

December 2005

Erickson v. Bartell Drug Co.: A Roadmap for Gender Equality in Reproductive Health Care or an Empty Promise

Brietta R. Clark

Follow this and additional works at: <https://lawandinequality.org/>

Recommended Citation

Brietta R. Clark, *Erickson v. Bartell Drug Co.: A Roadmap for Gender Equality in Reproductive Health Care or an Empty Promise*, 23(2) LAW & INEQ. 299 (2005).

Available at: <https://scholarship.law.umn.edu/lawineq/vol23/iss2/2>

Minnesota Journal of Law & Inequality is published by the University of Minnesota Libraries Publishing.



***Erickson v. Bartell Drug Co.:* A Roadmap for Gender Equality in Reproductive Health Care or An Empty Promise?**

Brietta R. Clark*

Introduction

In June 2001, a federal district court held in *Erickson v. Bartell Drug Co.*¹ that an employer's decision to exclude prescription contraceptives from its prescription benefits plan was sex discrimination in violation of Title VII of the Civil Rights Act,² as amended by the Pregnancy Discrimination Act (PDA).³ *Erickson* is an example that Title VII can be a powerful tool for ensuring gender equality in health care. Less well known is that plaintiffs have also tried using Title VII and the PDA to challenge exclusions of infertility treatments, but with very little success.⁴ This was true even where the employer excluded only surgical treatments that were used by women.

These cases are significant for two reasons. First, they illustrate the danger of discrimination in the allocation of employment-based health care benefits. Such discrimination represents the nexus of a long history of pregnancy-based employment discrimination and a devaluation of women's reproductive health care—a nexus that compounds several harms to women. Women are disadvantaged financially because they are

*Associate Professor of Law, Loyola Law School. J.D., University of Southern California Law School; B.A., University of Chicago. I would like to give special thanks to Melissa Cole, Judith Darr, Richard Hasen, Lisa Ikemoto, Sam Pillsbury, Katherine Pratt, Rhonda Reaves, Ted Seto, and Gary Williams for their thoughtful comments and helpful discussion. I also greatly benefited from the opportunity to present my ideas at St. Louis University's Health Law Scholars Workshop and the American Society of Law, Medicine, & Ethics Annual Health Law Teachers' Meeting. Finally, I am indebted to Jennell Mimms for her invaluable research assistance.

1. 141 F. Supp. 2d 1266, 1276-77 (W.D. Wash. 2001).
2. Title VII of the Civil Rights Act, 42 U.S.C. § 2000e (2000).
3. 42 U.S.C. § 2000e(k) (2000).
4. See *infra* notes 233-294 and accompanying text.

denied the complete insurance benefits afforded men. Lack of insurance coverage typically means a denial of medically necessary care creating physical, emotional, and further economic harm. Moreover, differential treatment of women's reproductive health care reflects and perpetuates stereotypes about proper gender roles and women's sexual freedom.

These cases also present competing theories of the role of civil rights law in challenging benefits exclusions. *Erickson* reveals the promise of Title VII as a powerful tool for challenging such exclusions. In contrast, the approach evident from other reproductive health benefits cases (what I term the "dominant approach") appears to be a watered-down version of Title VII that targets only the most obvious forms of discrimination and allows benefits exclusions to go essentially unchecked. This raises a critical question which I explore in this Article: Is Title VII, as amended by the PDA, really the powerful tool for ensuring gender equality in reproductive health care that *Erickson* suggests?

Part I lays out the basic legal framework for Title VII cases, including the elements required to make out the prima facie case for disparate treatment or impact claims, and the defenses available to employers.⁵ Despite the fact that Title VII expressly prohibits sex discrimination in the administration of fringe benefits, such as health insurance, courts have traditionally resisted seeing benefits exclusions as a civil rights issue.⁶ This resistance was exemplified in 1976 in the Supreme Court's decision in *General Electric Co. v. Gilbert*.⁷ In *Gilbert*, the Court held that an employer's short-term disability policy that excluded pregnancy-related disabilities did not violate Title VII's prohibition on sex discrimination.⁸ The Court refused to see the pregnancy exclusion as a sex-based classification that implicated Title VII and simply deferred to the employer's justifications for the exclusion.⁹ Women's advocates and Congress reacted swiftly, and in 1978, the PDA amended Title VII to expressly provide that classifications based on pregnancy, childbirth, or related medical conditions are sex-based classifications in violation of Title VII.¹⁰ In doing so, the PDA affirmed two important principles. First, it made clear that antidiscrimination law is an appropriate tool for

5. See *infra* notes 32-42 and accompanying text.

6. See *infra* notes 43-49 and accompanying text.

7. 429 U.S. 125 (1976); see *infra* notes 50-61 and accompanying text.

8. *Gilbert*, 429 U.S. at 128, 145-46.

9. *Id.* at 127-46; see *infra* notes 62-68 and accompanying text.

10. See 42 U.S.C. § 2000e(k) (2000); *infra* notes 69-70 and accompanying text.

challenging benefits exclusions.¹¹ Second, it reinforced the notion that pregnancy-related exclusions should be scrutinized closely because of the unique effects suffered by women and the likelihood that such exclusions are motivated by gender bias.¹²

In Parts II and III, I use these principles to determine whether Title VII, as amended by the PDA, is a viable tool for ensuring gender equality in reproductive health care, by focusing specifically on exclusions of prescription contraceptives and infertility treatment.¹³ In Part II, I demonstrate why express insurance exclusions for prescription contraception and infertility satisfy the *prima facie* case for Title VII.¹⁴ For each, I give extensive background about the purposes and forms of treatment and identify common patterns of insurance exclusions found in employment-based health plans.¹⁵ Most prescription contraception exclusions will constitute disparate treatment because the forms excluded tend to be those used only by women.¹⁶ Both prescription contraception and infertility exclusions appear to satisfy the *prima facie* case for disparate impact because of the greater cost burden and unique health risks suffered by women as a result of the exclusions.¹⁷

In Part III, I offer further evidence why courts should closely scrutinize these exclusions, with employers bearing the burden to justify them.¹⁸ Evidence suggests that such exclusions may be motivated by bias about women's proper reproductive role in society and by a fear of devices or drugs that enable women's sexual freedom or their ability to prioritize their career over childbearing.¹⁹ Furthermore, infertility exclusions also appear to be an extension of the longstanding bias of employers' devaluing pregnant or potentially pregnant employees.²⁰ Requiring the employer to state its justifications for reproductive health exclusions allows plaintiffs the opportunity to prove that

11. See 42 U.S.C. § 2000e(k).

12. See *id.*

13. See *infra* notes 84-232 and accompanying text.

14. See *infra* notes 84-160 and accompanying text.

15. See *infra* notes 85-127 and accompanying text.

16. See *infra* notes 128-136 and accompanying text.

17. See *infra* notes 128-136 and accompanying text.

18. See *infra* notes 161-232 and accompanying text.

19. See *infra* notes 164-196 and accompanying text.

20. See, e.g., Joan C. Williams & Nancy Segal, *Beyond the Maternal Wall: Relief for Family Caregivers Who Are Discriminated Against on the Job*, 26 HARV. WOMEN'S L.J. 77 (2003); see also *infra* notes 192-206 and accompanying text.

employers' justifications are mere pretext for bias.²¹ The likelihood that bias is really motivating these exclusions is suggested when we examine the most common employer justifications given and see that they are not legitimate on either medical or policy grounds.²² Comparing employers' treatment of female-specific reproductive health benefits to their policies for male-specific benefits and non-reproductive health conditions provides further support that such exclusions are really part of a larger pattern of discrimination in women's reproductive health care.²³ Finally, cost is always at the heart of employment benefits decisions, but it cannot be a defense to a disparate treatment claim. In addition, it is highly questionable whether cost can provide a legal or even credible defense or rebuttal for a disparate impact challenge to reproductive health exclusions. Admittedly, this is where the analyses for prescription contraception and infertility appear to diverge because of the different socio-economic and medical effects of treatment and implications for distributive justice concerns that underlie all health policy decisions.

Despite the fact that these exclusions result in harmful effects on women and are likely being used to advance parochial values of women's proper reproductive roles and limits on their sexual freedom,²⁴ I show that courts overwhelmingly resist the notion that exclusions are gender discrimination under Title VII.²⁵ In Part IV, I show that courts, under the "dominant approach," resist these claims by interpreting the PDA narrowly to only protect exclusions of sex-specific conditions, regardless of the relationship between the excluded treatment and pregnancy; focusing on the gender-neutral aspects of the exclusion as the predominate reason for denying the plaintiff's prima facie case; and failing to apply a meaningful disparate impact analysis that would take into account the disproportionate health and cost effects to women.²⁶

In Part V I consider why courts take this approach in light of the evidence presented of disparate effects and gender bias in Parts II and III of this Article.²⁷ Considering these benefits cases

21. See *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 807 (1973) (providing employees the opportunity to show that the explanation given by their employer for denying opportunities was merely pretextual or discriminatory).

22. See *infra* notes 207-232 and accompanying text.

23. *Id.*

24. See *infra* notes 161-232 and accompanying text.

25. See *infra* notes 233-294 and accompanying text.

26. See *infra* notes 235-294 and accompanying text.

27. See *infra* notes 293-347 and accompanying text.

within the larger context of Title VII litigation generally reveals two tensions that underlie this resistance: (1) judicial tendency to analyze reproductive health issues under a privacy rights paradigm as opposed to an equality paradigm;²⁸ and (2) misplaced fear by courts that plaintiffs are using the PDA to obtain special protection or entitlements for pregnancy, which would undermine the equality principles underlying Title VII.²⁹ I address these concerns by making clear that the dominant approach actually undermines the equality principles underlying Title VII.³⁰ In Part VI, I use the court's analysis in *Erickson* to demonstrate how a more protective model of Title VII should be used in challenges to reproductive health exclusions in order to achieve the promise of equality guaranteed in Title VII and the PDA.³¹

I. Title VII and the Pregnancy Discrimination Act

A. Basic Title VII Prohibition and Proof Structure

Title VII prohibits discrimination on the basis of sex in all aspects of employment, including discrimination with respect to the "compensation, terms, conditions, or privileges of employment."³² To make out a prima facie case, the plaintiff must allege that an employer intentionally treats men and women differently (disparate treatment)³³ or that the employer has a policy or practice that falls more harshly on men or women (disparate impact).³⁴

Where the employer has a policy that is facially discriminatory, the prima facie case for disparate treatment is easily made out.³⁵ However, in cases where a policy does not

28. See *infra* notes 293-347 and accompanying text.

29. See *infra* notes 307-313 and accompanying text.

30. See *infra* notes 314-342 and accompanying text.

31. See *infra* notes 348-363 and accompanying text.

32. 42 U.S.C. § 2000e-2(a)(1) (2000). The relevant provision states:

It shall be an unlawful employment practice for an employer [t]o fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment because of such individual's race, color, religion, sex, or national origin

Id.

33. See *L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 708 (1978).

34. See *Griggs v. Duke Power Co.*, 401 U.S. 424, 430 (1971) ("Under [Title VII] practices, procedures, or tests neutral on their face, and even neutral in terms of intent, cannot be maintained if they operate to 'freeze' the status quo of prior discriminatory employment practices.").

35. See, e.g., *Int'l Union v. Johnson Controls, Inc.*, 499 U.S. 187, 197-98 (1991)

facially treat men and women differently, a plaintiff may either present evidence showing that the employer intentionally adopted a policy for a discriminatory reason³⁶ or show that the policy's effects fall more harshly on one group than the other.³⁷

Once the plaintiff makes out the prima facie case, the burden shifts to the employer to rebut it in one of two ways. In either case, the employer may produce evidence of a legitimate, nondiscriminatory reason for the policy.³⁸ In disparate impact cases, the employer can also rebut the factual claim that the specific employment practice causes a significant adverse

(ruling that policy that excluded fertile women but not fertile men from a particular job involving lead exposure classifies by gender and childbearing capacity); *Dothard v. Rawlinson*, 433 U.S. 321, 331-32 (1977) (ruling that state regulation of height and weight requirements for maximum security prison guards that unfairly discriminated against women); *Wilson v. SW Airlines Co.*, 517 F. Supp. 292, 303-05 (N.D. Tex. 1981) (ruling on refusal to hire men for public contact positions of flight attendants and ticket agent to personify airlines' sexy image and promise to take passengers with love). Examples of this have occurred in the benefits context as well. See, e.g., a *Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1079-86 (1983) (explaining that the employer-sponsored pension fund in which women received lower monthly retirement benefits than male employees who contributed the same amount to the fund was a sex-based classification in violation of Title VII); *Manhart*, 435 U.S. at 712-15 (holding that policy requiring women to make larger contributions to an employer-operated pension fund than male employees discriminates on the basis of sex); see also EEOC Dec. No. 77-8 (Feb. 28, 1977) CCH EEOC Dec. ¶ 6563 (holding that providing group life insurance that provided for sex-based differences in death benefits, with women receiving greater benefits than men at each corresponding age level, violated Title VII); EEOC Dec. No. 70-513 (1970) CCH EEOC Dec. ¶ 6114 (holding that employer violated Title VII's prohibition against sex discrimination by refusing to pay death benefits to surviving spouses of deceased female employees while paying such benefits to surviving spouses of male employees.).

