may03.pdf (health care plan costs will rise between 14.4 percent and 17.2 percent, depending upon type of plan and including of prescription drug coverage).

as applying to a (heterosexual) couple, the emotional and health care burden falls more heavily on the woman. It is worth noting that all of the major cases dealing with reasonable accommodation of infertility treatment and coverage of infertility treatment have been brought by female plaintiffs.²¹⁶

Moving from the patient's perspective to a societal one, infertility is still considered a "woman's problem" by many.²¹⁷ As the sponsor of a recent public opinion poll regarding infertility noted, "women are feeling the brunt of responsibility when it comes to infertility, even though our research shows a public awareness about the male's role in conception problems."²¹⁸ Even the Merck Manual, one of the most influential and widely-used medical reference texts, lists infertility under "Women's Health Issues."²¹⁹

The resistance to coverage of infertility treatment can be seen as part of a larger pattern of resistance to coverage of treatments or conditions associated with sex or sexuality. Past and present debates over coverage of pregnancy, prescription contraception, and (to a lesser extent) Viagra, serve as a few examples. However, in the case of infertility treatment, the resistance to coverage appears profoundly gendered. As Professor Lisa Ikemoto has written, one popular narrative of infertility is female selfishness. Infertility is seen as the price women must pay for delaying motherhood for a career, for enjoying sexual freedom, or for exercising control over the reproductive process.²²⁰

While there is no doubt that infertility affects men, this suggests that infertility is still considered a "woman's problem," and lends support to the concept that exclusion of treatment for infertility can be seen as an issue of gender equality that should be cognizable under Title VII.

216. See, e.g., *Saks II*, 316 F.3d at 337; *Pacourek*, 916 F. Supp. at 797; *Erickson*, 911 F. Supp. at 316; *Zatarain*, 881 F. Supp. at 240; *Krauel*, 915 F. Supp. at 102.

217. Gilbert, *supra* note 28, at 1 (noting that infertility is "stereotypically thought of as a female problem").

218. Sigma-Tau Pharmaceuticals, Inc., *Gallup Survey Shows Communications/Perception Barriers Between Men and Women When Discussing Infertility* (May 26, 1999), available at <http://www.gobleedit.com/sigmatau/proceed/consumer/gendergap.html> (last visited Apr. 9, 2005).

219. THE MERCK MANUAL OF MEDICAL INFORMATION - SECOND HOME EDITION, available at <http://www.merck.com/mmhe/sec22.html> (last visited Apr. 9, 2005).

220. Lisa C. Ikemoto, *The Infertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L. J. 1007, 1042-44 (1996). Race and class also play a role, as the "infertile" are defined as white, married, middle-class women who are less deserving of sympathy. *Id.* at 1009.

B. INFERTILITY IS NOT A “LIFESTYLE CHOICE”

After receiving the insurance plan’s decision to deny coverage, Jane realizes that she cannot afford to pursue uncovered treatments. She experiences feelings of rage, grief and depression at the loss of a chance to conceive, deliver and raise a child. A well-meaning co-worker attempts to comfort her by saying that many young women today choose not to have children.

Some have argued that coverage of treatment to enable men and women to conceive, deliver and raise a child is not essential to a health care plan because reproduction is a choice. In the words of one commentator, “reproduction is a bodily function, but it is one the exercise of which is purely optional – a lifestyle choice.”²²¹ Indeed, in rejecting reproduction as a major life activity, the lower court in *Krauel* characterized reproduction in these terms, noting that “[s]ome people choose not to have children, but all people care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work, unless a handicap or illness prevents them from doing so.”²²²

While it is true that some people choose not to have children, the desire to have children is pervasive in our society.²²³ One widely-cited study found that only two percent of married women are childless by choice.²²⁴ Moreover, the loss of the chance to conceive, deliver and raise a child due to the disease of infertility is a real and devastating loss. As the court in *Pacourek* recognized:

Many, if not most, people would consider having a child to be one of life's most significant moments and greatest achievements, and the inability to do so, one of life's greatest disappointments. Since time immemorial, people have

221. See Sonfield, *supra* note 40, at 5 (“Infertility treatment is sometimes lumped together with cosmetic surgery as a ‘lifestyle’ type procedure rather than considered ‘serious medicine.’”) (quoting Deborah Wachenheim of RESOLVE); see also Pratt, *supra* note 18, at 1124-25 (quoting an exchange among tax professors on the issue of the deductibility of infertility treatment costs).

222. *Krauel*, 915 F. Supp at 106 n.1.