36. See, e.g., *Pers. Admin. v. Feeney*, 442 U.S. 256, 273 (1979).

37. See, e.g., *Dothard*, 433 U.S. at 331-32 (invalidating prison height and weight requirements for employment of guards because they disproportionately excluded women and were not justified by business necessity); *Wambheim v. J.C. Penney Co.*, 642 F.2d 362, 365-66 (Cal. 1981) (finding that employer's head-of-household rule, which allowed employees of both sexes to receive dependent medical benefits coverage for dependents if employee earned more than 50 percent of combined income of spouses, had a disproportionate impact on women); see also 42 U.S.C. § 2000e-2(k)(1)(A)(i) (1999). In a disparate impact claim, practices that are discriminatory in operation are illegal as well. *Griggs*, 401 U.S. at 431-32.

38. The employer merely has the burden of production. The burden then shifts back to the plaintiff to demonstrate that the reasons are mere pretext for discrimination. See *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 804-05 (1973). See 42 U.S.C. § 2000e-2(k)(1)(A)(i) which states that "An unlawful employment practice based on disparate impact is established . . . if a complaining party demonstrates that a respondent uses a particular employment practice that causes a disparate impact on the basis of race, color, religion, sex, or national origin and respondent fails to demonstrate that the challenged practice is job related for the position in question and consistent with business necessity . . ." "Demonstrate" is defined as meeting the burden of production and persuasion. 42 U.S.C. § 2000e(m) (2000).

disparate impact.³⁹

Title VII also creates affirmative defenses for employers.⁴⁰ In disparate treatment and impact claims, the employer will win if it can show that the sex-based characteristic is “a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.”⁴¹ For disparate impact claims, employers will win if they can prove that “the challenged practice is job-related for the position in question and consistent with business necessity.”⁴²

B. Title VII's Application to Benefits Exclusions and the History of the PDA

Title VII was originally enacted to address discrimination on the basis of race and color.⁴³ At the last minute, sex was added as a protected category in an attempt to derail the bill's passage.⁴⁴

39. 42 U.S.C. § 2000e-2(k)(1)(B)(ii). Typically, the rebuttal focuses on the quantitative aspects of the harm (i.e. how many men compared to women are hired, fired, or promoted). The employer may challenge the statistics used to show this disparity (such as whether the relevant pool of people was used for comparison, methods of gathering data, etc.). See, e.g., *AFSCME v. Doherty*, 169 F.3d 1068, 1070, 1075-76 (7th Cir. 1999) (describing that plaintiff presented evidence that an employer's layoff criteria disproportionately harmed black employees, and defendant tried to rebut plaintiff's evidence by showing that plaintiff had not accounted for all persons who were subject to the challenged practice). The employer may also challenge the plaintiff's claim about the significance of the disparity and whether it is enough to trigger a Title VII violation. *Id.*

40. See 42 U.S.C. § 2000e-2 (explaining unlawful employment practices).

41. 42 U.S.C. § 2000e-2(e). The Section provides that:

[I]t shall not be an unlawful employment practice for an employer to hire and employ employees . . . or for an employer . . . controlling apprenticeship or other training or retraining programs to admit or employ any individual in any such program, on the basis of his religion, sex or national origin in those certain instances where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.

Id. The bona fide occupational qualification (BFOQ) defense is available for both disparate impact and treatment claims; however, it is not available for claims of discrimination on the basis of race or color. *Id.*

42. 42 U.S.C. § 2000e-2(k)(1)(A)(i). The defense of business necessity is only available for disparate impact claims. *Id.* § 2000e-2(k)(2). There are three other possible defenses, but these only apply to professional development tests, bona fide seniority systems, and bona fide merit and piecework systems. See *id.* § 2000e-2(h).

43. See generally Rhonda M. Reaves, *One of These Things is Not Like the Other: Analogizing Ageism to Racism in Employment Discrimination Cases*, 38 U. RICH. L. REV. 839, 848-49 (2004).

44. See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1268-69 (W.D. Wash. 2001) (discussing the addition of “sex” to Title VII). See generally Jo Freeman, *How “Sex” Got into Title VII: Persistent Opportunism as a Matter of Public Policy*, 9 LAW & INEQ. 163 (1991); Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1283-84 (1991).

This attempt failed, and Title VII passed with sex included; however, there was no meaningful legislative discussion about the problems of sex discrimination in employment, the forms such discrimination took, or how it should be addressed.⁴⁵ Eventually, the U.S. Equal Employment Opportunity Commission ("EEOC") was charged to undertake a comprehensive study of these issues, and in 1972 it issued guidelines about what types of practices constituted Title VII violations.⁴⁶ The EEOC identified the unequal administration of health benefits as a form of discrimination against women, and it issued guidelines requiring employers to treat pregnancy the same as other conditions suffered by men and women for purposes of health and other benefit plans.⁴⁷ Based on these guidelines, women's advocates were optimistic that they could successfully challenge pregnancy-based exclusions under Title VII,⁴⁸ that is, until the Supreme Court issued a setback to these challenges in *General Electric Co. v. Gilbert*.⁴⁹

1. How *Gilbert* Led to the Birth of the PDA

In *Gilbert*, plaintiffs challenged an employer's benefit plan that excluded pregnancy-related disabilities from an otherwise comprehensive short-term disability policy under Title VII, based on both disparate treatment and impact claims.⁵⁰ In a divided opinion, the Court held that the exclusion did not constitute a sex-

45. See *Newport News Dock Co. v. EEOC*, 462 U.S. 669, 679-80 (1983) (citing H.R. REP. NO. 95-948, at 2, 8 (1978) and S. REP. NO. 95-331, at 7-8 (1977) (remarks of Sens. Williams, Javits, Mathias, Bayh and Reps. Sarasin and Hawkins); 124 CONG. REC. 21436 (1978); 123 CONG. REC. 10581, 29387, 39647, 29655 (1977)).

46. See H.R. REP. NO. 92-328, at 8 (1972). Interpretive guidelines were published in the Federal Register on April 20, 1979. 44 Fed. Reg. 23804-808 (1979).

47. See 29 C.F.R. §1604.10(b) (promulgated 1975) providing that:

[D]isabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom are, for all job-related purposes, temporary disabilities and should be treated as such under any health or temporary disability insurance or sick leave plan available in connection with employment [Benefits] shall be applied to disability due to pregnancy or childbirth on the same terms and conditions as they are applied to other temporary disabilities.

Id.

48. See Wendy W. Williams, *Equality's Riddle: Pregnancy and the Equal Treatment/Special Treatment Debate*, 13 N.Y.U. REV. L. & SOC. CHANGE 325, 335-36 (1985).

49. *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976); see *id.* at 145-46.

50. *Id.* at 127-28. Each of the respondents was pregnant and employed by General Electric in either 1971 or 1972, and each presented and was denied a claim for disability benefits to cover the period absent from work as a result of pregnancy. *Id.* at 128-29.

based classification under either theory.⁵¹ The majority's opinion focused on the disparate treatment claim and rejected it on primarily two grounds: (1) the lack of identity between the excluded benefits and gender; and (2) the facial parity that existed between men and women for the categories of benefits that were covered.⁵²

The majority found that because not all women would be adversely affected by the exclusion, there was a lack of identity between the pregnancy exclusions and gender.⁵³ The Court treated the classification as between pregnant and non-pregnant persons, the latter category containing both men and women.⁵⁴ Only pregnant women would be adversely affected, but non-pregnant women would be treated the same as men. The Court also found facial parity for men and women as there was no condition for which men were covered while women were not.⁵⁵ According to the majority, the fact that only women suffered the uncovered risk of pregnancy-related disability benefits was due to the biological fact that only women get pregnant; it was not due to intentional discrimination by the employer.⁵⁶ In a confusing part of the opinion that was essentially a restatement of its disparate treatment analysis, the Court also held that there was no disparate impact.⁵⁷

The Court concluded that because the policy exclusion did not constitute disparate treatment or impact, the plaintiff bore the burden of proving that the pregnancy exclusion was a mere pretext designed to effectuate an invidious discrimination against women.⁵⁸ According to the majority, the plaintiffs could not make this showing, despite an established history of explicit

51. *Id.* at 145-46.

52. *Id.* at 132-36. The Court borrowed the reasoning of a decision rejecting a similar challenge to a public employer's exclusion on equal protection grounds. *Id.* (adopting the reasoning of *Geduldig v. Aiello*, 417 U.S. 484 (1974)). In *Geduldig v. Aiello*, a similar disability program established under California law was challenged on the grounds that the benefit plan's exclusion of disability due to pregnancy constituted sex discrimination in violation of the Equal Protection Clause of the Fourteenth Amendment. 417 U.S. at 494-95. The Court rejected this claim holding that such pregnancy-based classifications do not constitute invidious discrimination under the Equal Protection Clause. *Id.*

53. *Gilbert*, 429 U.S. at 135. Justice Rehnquist's majority opinion followed *Geduldig's* conclusion regarding pregnancy rights. *See id.* at 133-34.

54. *Id.*

55. *Id.* at 137-40.

56. *Id.* at 138-39.

57. *Id.*

58. *Id.* at 136.

discrimination against female employees by the defendant.⁵⁹ The Court accepted the argument that the exclusion was justified because pregnancy was significantly different from the typical covered disease or disability.⁶⁰ The fact that pregnancy is "often voluntary and desired," as opposed to being an unwanted "disease" was one of the justifications accepted by the court.⁶¹

The majority's opinion sparked a stinging dissent, which criticized the majority for failing to think critically about the nature of the disability as sex-linked since only women would be affected by it.⁶² The dissent argued that the majority improperly focused on formal neutrality based on the parity of covered conditions and failed to look more comprehensively at the nature of the exclusions.⁶³ Rather than focusing on the equal inclusion of mutual risks, the majority should have compared the treatment of sex-specific conditions in order to determine the comprehensiveness of coverage for men versus women.⁶⁴ Using this approach, the dissent found the plan discriminatory on its face because it insured risks that were specific to the male reproductive system, such as prostatectomies, vasectomies, and circumcisions, but excluded pregnancy, a condition unique to women.⁶⁵

This led to the dissent's final criticism of the majority's analysis that the majority failed to critically examine the employer's history of discrimination against women in determining whether the exclusion was truly the result of a gender-neutral risk-assignment process.⁶⁶ For example, evidence showed that initially, General Electric did not even offer a benefit plan to female employees, because it believed that "women did not recognize the responsibilities of life [and] probably were hoping to get married soon and leave the company."⁶⁷ For the dissent, the sex-linked nature of the condition, coupled with the history of discrimination and stereotyping about female employees having children, led to the inevitable conclusion that the pregnancy

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.* at 148-49.

63. *Id.*

64. *Id.* at 152-53.

65. The dissent also cited to the EEOC guidelines for support that a pregnancy based exclusion constitutes a sex-based classification under Title VII. *Id.* at 157-58.

66. *Id.* at 148-50.

67. *Id.* at 150 n.1.

exclusion was a sex-based classification in violation of Title VII.⁶⁸

The dissent's view ultimately prevailed and in 1978, in response to *Gilbert*, Congress amended Title VII through the Pregnancy Discrimination Act of 1978.⁶⁹ The PDA amended the definition of discrimination to provide the following:

The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion⁷⁰

2. What the PDA Meant for Title VII Challenges to Benefits Exclusions

The PDA overturned *Gilbert* by "[making] clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions."⁷¹ This was acknowledged in 1983 by the Supreme Court in *Newport News Dock Co. v. EEOC*.⁷² *Newport News* was significant, however, because in its discussion of the PDA, the Court established two critical principles that should guide our application of Title VII and the PDA in

68. *Id.* at 153. The dissent concluded:

If the decision of this case, therefore, turns upon acceptance of the Court's view of General Electric's disability plan as a sex-neutral assignment of risks, or plaintiffs' perception of the plan as a sex-conscious process expressive of the secondary status of women in the company's labor force, the history of General Electric's employment practices and the absence of definable gender neutral sorting criteria under the plan warrant rejection of the Court's view in deference to the plaintiffs'. Indeed, the fact that the Court's frame of references lends itself to such intentional, sex-laden decision-making makes clear the wisdom and propriety of the EEOC's contrary approach to employment disability programs.

Id.

69. See *Newport News Dock Co. v. EEOC*, 462 U.S. 669, 679 (1983) (citing H.R. REP. NO. 95-948, 2nd Sess. at 2, 8 (1978) and S. REP. NO. 95-331, at 7-8 (1977); 124 CONG. REC. 21436 (1978); 123 CONG. REC. 10581, 29387, 39647, 29655 (1977) (remarks of Sens. Williams, Javits, Mathias, Bayh and Reps. Sarasin and Hawkins)).

70. 42 U.S.C. § 2000e(k) (2000).

71. *Newport News*, 462 U.S. at 684.

72. See *id.* at 669. This is the only other case decided by the Supreme Court which addresses the application of Title VII and the PDA to exclusions of pregnancy-related health benefits.

challenges to other benefits exclusions.