223 As the Supreme Court recognized, “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself.” *Bragdon*, 524 U.S. at 638.

224. See Patricia Schroeder, *Infertility and the World Outside*, 49 FERTILITY & STERILITY 765 (1988) (article by Congresswoman Schroeder, D-Colo., citing figures from the National Center for Health Statistics (NCHS)).

procreated, not as a lifestyle choice, but as an integral part of life.²²⁵

The intense desire to conceive, carry, birth and raise a child is also evident from the plaintiffs' vigorous pursuit of treatment and coverage of treatment in cases like *Erickson v. Board of Governors, Zatarain, Krauel, Pacourek* and *Saks*.

Moreover, similar arguments could be made for sexual functioning, as a certain percentage of people throughout the ages and across cultures have chosen to abstain from sexual activity.²²⁶ Therefore, medical treatments aimed at restoring sexual function could be viewed as non-essential because sexual activity is simply a "lifestyle choice." Interestingly, this argument was not widely raised with respect to Viagra, a drug developed for male sexual dysfunction.²²⁷ Instead, when Viagra was introduced in 1998, insurance companies "responded enthusiastically by willingly covering the prescriptions, at least in part,"²²⁸ and reports estimated that about half of the men taking Viagra received some form of insurance reimbursement.²²⁹ The outrage over the perceived inequity of employer health plan coverage of Viagra was a strong motivating factor in the movement for coverage of prescription contraceptives exemplified by *Erickson*.²³⁰ The sense of outrage may be heightened by a recent study indicating that Viagra is increasingly prescribed to younger men without markers for erectile dysfunction.²³¹

225. *Pacourek*, 916 F. Supp at 804.

226. *See, e.g.*, ELIZABETH ABBOT, *A HISTORY OF CELIBACY* 426 (2001) ("... for at least three thousand years in most parts of the world, celibacy has been far from uncommon and rarely considered unnatural. Billions of people have either chosen or been forced into celibacy for periods ranging from [a] few weeks [to a] lifetime").

227. *See Pratt, supra* note 18, at 1124-25.

228. Lisa A. Hayden, *Gender Discrimination within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 176 (1998-99).

229. *Id.* at 172; Debra Baker, *Viagra Spawns Birth Control Issue*, 84 A.B.A. J. 36 (1998).

230. *See, e.g.*, Marc Kaufman, *More Health Plans Cover Birth Control*, WASHINGTON POST, June 14, 2004, at A02 ("[a]t the Time Viagra came out and was immediately covered, many health plans were still defining contraceptives as lifestyle drugs . . . [t]he outrage that women felt was enormous and, we think, really drove the movement towards contraceptive equity.") (quoting Sharon Camp, president of the Guttmacher Institute); *see also* Hayden, *supra* note 228; Sylvia Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363 (1998); Baker, *supra* note 229, at 36.

231. *See* T. Delate et al., *Patterns of Use of Sildenafil Among Commercially Insured Adults in the United States: 1988-2002*, 16 INT'L J. OF IMPOTENCE RESEARCH 313 (2004).

The characterization of childbearing as a lifestyle choice also resonates with the pernicious image of the woman who “chooses” career and sex over motherhood described previously. As the Supreme Court recognized in *Bragdon*, “[i]n the end, the disability definition does not turn on personal choice.”²³² Although the Court made this statement in the context of the plaintiff’s choice to run the risks of reproduction – transmission of HIV to partner and child, in that case – it resonates here, as well. In fact, unlike in *Bragdon*, where the desire to reproduce was not related to the activity at issue in the case (being treated in a dentist’s office), in cases like *Saks* there is a tight link between the desire to reproduce and the underlying claim (seeking coverage of treatment to allow reproduction).

C. THE COST OF COMPREHENSIVE COVERAGE IS OVERSTATED

After receiving the insurance plan’s decision to deny coverage, Jane speaks with the Human Resources representative at her workplace. He tells her that their employer simply can’t afford to cover the excluded treatments, and that including expensive treatments like in vitro fertilization would dramatically increase the premiums for everyone in the group.

Employers and insurers have argued that increased coverage of treatments for infertility, in particular IVF, will dramatically increase health care costs and health insurance premiums: “[e]choing the traditional defense by the insurance industry against coverage mandates of all sorts, they argue that requiring employers to cover infertility treatment will force some employers to eliminate health benefits entirely and increase the already considerable number of uninsured Americans.”²³³

This argument is unconvincing because there is evidence that the cost of including comprehensive coverage of infertility treatment is overstated. For example, one study examined all IVF treatments performed in the United States during 1995, and projected that coverage of those treatments would increase group premiums by \$3.14 per employee per year.²³⁴ Other studies have reported similar figures.²³⁵ Notably, a study examining

232. *Bragdon*, 524 U.S. at 641.

233. Sonfield, *supra* note 40, at 5.

234. Collins et al., *An Estimate of the Cost of In Vitro Fertilization Services in the United States in 1995*, 64 FERTILITY & STERILITY 538 (1995).

235. See Hidlebaugh et al., *Cost of Assisted Reproductive Technologies for a Health Maintenance Organization*, 42 REPRODUCTIVE MED. 570, 570 (1997) (estimating the cost of including ART subject to preauthorization clinical criteria as \$2.49 per year); Sonfield, *supra* note 40, at 5 (summarizing similar studies).

utilization rates in Massachusetts, a state with mandated comprehensive coverage of infertility treatments, estimated the cost of such additional comprehensive coverage as \$2.49 per insured per year.²³⁶ These studies suggest that the cost of comprehensive infertility coverage is comparable to the cost of covering full contraceptive benefits.²³⁷

This argument is also unconvincing because comprehensive coverage does not necessarily mean unlimited coverage. Because the devastating emotional impact of infertility may lead to unreasonable expectations on the part of the person or couple seeking treatment, some have suggested external controls which give priority to people with better chances for success based on medical criteria, limit the number of cycles covered, direct people to the facilities with the highest success rates based on clear and consistent data, or limit the number of embryos that can be transferred at a time to reduce high-risk, high-cost multiple births.²³⁸ In addition, insurers could employ traditional methods of reducing the cost of coverage, such as negotiating discounts with providers, or charging higher co-payments for demonstrably more expensive procedures.²³⁹

In sum, although the data is not conclusive, the available evidence suggests that the cost argument is exaggerated. This does not suggest that coverage decisions should necessarily be made on the basis of cost-effectiveness alone.²⁴⁰ Indeed, the emotional, medical and social impact of infertility, particularly on women, raises issues of equity and prioritization that should also be considered. Nonetheless, given the popularity and power of the cost argument, its relative lack of support certainly bears closer scrutiny.

D. COMPREHENSIVE COVERAGE MAY LEAD TO A BETTER AND MORE COST-EFFECTIVE TREATMENT

Jane sees a new specialist and discovers that she has blocked fallopian tubes. Her doctor explains that he can either attempt to repair the damage to her fallopian tubes through one or more rounds of surgery, or he can

236. Hidlebaugh, *supra* note 235, at 570.

237. *See, e.g.*, Trussell, *supra* note 59, at 12 (noting widely cited estimate that it only costs an employer \$1.43 per employee per month to add full contraceptive benefits to a health plan).

238. Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1227-30 (1997).

239. *Id.* at 1230.

240. *Id.* at 1227. As Professor Peter J. Neumann has suggested, “[I]t may be more important to guarantee that every infertile couple has at least some access to IVF instead of simply maximizing the number of deliveries achieved for the dollars expended.” *Id.*

bypass the damaged area with IVF. The surgeries are covered under her employer's health plan, but IVF is not. Jane opts for tubal repair surgery. Two years and several surgeries later, she is still unable to conceive.

The pattern of exclusions in plans such as the one in *Saks* may lead to inefficient, wasteful and needlessly invasive treatment of infertility. Covering certain medications and procedures can lead patients to rely on the covered or less expensive treatments even though they may not be the most effective.²⁴¹ For example, a patient with a plan that excludes IVF but not intrauterine insemination may opt to undergo the latter even though it is not effective for her particular infertility problem.²⁴²

Choosing treatment options based on coverage alone may also be significantly more expensive. For example, patients in a situation similar to Jane's have undergone repeated attempts at tubal repair surgery – a procedure that “can be twice as expensive as one attempt at IVF, is more invasive and is less effective for some patients.”²⁴³ Interestingly, “[s]tudies show that tubal surgeries drop by 50 percent when [assisted reproductive technologies such as IVF] are covered by insurance.”²⁴⁴

There are human costs, as well. Surgery also requires significant recovery time, and a period of up to two years before success can be measured.²⁴⁵ In contrast, IVF can be performed on an outpatient basis, and success can be evaluated within two weeks.²⁴⁶ In addition, one study suggests that women who undergo infertility-related surgery reported significantly higher levels of depression than women who did not undergo surgery.²⁴⁷