In *Newport News*, the plaintiff challenged an employer-sponsored medical plan that provided the same hospitalization coverage for female and male employees, but different coverage for their spouses.⁷³ The spouses of female employees were covered for hospitalization for all illnesses and other medical conditions, but the plan capped the amount of hospitalization benefits for pregnancy reimbursable for the spouses of male employees.⁷⁴ The Court concluded that coverage was less comprehensive on the basis of sex because only pregnancy-related benefits were capped, while non pregnancy-related benefits were not.⁷⁵ Specifically, the Court found that because the employer provided less comprehensive coverage for male employees' dependents than for female employees' dependents, the plan did not even "pass the simple test of Title VII discrimination [enunciated before the PDA]."⁷⁶

The Court went further to note that, through the enactment of the PDA, Congress "unequivocally" rejected the reasoning in *Gilbert*, including the facial parity test of discrimination employed by the *Gilbert* majority.⁷⁷ It emphasized courts' duty to compare the employer's treatment of sex-specific benefits among men and women to determine whether the employer is providing "comprehensive coverage" for both.⁷⁸ Through its rejection of the *Gilbert* majority's opinion, the *Newport News* Court established two important principles underlying Title VII and the PDA. First, it left no doubt that antidiscrimination law is an appropriate and viable tool for challenging benefits exclusions. One of the quirks in Title VII challenges to benefits exclusions is that, typically, benefit plans do not contain an explicit classification for the entire class of women or men. Rather these plans involve line-drawing about the type of medical conditions and treatments that will be covered. The PDA makes clear that this will not insulate such exclusions from Title VII scrutiny. One of the most important

73. *Id.* at 670.

74. *Id.* at 670-72.

75. *Id.* at 682-83.

76. *Id.* at 683-84. The test referred to is the one enunciated in *L.A. Department of Water & Power v. Manhart*. See *supra* notes 34, 36 and accompanying text; see also *Manhart*, 435 U.S. 702 (1978).

77. See also *Newport News*, 462 U.S. at 676, 679 (citing H.R. REP. NO. 95-948, 2nd Sess. at 2, 8 (1978) and S. REP. NO. 95-331, at 7-8 (1977) (remarks of Sens. Williams, Javits, Mathias, Bayh and Reps. Sarasin and Hawkins); 124 CONG. REC. 21436 (1978); 123 CONG. REC. 10581, 29387, 39647, and 29655 (1977)).

78. *Newport News*, 462 U.S. at 676.

principles established by the PDA and affirmed by the Supreme Court in a number of decisions is that existing inequalities in the insurance or health care industry cannot merely be absorbed into an employment-based health system under Title VII.⁷⁹

Second, *Newport News* affirms that exclusions of pregnancy-related benefits should be scrutinized closely because such exclusions can be easy proxies for discrimination and are likely motivated by gender bias. Indeed, both the 1972 EEOC guidelines and the legislative history of the PDA rely heavily on the fact that gender discrimination in employment has historically centered on women's ability to become pregnant and biases about a woman's right to control her fertility.⁸⁰

While the PDA appears to have established such powerful guiding principles, these principles have been at best watered-down, and at worst ignored or rejected by lower courts wrestling with challenges to other reproductive health benefits exclusions. Courts appear to have difficulty understanding how other reproductive health exclusions fit into a framework which arose out of a concern about traditional employment discrimination against pregnant women. Admittedly, the *Gilbert* and *Newport News* scenarios present the easy case. In each one, the benefit exclusion was for pregnancy, a unique, sex-based condition.⁸¹ However, prescription contraception and infertility exclusions present a challenge because each has gender-specific and gender-neutral elements.⁸² In Parts II and III, I will demonstrate why express policy exclusions of prescription contraception and infertility should, at a minimum, constitute a prima facie case of sex discrimination under Title VII, and why such exclusions are likely motivated by the type of gender bias that Title VII and the PDA were enacted to eliminate.⁸³

79. See *Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1073, 1083, 1088 (1983) (holding that Title VII requires treatment of employees as individuals, not class members); *Newport News*, 462 U.S. at 669, 685; *Manhart*, 435 U.S. 702, 716-17 (noting that Title VII has no affirmative defense for price discrimination by cost justification).

80. See *Gilbert*, 429 U.S. at 157-59; see also *Newport News*, 462 U.S. at 676, 679 (citing Congress H.R. REP. NO. 95-948, 2nd Sess. at 2, 8 (1978) and S. REP. NO. 95-331, at 7-8 (1977); 124 CONG. REC. 21436 (1978); 123 CONG. REC. 10581, 29387, 39647, 29655 (1977) (remarks of Sens. Williams, Javits, Mathias, Bayh and Reps. Sarasin and Hawkins)).

81. See *supra* notes 50-57, 73-78 and accompanying text (describing the cases in detail).

82. See *infra* notes 85-120 and accompanying text (discussing contraception and infertility and how each relates to men and women).

83. See *infra* notes 85-232 and accompanying text.

II. Disparate Treatment and Disparate Impact in Prescription Contraception and Fertility Exclusions

A comprehensive background of the forms and effects of treatment designed to control fertility is necessary in order to understand how apparently gender-neutral reproductive health exclusions can result in different treatment of, or effects on, women and men.⁸⁴

A. Medical Information and Insurance Coverage Trends of Prescription Contraceptives and Infertility

1. Prescription Contraception

The primary purpose of prescription contraception is to prevent conception,⁸⁵ however, certain types of contraception can serve other purposes as well. In women, the birth control pill helps to prevent ovarian and endometrial cancer and provides relief from menstrual symptoms, such as irregular bleeding and severe cramping.⁸⁶ For both men and women, barrier methods of contraception, such as the diaphragm and male and female condoms, help prevent the spread of sexually transmitted disease.⁸⁷

Prescription contraception comes in several different forms including the birth control pill, the diaphragm, intrauterine devices (IUDs), and Norplant (capsules implanted into the woman's skin containing the hormone progesterin).⁸⁸ These forms of contraception are only available to women and are reversible. Surgical sterilization, a form of contraception available to men through vasectomies and women through tubal ligations, entails greater risk than the other forms of contraception and is considered irreversible.⁸⁹ Statistics from a study published in

84. See *infra* notes 84-232 and accompanying text.

85. See Jill L. Schwartz & Henry L. Gabelnick, *Current Contraceptive Research*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 30 (2002), available at www.guttmacher.org/pubs/journals/3431002.html (last visited Mar. 8, 2005).

86. Ronald Burkmann et al., *Safety Concerns and Health Benefits Associated with Oral Contraception*, 190 AM. J. OBSTETRICS & GYNECOLOGY 55, 512-15 (2004). The article lists other emerging benefits of oral contraception as well. See *id.* at 515-19.

87. Swartz & Gabelnick, *supra* note 85, at 310. These methods are less effective than others at preventing pregnancy. See *Contraceptive Method Effectiveness*, Engenderedhealth.org, at <http://www.engenderhealth.org/wh/fp/ceff.html#barrier> (last visited Mar. 8, 2005).

88. See Swartz & Gabelnick, *supra* note 85, at 310-15.

89. Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73

1998 show that 49 percent of traditional indemnity plans covered no reversible prescription contraceptives, with only 15 percent of plans covering all of the most commonly used methods.⁹⁰ Ironically, many of these plans covered sterilization for men and women.⁹¹

The coverage of prescription contraception has undergone quite a change over the last several years due in part to the emergence of managed care. In recent years, many states have also enacted laws mandating insurance coverage of all FDA-approved prescription contraceptives where the insurer covers other prescription drugs.⁹² Nonetheless, gaps in coverage persist. For example, some states only mandate coverage for certain types of contraceptives or require only that insurers give employers the option of purchasing contraceptive coverage, which employers often reject.⁹³ In addition, many of these laws only apply to certain types of insurers, such as health maintenance organizations (HMO) or plans for individuals or small groups.⁹⁴ Thus, many fee-for-service plans still do not provide coverage for contraception, forcing employees to choose between an HMO with prescription contraceptive coverage and a traditional fee-for-service plan without it. Finally, even where states have mandated coverage, state laws may not apply because of the Employee Retirement Income Security Act of 1974 (ERISA),⁹⁵ a federal law that regulates employment-based benefits and which has been interpreted to exempt self-insured employers from state mandates for benefits.⁹⁶

2. Infertility Treatment

Infertility is defined as the inability to conceive after one year of unprotected sexual intercourse or the inability of the woman to carry a pregnancy to term due to some breakdown in the

WASH. L. REV. 363, 368-69 (1998).

90. ALAN GUTTMACHER INST., *UNEVEN & UNEQUAL: INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES* 4 (1995) [hereinafter *UNEVEN & UNEQUAL*].

91. *Id.* at 9, 12.

92. *Id.* at 9.

93. *Id.*; see also Eve Gartner, Plaintiff's Counsel in *Erickson v. Bartell*, Remarks at the American Association of Law School Employment Law Panel Discussion on Coverage of Prescription Contraception (Jan. 6, 2004) [hereinafter Gartner's Remarks].

94. *UNEVEN & UNEQUAL*, *supra* note 90, at 9.

95. 29 U.S.C. §§ 1001-1461 (2000).

96. Rebecca Porter, *EEOC Rules Employers Must Cover Contraceptives*, TRIAL, Mar. 2001, at 94.

reproductive process of either the woman, man, or both.⁹⁷ Identifying the source of the problem and appropriate treatment can be very complex. The successful functioning of the reproductive process depends on many factors. Specifically, men must be able to produce healthy sperm, deliver this sperm to the woman for fertilization, and the sperm must be able to fertilize the egg upon meeting.⁹⁸ Women must be able to produce healthy eggs, have unblocked fallopian tubes that allow the sperm to reach the egg, and have the ability to allow the fertilized egg to become implanted in their uterus.⁹⁹ Infertility can occur when any part of this process is not working.¹⁰⁰ Practically, this means that in some cases the woman never achieves pregnancy; in others, the woman becomes pregnant, but cannot carry the baby to term, resulting in miscarriage.¹⁰¹

In both women and men, problems in the reproductive process can be either hormonal or structural or both.¹⁰² About 40 percent of the time, female infertility problems result from ovulation or hormonal disorders, such as irregular periods or decreased ovulation.¹⁰³ Infertility can also be the result of structural damage to the reproductive organs, such as a surgery in the pelvic area causing scar tissue and damage to the fallopian tubes.¹⁰⁴

For men, infertility can occur in one of two main areas: sperm production or sperm delivery.¹⁰⁵ Production problems result primarily from damaged or malformed testicles or structural abnormalities in the varicocele, duct of the epididymis, vas

97. THE STAFF OF RESOLVE & DIANE ARONSON, *RESOLVING INFERTILITY: UNDERSTANDING THE OPTIONS AND CHOOSING SOLUTIONS WHEN YOU WANT TO HAVE A BABY* 5 (1999) [hereinafter *RESOLVING INFERTILITY*]. This definition of infertility assumes heterosexual intercourse, which has implications for the rights of same sex couples and single individuals who desire infertility treatment. While the issue of discrimination on the basis of sexual orientation and marital status is beyond the scope of this Article, see Lisa C. Ikemoto, *The In/Fertile, the Too Fertile, and the Dysfertile*, 47 *HASTINGS L.J.* 1007 (1996) for an important discussion of this topic.

98. See *RESOLVING INFERTILITY*, *supra* note 97, at 34.

99. See *id.* at 21-30.

100. See *id.* at 5.

101. See *id.*

102. See *id.* at 89-174.

103. *Id.* at 89. For a detailed discussion of such hormonal disorders, see *id.* at 89-119.

104. See *id.* at 15, 121-53. Structural damage can also be caused by sexually transmitted diseases.

105. See *id.* at 30.

deferens, or ejaculatory ducts.¹⁰⁶ Male infertility may also be developmental or caused by an unrelated illness such as a sexually transmitted disease, kidney disease, or mumps.¹⁰⁷ Fertility problems in men are hormonal only about 10 percent of the time.¹⁰⁸

Infertility can be caused by medical treatment for unrelated problems. For example, one common cause of infertility is cancer treatment, such as chemotherapy or radiation.¹⁰⁹ Exposure to other environmental toxins or harmful substances, such as alcohol, tobacco, caffeine, and certain illicit drugs can also impair infertility.¹¹⁰ Finally, age can be a factor affecting infertility in men and women.¹¹¹

Different treatments are used either to correct or bypass infertility depending on the source of the problem. Infertility treatment generally falls into three main categories: (1) testing designed to diagnose and monitor infertility problems and treatment (for example, ovulation kits, blood/semen analysis, ultrasound);¹¹² (2) treatment designed to correct the actual structural or functional problem that is the source of the infertility (for example, fertility drugs used to correct hormonal imbalance in men or women or surgery to correct endometriosis in women or blocked vas deferens in men);¹¹³ (3) treatment designed to aid reproduction without sexual intercourse (for example, in vitro

106. See *id.* at 159-70. A varicocele is a bundle of enlarged veins in the scrotum. *Id.* They can impede sperm production due to increased blood to the area and an increase in temperature, which can only be discovered through a diagnostic work up. *Id.* Forty percent of infertile males have a varicocele. *Id.*; see also Fran Worrall, *Male Infertility 'A Common Problem' But Treatable*, ATLANTA J. CONST., June 10, 2003, available at <http://www.ajc.com/health/content/health/special/0603/10infertility.html> (last visited Mar. 31, 2005).