Overall, the evidence suggests that comprehensive coverage of treatments for infertility “can act to reduce incentives to seek inappropriate,

241. Pratt, *supra* note 18, at 1126-30.

242. *Id.*

243. Sonfield, *supra* note 40, at 5; *see also* Pratt, *supra* note 18, at 1126-30 (“[w]here insurance covers tubal surgeries, but not IVF, a woman with blocked fallopian tubes may have several tubal ligation surgeries to attempt to repair her tubes, instead of bypassing the tubes with IVF”); Bradley J. Van Voorhis et al., *Cost-Effectiveness of Infertility Treatments: A Cohort Study*, 67 FERTILITY & STERILITY 890 (1997) (finding that assisted reproductive technologies such as IVF were more cost-effective than surgery for women with blocked tubes).

244. Gilbert, *supra* note 28, at 44 (citations omitted).

245. *Id.* at 43.

246. *Id.* (citations omitted).

247. Domar, *supra* note 20, at 1162. The authors of that study opined that “the surgical experience itself may have led to feelings of discouragement due to physical discomfort, presence of a scar, loss of work, feeling mutilated, and decreased optimism as time passes.” *Id.*

and expensive, treatment.”²⁴⁸ In contrast, lack of comprehensive coverage for infertility treatments may lead patients to choose an inefficient, invasive, and potentially more expensive course of treatment.²⁴⁹ Decisions that uphold selective exclusions, such as *Saks*, could make this bad situation even worse.²⁵⁰

CONCLUSION

In the context of employer health plans generally, the protections of afforded by civil rights laws such as Title VII and the ADA are important but limited, and state law mandates requiring coverage of certain conditions or treatments are unlikely to lead to uniform results because of ERISA preemption. In the case of employer plan coverage of infertility treatment, a seemingly reachable goal after *Bragdon*, *Saks* seems to have aggravated an already bad situation. Given the rising cost of health care coverage, it is likely that the exclusion of coverage for treatment of infertility under employer plans will continue to be an issue. Although Title VII offers advantages over the ADA for purposes of challenging the exclusion of infertility treatment, employers and health plans can continue to expect the types of challenges outlined in this Article to the exclusion of coverage for infertility treatment under both Title VII and the ADA.

In addition to factual and doctrinal support for claims under Title VII and the ADA for equitable and non-discriminatory treatment, there are strong public policy arguments supporting comprehensive coverage of treatments for infertility. Infertility is still seen as a “woman's issue” and the failure to conceive, carry and deliver a child cannot be characterized as “lifestyle choice.” Moreover, there is evidence that the costs of comprehensive coverage for treatment of infertility are overstated, and that comprehensive coverage of treatment for infertility could lead to better, more humane, and more cost-effective treatment.

248. Sonfield, *supra* note 40, at 5.

249. The treatment may also be riskier if the woman chooses to transfer multiple embryos in a single cycle rather than bear the cost of multiple cycles. Assisted reproductive technologies such as IVF have raised concerns because they lead to significant increases in multiple birth rates, which are associated with serious health consequences for the mother and the children, as well as considerably increased cost. *See, e.g.*, Meredith A. Reynolds et al., *Does Insurance Coverage Decrease the Risk for Multiple Births Associated with Assisted Reproductive Technology?*, 80 FERTILITY & STERILITY 16 (2003). One recent study found that coverage of IVF effected embryo transfer decisions, although it was not clear that it reduces the incidence of multiple births or triplets or more. *Id.*

250. *See, e.g.*, Valerie Gutmann, *Assisted Reproductive Technologies: Failure to Cover Does Not Violate ADA, Title VII or PDA*, 31 J.L. MED. & ETHICS 314, 315-16 (2003).

In their influential article, “The Emergence and Transformation of Disputes: Naming, Blaming and Claiming...,” William L.F. Felstiner, Richard L. Abel and Austin Sarat observed that “[t]he individual’s sense of entitlement to enjoy certain experiences and be free from others is a function of the prevailing ideology, of which law is simply a component.”²⁵¹ Legal challenges in particular can be a “highly effective way of transforming ideology to create a sense of entitlement.”²⁵² Many workers and their families affected by the disease of infertility are struggling to receive treatment in the absence of adequate insurance coverage. Bolstered by public policy arguments, legal challenges such as those outlined in this Article can support the transformation of their struggle from a cruel twist of personal fate into a cognizable, legitimate and successful civil rights claim.

251. William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming and Claiming...*, 15 LAW & SOC’Y REV. 631, 643 (1980-81).

252. *Id.*