107. Worrall, *supra* note 106.

108. RESOLVING INFERTILITY, *supra* note 97, at 30.

109. "DES daughters" experienced infertility for a different reason. *Id.* at 15. These are women whose mothers were prescribed the drug Diethylstilbestrol (DES) while pregnant to lower the risk of miscarriage. *Id.* Unfortunately, it caused severe medical problems later in life for the daughters exposed to the drug in utero, including genital cancer and fertility problems. *Id.*

110. See *id.* at 15. For example, many workplace hazards, such as prolonged or extensive exposure to lead, chlorinated hydrocarbons, and ionizing radiation, can damage the reproductive system. *Id.*

111. See *id.* at 14, 148-49. Both sperm motility and egg production tend to decrease with age, though for women the decline is much more dramatic. *Id.*

112. See *id.* at 63-88 (describing the first steps in infertility treatment).

113. The term "fertility drugs" describes the hormonal preparations used to treat female infertility, either to stimulate ovulation or support the uterine lining in women where the problem is implantation or failure to carry the pregnancy to term. GEOFFREY SHER ET AL., *THE A.R.T. OF MAKING BABIES* 201 (1998). However, some of these drugs are also used to enhance male sperm function and production. *Id.*

fertilization (IVF)).¹¹⁴

Diagnosing and monitoring infertility can be a very involved process and requires sex-specific treatment for men and women. For men, testing focuses on the prostate examination and semen analysis.¹¹⁵ For women, the diagnosis usually involves more extensive and invasive testing, that may include a pelvic examination, repeated testing to monitor body temperature and ovulation, transvaginal ultrasound, and x-ray of the fallopian tubes and uterus.¹¹⁶

Treatment to correct or bypass infertility is even more varied and complex. Conventional treatments, including lifestyle changes (losing weight, cessation of certain drugs or alcohol, etc.), surgery, or fertility drugs are generally recommended before resorting to assisted reproductive technology.¹¹⁷ Assisted Reproductive Technology (ART) describes "all treatments or procedures that involve the handling of human eggs and sperm for the purpose of helping a woman become pregnant."¹¹⁸ In-vitro fertilization (IVF) is the most commonly known ART, and can be used to bypass infertility problems in cases where conventional treatment may not be effective.¹¹⁹ While IVF focuses on the woman, it can be used to bypass either male or female infertility or

114. In some cases, infertility may be due to an infection or disease that could be transmitted from the father or mother to the fetus. Assisted reproductive technology can serve an important purpose in these cases, since it enables reproduction while preventing the spread of HIV to the mother and fetus where the father is HIV-positive. See *Highlights in Fertility & Sterility: For Couples Trying to Conceive When the Male Partner is HIV-Positive, Enhanced Technique Provides Greater Assurance that Washed Sperm is Virus-Free* (2002), American Society for Reproductive Medicine, at <http://www.asrm.org/Professionals/Fertility&Sterility/highlights/highlights.html> (last visited Mar. 8, 2005).

115. See RESOLVING INFERTILITY, *supra* note 97, at 80-87 (describing the complete medical workup performed on men).

116. See *id.* at 63-80 (describing the complete medical workup performed on women).

117. See *id.* at 176-96 (explaining Assisted Reproductive Technology (ART) and the decision-making process before undertaking ART). Despite the prominence of IVF, according to statistics by American Society for Reproductive Medicine, it currently accounts for less than 3 percent of all infertility treatment in the U.S. AM. SOC'Y OF REPROD. MED., FREQUENTLY ASKED QUESTIONS ABOUT INFERTILITY, at <http://www.asrm.org/Patients/faqs.html> (last visited Mar. 31, 2005). About 85 to 90 percent of most infertility cases are treated with drug treatment or surgical repair of reproductive organs. *Id.*

118. RESOLVING INFERTILITY, *supra* note 97, at 175 (citing the U.S. Centers for Disease Control and Prevention).

119. In IVF, eggs are surgically removed from the ovary and mixed with sperm outside the body in a petri dish. *Id.* at 176. If the eggs become fertilized, they are then surgically implanted into the woman's uterus. *Id.*

both.¹²⁰

Employers and insurance companies have a great deal of discretion regarding coverage of infertility benefits because only fourteen states have laws regulating coverage.¹²¹ However, these laws merely require insurers either to cover or *offer* some form of infertility diagnosis and treatment.¹²² Thus, infertility treatment exclusions vary by employer and the type of treatment excluded is not always clear from the express terms of the exclusion.¹²³ For example, many insurance plans cover testing to diagnose the cause of infertility, but exclude treatment designed to correct the problem or monitor a woman's health during treatment.¹²⁴ Some plans only exclude assisted reproductive technology procedures, such as IVF.¹²⁵ Many plans have blanket exclusions for infertility treatment, the effects of which are not clear cut. These provisions appear to exclude any service or device relating to fertility; however, where the medical condition causing infertility may have other harmful effects, treatment may be covered as necessary for reasons unrelated to fertility.¹²⁶ Surgery for structural problems

120. For example, one article describes a man born without a right or left vas deferens, the tubes that transport sperm from the testicles to the urethra. See Worrall, *supra* note 106. This problem occurred as a result of his cystic fibrosis. *Id.* In this case, the man's body was producing sperm but had no way to transport it to fertilize an egg. *Id.* So he and his wife underwent IVF using a procedure called intracytoplasmic sperm injection (ICSI) in which sperm are retrieved via needle aspiration and individually injected into a female's mature eggs. *Id.* The eggs were successfully fertilized and implanted. *Id.*

121. AM. SOC'Y OF REPROD. MED., STATE INFERTILITY INSURANCE LAWS, *supra* note 117 (noting that the states are: Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas and West Virginia). An example of very protective legislation is a New Jersey statute which states that a hospital service corporation that provides pregnancy benefits cannot be issued unless it includes medically necessary expenses for the diagnosis and treatment of infertility. N.J. STAT. ANN. § 17:48-6x (West 2001). It must include, without limitation, diagnostic testing, medication, surgery, artificial insemination, IVF, embryo transfer, GIFT, ZIFT, and ICSI. *Id.* Covered treatments involving egg retrieval are limited to persons who have tried all reasonable, less expensive medically appropriate treatments, but who are still unable to become pregnant or carry a pregnancy. *Id.* There is a limit of four egg retrievals per patient and retrievals are only covered for patients forty-five years old or younger. *Id.*

122. AM. SOC'Y OF REPROD. MED., *supra* note 117.

123. *Id.*

124. *Id.*

125. See *infra* notes 280-292 and accompanying text (discussing a case in which the insurance policy at issue specifically exempted IVF).

126. See *infra* notes 251-294 and accompanying text (discussing *Krauel v. Iowa Methodist Med. Ctr.* and *Saks v. Covey*). For example, endometriosis is a condition in women that can cause other severe health problems including excessive bleeding and pelvic pain. SHER ET AL., *supra* note 113, at 200. Thus a plan that expressly

falls into this category and will often be covered despite express infertility exclusions. Treatment such as fertility drugs, ovulation kits, and IVF, however, would be excluded.¹²⁷

B. Satisfying the Prima Facie Case for Title VII as Amended by the PDA

1. Is the Policy Facially Discriminatory?

Under the test of discrimination first enunciated by the *Gilbert* dissent, and subsequently adopted by the Supreme Court in *Newport News*, an exclusion that only affects one sex is a sex-based classification.¹²⁸ Thus, where an employer excludes only forms of fertility treatment and contraception available to women, a disparate treatment claim can be made out. In the case of prescription contraception, this means that plaintiffs could easily challenge many of the insurance plans described above on disparate treatment grounds because they exclude only forms used by women, while covering surgical procedures used by men and women.¹²⁹ The differential treatment becomes even clearer when we consider the non-contraceptive purposes of the "birth control" pill, such as tempering the symptoms of menstruation and acting as a preventive measure against certain types of cancer.¹³⁰ In these circumstances, excluding the pill from coverage means that women are denied medically necessary treatment, whereas men would have access to treatment for a comparable condition.¹³¹ In light of these trends, it seems unnecessary to consider a disparate impact claim for prescription contraceptive exclusions. However, if a plan excludes *all* prescription contraceptive treatment, not just that used by women, the link between gender and excluded treatment required by Title VII seems tenuous. Moreover, focusing on the form of treatment as sex-linked may be limiting in the future, since advances in technology may make prescription

excludes infertility treatments may still cover surgery to correct endometriosis. Where a man suffers from impotence, Viagra and penile implants may still be covered as medically necessary to alleviate sexual dysfunction, regardless of its relationship to infertility.

127. *Id.*

128. See *supra* notes 32-82 and accompanying text (describing Title VII and the Pregnancy Discrimination Act).

129. See *supra* notes 86-96 and accompanying text.

130. See *supra* note 86 and accompanying text.

131. See, e.g., *infra* notes 236-243 and accompanying text (discussing a case in which the plaintiff sued for reimbursement of the costs for birth control pills to treat hormonal imbalance).

contraception available to men and women.¹³² Therefore, a disparate impact argument should be considered.¹³³

Infertility exclusions in policies probably could not be challenged as facially discriminatory because, as noted above, most are blanket exclusions that affect men and women.¹³⁴ An argument has been made that policies excluding only assisted reproductive technology are facially discriminatory because the excluded treatment is technically only performed on women. This argument is unlikely to be successful, however, because it relies on an incomplete picture of assisted reproductive technology (ART) which is used to circumvent both male and female fertility problems and often encompasses procedures that involve the male.¹³⁵ Consequently, a disparate impact claim is more suitable for challenging such exclusions.¹³⁶

2. Do Reproductive Health Exclusions Create a Disparate Impact on Women?

a. Cost

The most obvious claim of disparate impact for both prescription contraception and infertility exclusions is based on cost. The forms of prescription contraception excluded are either exclusively or predominantly those used by women, creating a greater burden on women who bear the cost of treatment—approximately \$300 to \$500 per year.¹³⁷ While this amount may seem insignificant, for many women it is prohibitive.¹³⁸ As I will

132. See generally *Male Contraceptive Tests Positive*, CNN, Oct. 6, 2003, at <http://www.cnn.com/2003/HEALTH/10/06/male.pill/> (last visited Mar. 8, 2005) (stating that it would be five to ten years before a male contraceptive was available commercially); *Your Health—Male Contraceptive Pill on the Horizon?*, CNN, Sept. 8, 2000, at <http://archives.cnn.com/2000/HEALTH/09/08/your.health.male/> (last visited Mar. 3, 2005) (predicting that a male contraceptive pill could be available by 2005).

133. See *infra* notes 137-196 and accompanying text (undertaking a disparate impact analysis).

134. See *supra* notes 121-124 and accompanying text.

135. One example is where sperm aspiration or extraction procedures are used to retrieve sperm. See *RESOLVING INFERTILITY*, *supra* note 97, at 187 (explaining that when the man cannot produce sperm in his ejaculate, invasive procedures can be used to obtain the sperm directly from the testicle (Testicular Sperm Extraction) or from the epididymis (Microsurgical Epididymal Sperm Aspiration)).

136. See *infra* notes 137-196 and accompanying text (considering a disparate impact claim relating to infertility treatment coverage).

137. See Schwartz & Gabelnick, *supra* note 85, at 310 (describing the possible costs of oral contraceptives and other forms of female birth control).

138. There are several studies that demonstrate that lack of insurance coverage

discuss below, where the cost of prescription contraception is prohibitive, the result is an even more serious harm—denial of treatment to prevent conception effectively.

At first glance, it may be less obvious that infertility exclusions create disparate cost effects because, unlike pregnancy, infertility exclusions affect men and women. Measuring disparities in cost to women and men for infertility treatment is difficult since it depends in part on the nuances of the particular insurance plan and data about the costs of various types of treatment. From the above discussion, however, it should be clear that even blanket exclusions of infertility treatment can result in a greater financial burden on women. First, women have to undergo many more tests and procedures in the process of diagnosis and treatment, even when male infertility is the source of the problem.¹³⁹ Second, even blanket exclusions are practically more likely to exclude treatment for female-infertility, such as fertility drugs to correct hormonal problems, than male-specific treatment. This is because surgery used to correct structural problems, which is more often the cause of male infertility, can conceivably be covered as necessary to treat a medical condition unrelated to infertility.¹⁴⁰ The result of this differential treatment is significant since infertility is hormonal in women 30 percent of the time, but only about 10 percent of the time in men.¹⁴¹ Thus, despite the apparent facial neutrality, there can be disparate cost effects that fall more harshly on women.

affects one's access to treatment. See, e.g., ALINA SALGANICOFF ET AL., KAISER FAMILY FOUND. & CTR. FOR HEALTH POL'Y RES., WOMEN'S HEALTH IN THE UNITED STATES: HEALTH COVERAGE AND ACCESS TO CARE vii (May 2002) (finding that costs related to health care and prescription drugs present significant barriers for women); Law, *supra* note 89, at 368-69 (discussing a 1998 study by the Alan Guttmacher Institute showing that sterilization was the most commonly used form of contraception in the United States, despite the fact that the birth control pill is an effective, reversible and safe form of contraception, and that this is probably due to the fact that more plans covered sterilization and failed to cover other methods of birth control); Schwartz & Gabelnick, *supra* note 85; see also *McRae v. Califano*, 491 F. Supp. 630, 668-73, 690 (E.D.N.Y. 1980). But see, e.g., Ernest F. Lidge III, *An Employer's Exclusion of Coverage for Contraceptive Drugs is Not Per Se Sex Discrimination*, 76 TEMPLE L. REV. 533, 568 (2003) (arguing that the cost differential probably is not a significant enough disparity to make out a Title VII claim).

139. See *supra* note 116 and accompanying text.

140. See RESOLVING INFERTILITY, *supra* note 97, at 64 (1999) (describing that structural deficiencies that were not only linked to fertility are more prevalent in male infertility than female infertility).

141. *Id.*

b. Health Effects

Exclusions of prescription contraception and infertility treatments can also result in very serious health risks for women. The failure to prevent conception has obvious unique physical effects on women since only women get pregnant and suffer the physical risks that accompany pregnancies. Where a patient has a medical condition or illness that would be aggravated by carrying a fetus to term, contraception would be necessary not only to prevent pregnancy, but also to protect the woman's health or life.¹⁴²

Even where a patient does not have a medical condition that could be aggravated by pregnancy, the ability to prevent and control the timing of pregnancy is an important health issue for women. For example, studies show a link between unintended pregnancy and rates of infant mortality and morbidity.¹⁴³ Studies also point to the disproportionate toll unwanted pregnancies take on women socio-economically: a woman's inability to prevent pregnancy can effectively undermine her attempts to become stable economically and to control how and in what ways she will contribute to society.¹⁴⁴ Economic instability also explains the higher risks to both mother and child's physical health in cases of unwanted pregnancy since a lack of planning may mean that the woman does not have the resources to respond to the demands of pregnancy and infancy. Even where unintended pregnancies end in abortion, women can suffer severe emotional, physical, and financial burdens that men do not.¹⁴⁵

Less well known are the disparate health effects that occur with infertility exclusions.¹⁴⁶ It is true that for both men and women, there is a gender-neutral effect of the exclusion—denial of treatment needed to correct or bypass an infertility problem.¹⁴⁷

142. See *McRae v. Califano*, 491 F. Supp. 630, 670 (E.D.N.Y. 1980) (describing the number and types of illnesses that can be aggravated by pregnancy).

143. See Law, *supra* note 89, at 365-66.

144. *Id.* at 364-68

145. *Id.*; see also ALAN GUTTMACHER INST., CONTRACEPTIVE USE: FACTS IN BRIEF, at http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Mar. 31, 2005) [hereinafter CONTRACEPTIVE USE] ("Unintended pregnancies among women who do not use a method of birth control are almost as likely to end in abortion as in birth.")

146. The link between denial of coverage and access is also clear in the infertility context. Statistics show that people needing IVF, for example, are not seeking it due to lack of insurance. See Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 NEW ENG. J. MED. 661 (2002).

147. At least one source argues that traditional options are only effective for about 50 percent of infertile couples, but for the remaining 50 percent, IVF may be

For both men and women, this denial can also create significant emotional effects from the failure to have a child.¹⁴⁸ Nonetheless, there are gender-specific effects that result, and, as with prescription contraception, the relationship of the treatment to pregnancy plays a critical role in understanding these effects.¹⁴⁹

First, many individuals without infertility coverage choose to pursue treatment despite the lack of insurance, paying out of pocket.¹⁵⁰ While this might appear to minimize claims of disparate health effects, a recent study has shown that even in such cases, women may suffer adverse health effects as a result of the insurance exclusion.¹⁵¹ In 2002, the *New England Journal of Medicine* published the results of a study to determine the utilization and outcomes of IVF services according to the status of insurance coverage.¹⁵² One of the most significant findings was that lack of insurance coverage may adversely affect the type of infertility treatment received by women, which could in turn create potential health risks to women and their fetuses.¹⁵³ Researchers found that in states without mandated coverage for IVF, a greater number of embryos were transferred per cycle and there were higher rates of multiple births, especially of three or more infants.¹⁵⁴ The authors speculated that in states without mandated coverage, physicians may be transferring more embryos per IVF cycle because of the financial pressure to achieve a "successful" outcome the first time.¹⁵⁵ Given the increased risk of multiple births when more embryos are transferred per cycle, this has significant implications for maternal and fetal health. First, multiple births increase the short- and long-term health risks for the pregnant woman, including premature labor, premature delivery, pregnancy-induced hypertension, gestational diabetes,

the only recourse. See SHER ET AL., *supra* note 113, at 2-3. However, as noted earlier, IVF currently only accounts for 3 percent of infertility treatments. See *supra* note 117.

148. See RESOLVING INFERTILITY, *supra* note 97, at 40-42 (describing emotional effects of inability to bear children).

149. See *infra* notes 151-160 and accompanying text.

150. See SALGANICOFF, *supra* note 138, at viii. But see JACK HADLEY, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE COST OF NOT COVERING THE UNINSURED PROJECT 6 (May 2002) (noting that pregnant women may wait to receive prenatal treatment until they have insurance).

151. See Jain et al., *supra* note 146, at 665 (describing the risks associated with transferring more embryos per cycle, a practice more common in states that do not require insurance coverage for IVF than those that do).

152. *Id.* at 661.

153. *Id.*

154. *Id.*

155. *Id.*

and uterine hemorrhage.¹⁵⁶ Moreover, children born of multiple births are at greater risk for respiratory distress, intracranial hemorrhage, cerebral palsy, and blindness due to prematurity, as well as increased risk of death, and physical, mental, and developmental disabilities.¹⁵⁷

Alternatively, if denial of coverage causes individuals to forgo treatment, women suffer additional consequences that men do not. Where a woman is able to conceive, but cannot carry the pregnancy to term, denying treatment means that the woman may continue to suffer the health risks and emotional devastation of repeated miscarriages.¹⁵⁸ Regardless of whether the infertility occurs in this way or results in an inability to conceive at all, some have argued that there is still a unique consequence that results from the woman's inability to have the physical and emotional experience of pregnancy and ultimately to bear a child.¹⁵⁹ Both men and women who have suffered through this process have testified to the unique and particularly isolating pain that women suffer, due in part to the reality that for many women, their self-image and society's image of them is strongly tied to the ability to have a child.¹⁶⁰

156. *Id.*

157. The study also noted that such policy exclusions have an indirect effect on the quality of reproductive health care. *Id.* at 665. The normal trend for new medical treatments that are costly in the beginning is that they become less costly and more effective with more frequent use and the technology and physicians' expertise are refined. One of the factors affecting utilization of medical treatment is insurance coverage and reimbursement. This trend is no less true in the IVF context. With insurance coverage comes increased utilization by patients, and as demand increases, more clinics open and more procedures are performed, which will ultimately lead to improved access and quality. *Id.* The authors of the study note that currently, as a result of a lack of reimbursement, not many procedures are being performed, and of those that are, they are spread among a number of clinics that may be performing fewer than 100 procedures per year. *Id.* This leads to questions about the quality of care being delivered. This has a unique health effect on women since better quality care means reducing the number of IVF trials and physical burdens for women, as well as helping to reduce multiple births which pose health risks to women and their fetuses. *Id.*; see also SHER ET AL., *supra* note 113, at 46.

158. ELLEN SARASOHN GLAZER, EXPERIENCING INFERTILITY: STORIES TO INFORM AND INSPIRE 118-23 (1998).

159. See, e.g., ELLEN SARASOHN GLAZER & SUSAN LEWIS COOPER, WITHOUT CHILD: EXPERIENCING AND RESOLVING INFERTILITY (1998) [hereinafter WITHOUT CHILD].

160. See generally *id.* One man's testimony about his own experience bears this out:

One of the most important realizations we came to out of our struggles was that it is impossible to compare losses. It seems true, as much of the research suggests, that women who do not become successfully pregnant lose a more intimate and profound physical experience than do men who

Thus, at a minimum, evidence of the forms of treatment excluded and the disparate cost and health effects of reproductive health exclusions should satisfy the prima facie case for a Title VII violation and shift the burden to the employer to justify the exclusions. This gives plaintiffs the opportunity to challenge such justifications as pretext for bias.

III. Burden Shifting: Are Employers' Justifications a Pretext for Gender Discrimination?

Exposing hidden bias is probably the biggest hurdle to overcome in convincing courts that reproductive health exclusions are really a proxy for gender discrimination. In Section A, I explore the broad forms that gender discrimination has taken in health care and employment contexts.¹⁶¹ Gender discrimination has historically been rooted in an ideology of women's proper reproductive and sexual roles, one that devalues women's sexual freedom or prioritize career over childbearing.¹⁶² Denying women access to treatment that which enables them to have sex without the consequences pregnancy and to control the timing of pregnancy is a logical extension of this kind of discrimination. Such covert bias may be difficult, if not impossible, for the plaintiff to prove in most instances. This is precisely why the burden-shifting component is so critical. In Section B, I will show how a close examination of common justifications for such exclusions further strengthens my contention that hidden bias, not legitimate medical or policy distinctions, is the real motivating factor.¹⁶³

A. Evidence of Bias in Health Care and Employment

1. The Health Care Industry

As already noted above, existing gender discrimination in the insurance industry cannot merely be absorbed into an employer's benefits scheme without violating Title VII. It is difficult to know whether in fact this has happened simply by looking at the benefit excluded. A closer look at the health care industry more broadly provides context needed to understand how reproductive health

do not sire a child. There is also evidence to show that now, as in earlier times, women are more stigmatized for a failure to bear children than are men for not siring them.

Id. at 41.

161. See *infra* notes 164-206 and accompanying text.

162. See *infra* notes 164-196 and accompanying text.

163. See *infra* notes 207-232 and accompanying text.

exclusions may be part of a larger pattern of discrimination against women.

Numerous studies have documented gender discrimination, conscious and subconscious, at all levels of health care, from the exclusion of adequate numbers of women as clinical research subjects¹⁶⁴ to disparities in the delivery of health care.¹⁶⁵ This discrimination is most pronounced in the area of women's reproductive health.¹⁶⁶ Prior to the PDA, many private and public disability and health insurance plans treated pregnancy worse than other medical conditions based on the notion that pregnancy was not an illness or disease, but was a voluntary or desired condition.¹⁶⁷ In this way, the significant medical effects and risks involved in even normal pregnancies were overshadowed by the characterization of pregnancy as a moral or personal "choice" about whether to have a child.¹⁶⁸

At the same time, a different trend was occurring in the public benefits context. Social activists were successfully pushing for laws that would provide support to indigents, and in this context, the importance of ensuring access to pregnancy care was prominent.¹⁶⁹ In fact, the health needs of pregnant women and mothers were the focal point of public health and welfare laws designed to protect women:

[A] review of major federal legislation related to women's health show[s] that virtually all of women's health entitlements and rights have revolved around women's roles as bearers and caregivers of children. For example, at different historical points, the federal government has

164. See Caroline W. Jacobus, *Legislative Responses to Discrimination in Women's Health Care: A Report Prepared for the Commission to Study Sex Discrimination in the Statutes*, 16 WOMEN'S RTS. L. REP. 153, 312-13 (1995); Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women's Health Care*, 32 HOUS. L. REV. 1201, 1202-10 (1996).

165. See, e.g., Kevin A. Schulman et al., 340 NEW ENG. J. MED. 618, 618-19 (1999) (discussing a controlled experiment finding that the race and sex of patients influence how physicians manage chest pain); see also Carol Jonann Bess, *Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease*, 6 HAST. WOMEN'S L.J. 41, 41-43 (1995); Jacobus, *supra* note 164, at 309-13; Rothenberg, *supra* note 164, at 1210-17; Jacobus, *supra* note 164, at 309-13.

166. See Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 186-98 (1999); Jacobus, *supra* note 164, at 267-71.

167. See *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125, 151 (1976) (Blackmun, J., concurring in part).

168. This clearly does not account for pregnancy due to rape or in circumstances where the birth control method used was not successful.

169. ANDREA TONE, *DEVICES AND DESIRES: A HISTORY OF CONTRACEPTIVES IN AMERICA* 261-62 (2001).

promulgated laws which provide for limited entitlements for women's prenatal care, for neonatal care and for the care of young children.¹⁷⁰

This legislation largely neglected women's health needs unrelated to their role as child bearers.¹⁷¹ For example, there were no legislative mandates to cover prescription contraception, and there were legislative prohibitions on the use of federal Medicaid funds for abortions even where a physician considered it medically necessary.¹⁷² In fact, despite attempts, to date no federal legislation has been enacted to require prescription contraception or fertility treatment in employment-based plans.

It is also telling that reproductive health care such as prescription contraception, infertility, and abortion have routinely been labeled as not medically necessary, but rather a luxury or lifestyle choice.¹⁷³ As with early distinctions made between pregnancy and other medical conditions, the tendency has been to ignore the health implications of denying treatment, and to only focus on the aspect of the treatment that involves a personal choice about family planning. While this tendency may be due to ignorance of these health implications, a closer look reveals that these labels are based more prominently on assumptions about proper gender roles and the morality of women controlling their fertility.

a. Birth Control and Sexuality: "A Threat to Women's Virtue"

There is a long history of prescription contraceptive access being denied in order to advance values about the morality of women's sexual freedom.¹⁷⁴ In the early 1900s, for example, access to birth control was threatened by the Federal Comstock law that classified contraceptive information and supplies as obscene

170. Susan L. Waysdorf, *Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 767 (1995-96).

171. See *id.* at 813 (arguing that "Medicaid has maintained the historic link between public health care entitlement and women's fertility role").

172. See, e.g., *Harris v. McRae*, 448 U.S. 297, 302, 326-27 (1980) (upholding federal prohibition of Medicaid funds for abortions not necessary to save the life of the mother or resulting from rape); *Beal v. Doe*, 432 U.S. 438, 447 (1976) (upholding exclusion of funding for "non-therapeutic" abortions).

173. See *infra* note 187 and accompanying text.

174. See generally TONE, *supra* note 169, at 4; *Collection of Margaret Sanger Papers, Birth Control and the Good Old Boys in Congress*, Margaret Sanger Papers Project Newsletter, #26 (2000-01) available at http://www.nyu.edu/projects/sanger/good_old_boys.htm (last visited Mar. 8, 2005). [hereinafter *Collection of Margaret Sanger Papers*].

material and would have interfered with doctors' ability to dispense birth control.¹⁷⁵ Advocates such as Margaret Sanger attempted to get the law overturned by lobbying legislators, and in doing so, learned that much of the support for the Comstock law was due to legislators' concerns about how encouraging birth control would affect the proper role of women in society, and in particular women's sexuality.¹⁷⁶ Sanger's notes from a meeting with staffers revealed the following concerns by legislators:

"Opposed to bill—'conscientiously, because we have not the right to deny the joy of life to millions;' morally and politically we need 'more people.' Only way to control births is self-control."

... said "he did not believe there would be any virtue among women any longer if such a law was passed. He said that it would tend to put men and women on the same standard and he also felt that it would increase immorality by removing the fear of pregnancy."

"Rather impossible [for him to support bill] at present time. I'm afraid I'm a little old fashioned on that. I'm not ready to teach our children to become whores yet.'..."¹⁷⁷

One of Sanger's strategies was to educate the public about why prescription contraception was necessary to protect women's health. Through her founding of the American Birth Control League in 1921, a lobbying group organized to secure medical acceptance of birth control on public health grounds, Sanger worked to promote "physician-controlled contraception."¹⁷⁸ While this medicalization of reproductive health was somewhat successful, the view of access to prescription contraception as a health issue, as opposed to a moral decision about sexual freedom, has never been completely accepted.¹⁷⁹

175. *Id.* *Collection of Margaret Sanger Papers*, *supra* note 174.

176. *Id.*

177. *Id.*

178. TONE, *supra* note 174, at 122, 130.

179. Sanger's attempt to educate the legislators on the "scientific and social merits" of birth control couldn't overcome their concerns about the message it would send regarding the immorality of sexual promiscuity and actions taken to avoid pregnancy. See *Collection of Margaret Sanger Papers*, *supra* note 174. This is exemplified in notes from one of her staffers' exchanges:

I asked [the Senator] pointedly if he was opposed to a physician prescribing effective harmless contraceptive methods in a case where the indication was that a pregnancy would result in death. He replied: 'Certainly not. I am not inhuman but I have not considered birth control from that standpoint. I have considered it only from the conditions that are existing throughout the country today where every boy and girl or anybody can buy what they want and there seems to be no restriction.'

Id. Then in the second interview: "[The Senator] is most discouraging—there is no doubt of his opposition—he feels birth control is murder and that life is taken." *Id.*

A few scholars have argued that this same bias motivates today's insurance exclusions of prescription contraception.¹⁸⁰ Comparing insurers' treatment of different forms of contraception and their coverage of treatment for male impotence provides some support of this. For example, sterilization, available to both men and women, is usually covered, while prescription contraception used by only women is excluded.¹⁸¹ This is significant because the excluded forms tend to be the reversible forms of contraception that give women greater opportunity for a low risk and easy way to prevent pregnancy.¹⁸² Sterilization for women is technically irreversible and entails greater risk and sacrifice.¹⁸³ This can act as a significant barrier to accessing birth control for women who do not want to give up the ability to have children permanently. Indeed, this may be the intention.

A more prominent example has arisen within the last few years with the introduction of Viagra. Many insurance companies and employers rushed to cover Viagra, while continuing to exclude prescription contraception.¹⁸⁴ Even where the focus is on prescription contraception as a means to facilitate women's sexual freedom, a number of people have pointed out the double standard created by insurers who cover the expensive drug Viagra and penile implants enabling male sexual activity, while excluding the less expensive birth control pill and other forms of prescription contraception that do the same for women.¹⁸⁵

Health advocates cite many of the justifications above given by employers as further evidence of this bias, including the characterization that such treatment is really a luxury or lifestyle choice.¹⁸⁶ At least one scholar has argued that "companies who describe contraception as a 'lifestyle drug' tread dangerously close

180. See *infra* note 188 and accompanying text.

181. See Law, *supra* note 89, at 372.

182. *Id.*

183. *But see* Law, *supra* note 89, at 372 (suggesting that the preference for covering irreversible sterilization over reversible forms of contraception may be due to the fact that insurance has traditionally favored surgical services over other medical services).

184. See Debra Baker, *Viagra Spawns Birth Control Issue*, A.B.A. J., Aug. 1998, at 36; Hayden, *supra* note 166, at 172. However, more plans are refusing to cover Viagra citing its high cost and potential for abuse. See Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 119 (1998).

185. See Hayden, *supra* note 166, at 172; Kathryn Kindell, *Prescription for Fairness: Health Insurance Reimbursement for Viagra and Contraceptives*, 35 TULSA L.J. 399, 399-400 (2000).

186. See *infra* note 187.

to stereotyping women who elect to control their fertility as 'promiscuous' or 'scandalous.'" ¹⁸⁷ Finally, anecdotal evidence reveals that state legislators and much of the public continue to oppose bills that would mandate prescription contraception coverage precisely because of concerns that birth control will encourage women's promiscuity.¹⁸⁸

b. Controlling Fertility: "Women Shouldn't Play God"

While infertility is not unique to women, it is nonetheless believed to be a woman's problem. Even where people are aware that the problem can be traced to male infertility, focus remains on the woman. This is not surprising given that regardless of whether the man or woman is infertile, significant treatment must usually be performed on women and that the ultimate goal is for the woman to achieve a successful pregnancy.¹⁸⁹ Because of this assumed link between gender and infertility, decisions about fertility treatment are often related to or motivated by gender-based assumptions.

This is illustrated by a closer look at two common justifications for excluding insurance coverage of infertility treatment—that treatment is "unnatural" and merely a "luxury" or "lifestyle choice," and not medically necessary.¹⁹⁰ In some cases, this bias may be subtle, if not completely hidden. For example, the characterization of infertility treatment as not medically necessary may simply be due to ignorance of the medical causes and forms of infertility.¹⁹¹ However, when such justifications are probed, they often reveal deeper assumptions about women's responsibility for causing the infertility, rooted in an ideology about women's reproductive role in society.

For example, most people are aware that age can be a significant factor in female infertility, but there seems to be an

187. Hayden, *supra* note 166, at 184.

188. See Beh, *supra* note , at 128 (discussing moral hazards of overuse of reproductive technologies).

189. See RESOLVING INFERTILITY, *supra* note 97, at 7.

190. See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1272 (W.D. Wash. 2001).

191. See also SHER ET AL., *supra* note 113, at 186 ("When most insurance companies reimburse for procedures such as penile implants done in cases of male impotence and yet refuse to cover infertility, it makes one wonder how many directors and CEOs of these companies are older men who view male impotence as a life-endangering condition and the desire of a woman to have a baby as a vanity." (quoting himself from the Oprah show)).

overemphasis on age as the key factor triggering infertility.¹⁹² The gender bias becomes apparent because of the further speculation and characterization of blame about what the afflicted woman did to bring about the infertility. One of the most common assumptions is that a woman has waited "too long" to try to have children, usually because she decided to delay pregnancy until her career was established.¹⁹³ The assumption that a woman prioritized her career over pregnancy coupled with the characterization that she waited "too long" reflect the judgment that a woman is morally blameworthy for intentionally delaying her pregnancy and that she is the real cause of her own infertility.¹⁹⁴ It is this assumption or element of blame that implicitly characterizes infertility as the result of a "lifestyle" or even "unnatural" choice by women for which they are now being punished—that is, the unnatural or lifestyle label really describes a belief about the choices made by a woman that led to her infertility; not the infertility treatment itself.

If a woman has used birth control to prevent pregnancy, this has been used as evidence that a woman who tries to control her fertility in order to have sex without the fear of pregnancy transgresses some moral tenet. This transgression is seen as adding to her blameworthiness for the infertility—as if infertility is punishment for her hubris attempt to control her fertility and exercise her sexual freedom.¹⁹⁵ Unfortunately, many women internalize this feeling, which further exacerbates the emotional effects they suffer. The most compelling and tragic evidence of this comes from the women themselves—not in court cases litigating this issue—but through personal narratives, journals, and other literature that describes the psychological trauma infertile women experience.¹⁹⁶

192. See Beh, *supra* note 184, at 123.

193. *Id.*

194. *Id.*

195. Tragic events like the Dalkon Shield example further exacerbate and illustrate this phenomenon. See Morton Mintz, *At Any Cost: Corporate Greed, Women, and the Dalkon Shield*, in *CORPORATE VIOLENCE: INJURY AND DEATH FOR PROFIT* (Stuart L. Hills ed., 1987) (describing infertility as one of the horrible side effects of the IUD produced by the A.H. Robins company). See also Beh, *supra* note 187, at 123 ("Women especially had to be careful not to enjoy sex because they were maternal, rather than sexual creatures.").

196. See generally *RESOLVING INFERTILITY*, *supra* note 97; SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, *CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL & ETHICAL CONSIDERATIONS* (1998).

2. Employment Discrimination

Insurance exclusions may violate Title VII whether or not an employer intends to discriminate against women because employers can not just adopt an insurer's policy if its exclusions are discriminatory.¹⁹⁷ Some employers purchasing an insurance policy for its employees blindly accept the insurance company's basic policy without much thought and elect not to buy anything that would add to the cost. However, this is not necessarily the case. First, employers are not merely passive recipients of package designs, but often can and do tailor packages based on cost and employee demands.¹⁹⁸ Second, these exclusions implicate the kind of bias underlying traditional pregnancy-based discrimination, and acceptance of such exclusions reflects this bias, either consciously or subconsciously. In fact, there is evidence that such bias is conscious and alive in most workplaces today.

As described in Part II, the long history of gender discrimination in employment is well-documented and its focal point has been pregnancy.¹⁹⁹ Employers have been quite hostile to women employees as evidenced by overt exclusions, denial of

197. See *supra* notes 174-196 and accompanying text.

198. See Eduardo Porter, *Cost of Benefits Cited as Factor in Slump in Jobs*, N.Y. TIMES, Aug. 19, 2004, at A1 (discussing rising costs of health insurance as factor for employers to drop benefits); see also Sue Fox, *Public, Private Employees Feeling Pinch of Rising Health-Care Costs*, L.A. TIMES, Dec. 14, 2003. Employers essentially have a dual role as employer and financier of health care. Typically, employers finance health care for their employees in one of two ways. The employer can act as a purchaser of health care on behalf of its employees or it can "self-insure" by establishing its own health insurance plan for its employees. See Diana Slivinska, *Health Care Cost-Containment and Small Businesses: The Self-Insurance Option*, 12 J.L. & Com. 333, 333-34 (1993). In the first case, the employer pays a fixed monthly premium to an insurance company in exchange for the insurance company agreeing to pay for certain medical services designated in the insurance policy. See *id.* at 334. Usually, the employee must bear a portion of the cost in the form of a pay deduction. See *id.* at 336. In self-insurance plans, the employer usually contracts with a company to manage the administrative aspects of the insurance, but the employer is really acting as the insurer since it bears the risk of loss for any amount paid out for health care. See *id.* In self-insured plans, any increase any benefits covered increases the employer's potential risk of having to pay out more money than projected, while in purchased insurance plans, the added benefit can increase the premiums paid by the employer or employee. See *id.* Employers have also tried to avoid liability under Title VII claiming that it is the insurance company, not the employer, who determines what benefits are excluded. The Supreme Court has rejected this argument in other benefits cases. See *Norris*, 463 U.S. at 1083 ("An employer that offers one fringe benefit on a discriminatory basis cannot escape liability because he also offers other benefits on a nondiscriminatory basis."). This reasoning applies even more so in the health benefits context because employers play a role in designing the health plan and often have the option of adding benefits for an additional price.

199. See *supra* notes 84-160 and accompanying text.

promotions, and pay differentials to name just a few examples.²⁰⁰ Employers have historically offered several justifications for such discrimination, including beliefs that pregnancy makes women unsuitable for certain kinds of work, that the cost of pregnancy creates intolerable burdens to employers and male employees, and that women, who will ultimately get pregnant and leave anyway (to stay home and be supported by a husband) are stealing job opportunities from deserving men.²⁰¹

There is evidence that these same fears lead employers to discourage women from undergoing infertility treatment.²⁰² Several cases have been brought under Title VII and the PDA to challenge adverse actions, such as termination, allegedly motivated by assumptions about the effects of a woman's pregnancy or infertility treatment on her job performance.²⁰³ To the extent that women, because of their capacity to become pregnant, will need time off to undergo more diagnostic or other treatment procedures, not to mention the resulting pregnancy that will hopefully be achieved, employers may view this as a conflict with the employee's ability to be a productive employee.²⁰⁴ In fact,

200. See ANN CRITTENDEN, *THE PRICE OF MOTHERHOOD: WHY THE MOST IMPORTANT JOB IN THE WORLD IS STILL THE LEAST VALUED* 87-98 (2001).

201. SUE HEADLEE & MARGERY ELFIN, *THE COST OF BEING FEMALE* 5-20 (1996). Research reveals that working mothers in the United States earn less than men and childless women, per hour, even after controlling for education and experience. See CRITTENDEN, *supra* note 200, at 94.

202. See *infra* note 203.

203. See, e.g., *Laporta v. Wal-Mart Stores*, 163 F. Supp. 2d 758 (W.D. Mich. 2001) (ruling on plaintiff who alleged that she was terminated as a result of her need to seek infertility treatment); *Lehman v. Adecco N. Am.*, 2001 U.S. Dist. LEXIS 6391 (N.D. Ill. 2001) (ruling on plaintiff who alleged that she was terminated because she communicated her intent to undergo infertility treatment to become pregnant); *Koerts v. MCI Telecommunications Corp.*, 1997 W.L. 30987 (N.D. Ill. 1997) (ruling on plaintiff who alleged that she had been discharged as a result of her undergoing in vitro fertilization treatments); *Piantanida v. Wyman Ctr., Inc.*, 116 F.3d 340 (8th Cir. 1997) (ruling on plaintiff who alleged that she was demoted because she had become pregnant); *Pacourek v. Inland Steel Co.*, 916 F. Supp. 797 (N.D. Ill. 1996) (ruling on plaintiff who alleged that she was terminated as a result of her undergoing infertility treatment); *Erickson v. Bd. of Governors*, 911 F. Supp. 316 (N.D. Ill. 1995) (ruling on plaintiff who alleged that she was terminated as a result of undergoing infertility treatment); *Turic v. Holland Hospitality, Inc.*, 85 F.3d 1211 (6th Cir. 1995) (ruling on plaintiff who alleged that she had been discharged because of her intent to have an abortion); *Troupe v. May Dep't Stores Co.*, 20 F.3d 734 (7th Cir. 1994) (ruling on plaintiff who alleged that she was discharged because of time off needed due to her pregnancy).

204. *RESOLVING INFERTILITY*, *supra* note 97, at 224-25.

Women are particularly affected [by infertility], since they are the ones who undergo ovulatory stimulation and have to deal with medical appointments that can mean hours and even days away from work. Although the Family and Medical Leave Act (FMLA) requires many employers to allow both men and women to take unpaid leave for

evidence shows that many employers expressly do not want to cover infertility treatment because of the concern that too many women would take advantage of it.²⁰⁵ Anecdotal evidence also reveals a pervasive practice among women who hide the fact that they are receiving infertility treatment and their plans to have a child in general for fear of discrimination by their employers.²⁰⁶ In this respect, an employer's reason for denying infertility benefits may merely be an extension of the same biases that have formed the basis for a pervasive history of pregnancy-based employment discrimination—the type of bias the PDA was expressly enacted to prevent.

B. Common Employer Justifications

As noted above, employment-based insurance plans and policy justifications vary from case-to-case, so it is nearly impossible to anticipate whether an employer will be able to successfully rebut a plaintiff's claim.²⁰⁷ However, several justifications have been consistently offered for such exclusions, and these justifications illustrate employers' difficulty in rebutting the prima facie case either because of inconsistencies with other coverage decisions or a lack of sound actuarial or medical grounds for the exclusion.

As already noted, a recurring reason for excluding both prescription contraception and infertility treatment is the perception that they are merely a luxury or lifestyle choice, and not medically necessary health care.²⁰⁸ In fact, infertility treatment is often likened to "elective" procedures such as cosmetic surgery.²⁰⁹ These justifications are easily challenged since they are not consistent with sound medical judgment about

pregnancy and related matters without worry about losing their jobs, doing so is often not practical or is cost-prohibitive in terms of lost wages and benefits. As well, smaller employers—which account for nearly half of the nation's employment—are not bound by the FMLA. And although the FMLA may assure you can return to your job, taking extended periods of time off work can derail your career track.

Id.

205. See *infra* notes 252-270 and accompanying text (discussing *Krauel v. Iowa Methodist Medical Center*).

206. See, e.g., RESOLVING INFERTILITY, *supra* note 97, at 225.

207. See *supra* note 197-206 and accompanying text.

208. See, e.g., *supra* note 191 and accompanying text

209. See RESOLVING INFERTILITY, *supra* note 97, at 296; see Brock, *supra* note 208, at 224-25. Dan W. Brock, *Funding New Reproductive Technologies: Should They Be Included in Health Insurance Benefit Packages*, in NEW WAYS OF MAKING BABIES: THE CASE OF EGG DONATION 213, 224-25 (Cynthia B. Cohen ed., 1996).

the causes and treatment necessary to correct infertility. While the decision about whether to have a family is a deeply personal one that inevitably involves some "lifestyle" choices, a women's ability to prevent and control the timing of her pregnancies is an important health issue.²¹⁰

Employers are most vulnerable to Title VII claims when their justifications for female reproductive health exclusions are patently inconsistent with their own policy decisions for other treatment. For example, employers have justified prescription contraception exclusions on the grounds that it is "preventive" and not necessary to treat or correct an existing illness.²¹¹ This argument is not credible for many plans that do cover other preventive medications.²¹²

For IVF and other assisted reproductive treatment, employers and insurers have argued that the treatment should not be considered medically necessary because it does not cure or correct the actual cause of the infertility.²¹³ This is also

210. This justification does not account for the fact that pregnancy is not always desired and can be medically risky if it would exacerbate an already serious illness. See ALAN GUTTMACHER INST., *CONTRACEPTIVE USE: FACTS IN BRIEF* (stating that "[m]ore than 3 million unintended pregnancies occur each year in the United States"); see also Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty & the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625, 641-48 (2003); Melissa Cole, *Beyond Sex Discrimination: Why Employers Discriminate Against Women with Disabilities When Their Employee Health Plans Exclude Contraceptives from Prescription Coverage*, 43 ARIZ. L. REV. 501, 508-21 (2001).

211. See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1272 (W.D. Wash. 2001).

212. One other common reason that may be offered is that offering contraceptions would violate religious beliefs. See, e.g., Milt Freudenheim, *Federal Health Plans to Include One Shaped by Catholic Tenets*, N.Y. TIMES, Sept. 25, 2004, at A1, Lexis/Nexis. There is a special exemption in Title VII for religious organizations "with respect to the employment of individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational, institution, or society of its activities." 42 U.S.C. § 2000e-1(a) (2000). However, this exemption has been interpreted narrowly and it is questionable whether it could be used in the benefits context at all. See *Law, supra* note 89, at 384-86. At least one employer has tried unsuccessfully to challenge a mandate to provide prescription contraception under the federal Free Exercise Clause of the First Amendment. See *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67 (Cal. 2004); see also Clark, *supra* note 210, at 649-65 (arguing that the federal Free Exercise Clause probably does not provide any protection against laws designed to remedy discrimination in health care by increasing access to reproductive health services for women).

213. See Brock, *supra* note 209, at 225-26. Another reason given for the exclusion of IVF and certain surgical implantation procedures is that the treatment is "experimental" or "not standard practice." The fact that a treatment is "experimental" can be the basis of a legitimate exclusion in health plans. This is easily subject to challenge for infertility, however, if it is merely assumed, and not

disingenuous in light of the fact that employers usually cover other medical care that does not actually cure the underlying medical problem, but serves only to ameliorate its harmful effects, such as penile implants, dialysis treatment for diabetics, and drug medication for high blood pressure.²¹⁴

For the exclusion of both prescription contraception and infertility treatments, employers have asserted cost as either a legitimate nondiscriminatory reason or as a defense of business necessity to overcome the plaintiffs' claim of discrimination.²¹⁵ Cost is such an important factor because a critical aspect to our employment-based system of financing health care is that it is voluntary. Consequently, any debate about expanding employment-based health benefits centers around the fear that if costs get too high, employees' premiums will become prohibitively expensive or employers will stop providing health insurance altogether.²¹⁶

based on scientific evidence. For example, much is made of the fact that outcomes are not guaranteed or predictable; however, this is not unique to fertility treatment. See RESOLVING INFERTILITY, *supra* note 97, at 302.

214. See RESOLVING INFERTILITY, *supra* note 97, at 302. Cancer treatment provides a perfect example of the inconsistent treatment of reproductive health. Much of the treatment that cancer patients get is designed to treat or ameliorate many of the complications that result from cancer, such as medication prescribed to alleviate the pain or nausea from cancer treatment. Moreover, even though we know that infertility is one of the many effects of cancer treatment, infertility caused by such treatment remains excluded.

215. See, e.g., Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 680 (8th Cir. 1996) (stating that cost was a motivating factor in employer's decision to exclude coverage for infertility treatment); *Erickson*, 141 F. Supp. 2d at 1274 (stating employer's argument that it should be permitted to exclude prescription contraception from its employee benefit programs in order to control costs); *EEOC Decision Coverage of Contraception*, nn.17-19 and accompanying text (arguing that contraception was excluded for "strictly financial reasons"), available at <http://eeoc.gov/policy/docs/decision-contraception.html> (last visited Mar. 8, 2005); see also *SHER ET AL.*, *supra* note 147, at 185-87.

216. The critical role of employment-based health benefits in the U.S. health care delivery system has been especially prominent in the news the last few years. See, e.g., John M. Broder et al., *Problem of Lost Health Benefits is Reaching into the Middle Class*, N.Y. TIMES, Nov. 25, 2002, at A1; Daniel Costello, *Firms Cut Back Medical Coverage: Faced with Soaring Costs, Many Employers Are Discouraging Workers from Adding Spouses or Children to Their Insurance Plans*, L.A. TIMES, Oct. 6, 2003, at F1; Sue Fox, *Public, Private Employees Feeling Pinch of Rising Health-Care Costs*, L.A. TIMES, Dec. 14, 2003, at B1; Eduardo Porter, *Cost of Benefits Cited as Factor in Slump in Jobs*, N.Y. TIMES, Aug. 19, 2004, at A1; *Union for Grocery Store Clerks Explains How Contract Might Affect Health Care*, CAL. HEALTHLINE, Oct. 23, 2003, available at <http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID95803&classcd=CL350> (last visited Mar. 5, 2005).

1. The Availability of the Cost Defense

The Supreme Court has repeatedly held that there is no cost defense under Title VII.²¹⁷ In *Newport News*, for example, the Court noted that "no [cost] justification is recognized under Title VII once discrimination has been shown."²¹⁸ Moreover, in two other benefits cases, the Court rejected cost as a rebuttal to the plaintiff's prima facie case of discrimination.²¹⁹ These cases were decided on disparate treatment grounds, however, and there is other authority suggesting that the need to control cost may qualify as a business necessity in disparate impact claims.

For example, in *Wambheim v. J.C. Penney Co.*,²²⁰ a Title VII challenge was brought against an employer's medical insurance "head-of-household rule." This rule allowed an employee to obtain coverage for a spouse only if the employee earned more than half of the couple's combined income.²²¹ The plaintiffs successfully alleged a prima facie case of disparate impact.²²² The plaintiffs lost, however, because the Ninth Circuit found that the rule was instituted for a legitimate, business reason:

[It was] designed to benefit the largest number of employees and those with the greatest need. [The employer] concluded that dependent children and spouses covered under the head-of-household rule have the greatest need for dependent coverage. Qualifying spouses are less likely to have other medical insurance. It seeks to keep the cost of the plan to its

217. See *Newport News Dock Co. v. EEOC*, 462 U.S. 669, 683 n.26 (1983); *Norris*, 463 U.S. at 1074-75 (per curiam); *L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 716-17 (1978).

218. 462 U.S. at 683 n.26. *But see* *Int'l Union v. Johnson Controls, Inc.*, 499 U.S. 187, 211 (1991) (reserving the possibility that a policy or action may be so prohibitively expensive as to qualify as a BFOQ defense to disparate treatment).

219. See *Manhart*, 435 U.S. at 716-17. In *Manhart*, the city required women to pay more into the company retirement fund than men. *Id.* The city argued that there was no discriminatory effect on women as a class because there was a like difference in the cost of benefits being provided for women versus men. *Id.* The Court rejected this argument on the grounds that "neither Congress nor the courts have recognized such a defense under Title VII." *Id.* at 717; see also *Norris*, 463 U.S. at 1086 (rejecting a similar cost argument by employer attempting to justify a retirement plan that paid women lower monthly benefits than a man who had made the same contributions); 29 C.F.R. § 1604.9(e) ("It shall not be a defense under Title VII to a charge of sex discrimination in benefits that the cost of such benefits is greater with respect to one sex than the other.").

220. 705 F.2d 1492 (9th Cir. 1983).

221. See *id.* at 1493.

222. See *id.* at 1494-95. Despite the fact that 70 percent of Penney's employees were female, only 37 percent of the women and 95 percent of the men covered by the medical plan received dependent coverage. Moreover, "[o]nly 12.5 percent of the married female employees qualified as heads of household, while 89.34 percent of the married males qualified." *Id.* at 1493-94.

employees as low as possible, so that the needy can afford coverage. If all spouses are included, the contribution rates will increase.²²³

Under this approach, cost considerations would be relevant in disparate impact claims, especially in light of the perceived precariousness of employment-based coverage if costs are not contained.²²⁴ The problem with this approach, however, is that cost is at the heart of any benefits decision. This would seem to create a justification that could completely eradicate any meaningful disparate impact claims in the benefits context. Moreover, this is inconsistent with the broader principle established in the benefits cases about the role of cost. The Supreme Court has repeatedly made clear that while cost can be a legitimate factor in an employer's decision, employers can not treat women and men differently in coverage decisions because of cost differentials in the type of treatment for each class.²²⁵ In other words, cost should not be used to justify or mask gender discrimination.

2. Determining Whether Cost is a Pretext for Discrimination

Assuming that a cost defense is available in disparate impact claims, courts can not nonetheless merely defer to the employer's claim that cost is the motivating reason for the exclusion.²²⁶ Given the difficulty of proving actual motive, health advocates can challenge the legitimacy of a cost justification by demonstrating that the alleged cost increase is not significant enough to justify the exclusion. This has been easy to do in the case of prescription contraceptives because the cost of prescription contraception for an employer is minimal in light of the employer's resources and ability to spread its costs among employees.²²⁷ In fact, evidence

223. *Id.* at 1495.

224. *See supra* notes 137-160 and accompanying text.

225. *See Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1085 (1983); *L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 710 (1978).

226. *See, e.g., Wambheim*, 705 F.2d at 1495 (noting that a cost defense could not overcome a showing by the plaintiff that the rule is a pretext for impermissible discrimination).

227. *See ALAN GUTTMACHER INST., The Cost of Contraceptive Insurance Coverage* (2003) (adapted from an article by Cynthia Dailard, in *The Guttmacher Report on Public Policy*, March 2003), at http://www.agi-usa.org/pubs/ib_4-03.html (last visited Mar. 5, 2005)(estimating that average added cost to employers of covering contraceptives is \$1.43 per employee per month if the employer covers 80 percent of the premium).

suggests that employers save money by covering prescription contraception because it prevents pregnancy and the tremendous costs that can accompany unwanted or medically risky pregnancies.²²⁸

In the infertility context, this has been harder to do. Beliefs about the exorbitant cost of infertility treatments are pervasive, due in part to society's preoccupation with the cost of IVF.²²⁹ In contrast to the case of prescription contraception, it seems intuitively clear that infertility coverage will actually increase overall costs since, if successful, it will lead to pregnancy which requires additional treatment and monitoring of the woman's and child's health. Furthermore, certain fertility treatments are associated with an increased risk of multiple births, which can cause harmful effects to women and their fetuses, which in turn lead to greater societal cost.²³⁰

The significance of these economic or health effects of covering infertility is not clear cut. For example, one study has estimated that the additional cost of covering IVF would likely only be a small fraction of the total cost of a family plan.²³¹ Moreover, as noted in Part II, health risks and social costs due to multiple births are not necessarily avoided by, and may in fact be aggravated by, denying coverage of fertility treatment.²³²

Without actuarial support for the high costs of covering the various types of infertility treatment, courts should not automatically defer to employers' characterization of such justifications as significant enough to qualify as a business necessity or a legitimate, nondiscriminatory reason for the exclusion. While rising health care costs are a significant concern and employers must have decision-making discretion to control business costs and allocate resources in ways that advance legitimate medical and health care policy, this is not what I see being done currently. Rather, the evidence points to employers

228. See *id.*

229. Cf. SHER ET AL., *supra* note 113, at 129 (warning couples about the financial commitment of IVF); see also Brock, *supra* note 209, at 228 (noting that the cost of assisted reproductive technology for a single pregnancy can reach into the thousands or even tens of thousands of dollars, but that many other treatments designed to improve quality of life can have comparable cost).

230. See, e.g., John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J.L. & MED. 7, 10 (2004).

231. See Brock, *supra* note 209, at 228 (noting that the estimated cost of mandated coverage of infertility treatment in Massachusetts is about 4/10 of 1 percent of a family premium).

232. See *supra* notes 137-160 and accompanying text.

acting inconsistently with their other policy choices and accepted scientific knowledge about the health implications of denying reproductive health treatment. Unless purported justifications are scrutinized and the challenged exclusions are compared with treatment of male reproductive health benefits, employers will be able to use these apparently neutral classifications to advance certain values about women's reproductive roles in ways that create disparate financial, emotional, and physical health risks to women.

IV. The Dominant Approach: Title VII Challenges to Reproductive Health Exclusions

Parts II and III of this Article demonstrate that, at a minimum, prescription contraception and infertility exclusions make out the prima facie case for gender discrimination, and employers' justifications for such classifications should be closely scrutinized.²³³ However, in this Part, I will show that most courts resist seeing these challenges as issues of gender discrimination under Title VII and the PDA, under what I term the "dominant approach." While *Erickson v. Bartell Drug Co.* was widely viewed as an example that Title VII can be a powerful tool for ensuring gender equality in employment-based health care, *Erickson* appears to be the lone exception to this dominant approach.

Challenges to reproductive health benefit exclusions implicate the same issue that troubled the Supreme Court in *Gilbert*: whether there is sufficient identity between the excluded benefit and gender for the plaintiff to make out a prima facie case. This issue is actually framed as a definitional one—that is, whether the excluded condition or treatment is "pregnancy-related" for purposes of making out a prima facie case under the PDA. The way courts have chosen to answer this question forms the basis for the two different visions of Title VII and the PDA that I identify.

In this Part, I will review the cases that follow the dominant approach to sketch out the framework being used in challenges to benefits exclusions.²³⁴ Under the dominant approach, courts distinguish Title VII from the PDA, viewing the original language under Title VII as much more straightforward and easier to apply. If they can decide the case based on this original language—the "on the basis of sex" requirement—they do so. Thus, courts focus

233. See *supra* notes 84-232 and accompanying text.

234. See *infra* notes 235-294 and accompanying text.

on the form of treatment or condition excluded to try to find a clear gender link. Where the form of treatment is only used by women (that is, in the cases challenging exclusions of the prescription contraception used only by women), courts find that a facial disparate treatment claim is easily made out. There is no need to consider a disparate impact claim.

In cases where a perfect gender link cannot be found (that is, in the cases challenging infertility benefits or exclusions of both male and female contraceptive treatment), gender neutrality is assumed and no prima facie case for disparate treatment is made out under the original Title VII language. While plaintiffs try to make a disparate impact claim, drawing upon the PDA to help illustrate the gender-specific effects that occur due to women's unique ability to become pregnant, this clearly makes courts uncomfortable. Courts dismiss the claim often on ambiguous or unsatisfying grounds. Moreover, despite the courts' purported consideration of disparate impact or PDA-based claims, they seem to view the PDA as completely irrelevant where the form of the exclusion is apparently gender neutral. In other words, just like the *Gilbert* majority, courts today continue to refuse to look closely at pregnancy-related classifications that do not have a perfect gender link and treat disparate treatment and disparate impact claims as one in the same.

A. Prescription Contraception Cases

To date, there is only one other case²³⁵ besides *Erickson* analyzing a prescription contraception exclusion in depth. In *EEOC v. UPS*,²³⁶ the plaintiff presented a claim for reimbursement for prescription contraception to treat a female hormonal disorder that was denied by the plaintiff's employer.²³⁷ The EEOC filed a complaint against the employer claiming that the denial violated Title VII.²³⁸ The crux of the complaint was that the defendant violated the plain language of Title VII, by treating women and men differently by the express terms of the policy.²³⁹ The employer's plan covered drugs for male hormonal disorders,

235. A challenge to prescription contraception exclusions was also brought in *Mauldin v. Wal-Mart Stores, Inc.*, 89 Fair Empl. Prac. Cas. (BNA) 1600 (N.D. Ga. 2002) (granting class certification for Title VII lawsuit challenging the exclusion on disparate treatment and disparate impact grounds).

236. 141 F. Supp. 2d 1216 (D. Minn. 2001).

237. *Id.* at 1217.

238. *Id.*

239. *Id.* at 1219.

but failed to cover the pill, an important treatment used for female hormonal disorders.²⁴⁰ The court agreed that this differential treatment of men and women's coverage for comparable hormonal disorders constituted a facial disparate treatment and disparate impact claim under Title VII.²⁴¹

While the EEOC based its original claim on the basic Title VII prohibition, it had requested permission to supplement the record to include a PDA-based claim that the exclusions of prescription contraception were "pregnancy-related" and thus violated the PDA's prohibition on discrimination on the basis of pregnancy-related conditions.²⁴² Although the court did not have to address the PDA-based claim, it nonetheless noted that it had "serious doubts about the merits of a PDA claim in this context"²⁴³

Another court has expressly rejected the argument that the PDA protects prescription contraception.²⁴⁴ In *Alexander v. American Airlines*,²⁴⁵ the plaintiff challenged an employer's exclusions of pap smears, contraceptive medications and devices, and infertility medications and treatments.²⁴⁶ The court granted the employer's motion to dismiss on the contraceptive claims because the plaintiff lacked standing.²⁴⁷ In an unreported decision, the court noted that even if there was standing, it would reject the claim because contraception is not protected under the PDA.²⁴⁸ It made the broad claim that there cannot be gender discrimination if contraception used by men and women is excluded.²⁴⁹ The court failed to even acknowledge the possibility of a disparate impact claim.²⁵⁰

240. *Id.*

241. *Id.* at 1219-20. Another argument that surfaced was based on a "couple assumption." *See id.* The employer tried to argue that male and female employees were equally burdened by the exclusion, since oral contraceptives were not available to the spouses of male employees. *Id.* The court rejected this argument and noted that since oral contraceptives were only prescribed to women, only women were burdened and thus the exclusion constituted a prima facie case for disparate impact. *Id.*

242. *Id.* at 1218 n.1.

243. *Id.*

244. *Alexander v. Am. Airlines, Inc.*, No. 4:02CV0052, 2002 WL 731815, at *4 (N.D. Tex. Mar. 1, 2002) (not reported in federal supplement).

245. *Id.*

246. *Id.* at *1.

247. *Id.* at *2.

248. *Id.* at *4.

249. *Id.*

250. *See id.*

In both cases, the courts looked for an obvious link between gender and the exclusion. Where the form of the exclusion was only available to women, a disparate treatment claim was easy. Neither the relationship of the exclusion to pregnancy nor the PDA was considered relevant. Moreover, the employer was not required to justify the exclusion.

B. Infertility Treatment Cases

Courts are even more hostile to challenges to infertility treatment under the dominant approach. They are either dismissing such claims or granting summary judgment to the employer. The cases below cite as an overriding factor the gender-neutral elements of infertility—that infertility afflicts men and women, that the excluded treatments are those used by men and women, and that such treatments are often used to treat some combination of male and female infertility.²⁵¹ Courts depend almost exclusively on these facts in rejecting any claims of disparate treatment or disparate impact under the original language of Title VII. Gender neutrality is also used by courts to reject plaintiffs' PDA-based claims, namely as justification for why courts define "pregnancy-related" narrowly to exclude infertility from protection.

This approach is exemplified in *Krauel v. Iowa Methodist Medical Center*.²⁵² The plaintiff, Ms. Krauel, was an employee of Iowa Methodist Medical Center (IMMC) and was diagnosed with endometriosis which led to infertility.²⁵³ Krauel underwent a laparoscopy (laser surgery) to eliminate the condition, but was still unable to become pregnant after one year.²⁵⁴ She then underwent fertility treatments, including artificial insemination, and after three treatments became pregnant.²⁵⁵ IMMC covered the laparoscopy, pregnancy, and delivering expenses, but it denied coverage for Krauel's fertility treatment based on an express exclusion in the plan.²⁵⁶

Krauel brought suit against IMMC alleging that the

251. See *infra* notes 253-293 and accompanying text.

252. 95 F.3d 674 (8th Cir. 1996).

253. *Id.* at 675. "Endometriosis is a condition in which the lining of the uterus grows aberrantly . . . outside the uterus including in the fallopian tubes and ovaries." *Id.* at 675 n.2.

254. *Id.* at 675-76.

255. *Id.* at 676.

256. *Id.* This is an example of the fact that blanket exclusions of infertility do not foreclose all treatment.

exclusion for fertility treatments violated Title VII and the PDA.²⁵⁷ She argued that the infertility exclusion was an impermissible sex-based classification under the original language of Title VII and that it violated the PDA since it was treatment of a medical condition "related to pregnancy or childbirth."²⁵⁸ The Eighth Circuit treated these as independent claims and first rejected the plaintiff's PDA claim, holding that infertility did not qualify as a "pregnancy-related condition" for purposes of protection under the PDA.²⁵⁹ It distinguished pregnancy and childbirth, which occur after conception, from infertility, which prevents conception, finding them "strikingly different."²⁶⁰ It failed to note, however, why this difference was so "striking" or why a difference in timing should result in different legal protection under the PDA.²⁶¹

The plaintiff also presented evidence that the policy was the result of intentional discrimination by the employer.²⁶² The plaintiff alleged that the Vice President of IMMC said that coverage for infertility treatment was excluded "because too many women of child-bearing age were employed by IMMC and infertility treatments result in too many multiple births, thereby creating a financial burden on the Plan."²⁶³ The court dismissed this claim using circular reasoning, holding "as a matter of law that the alleged statements do not rise to the level of sex discrimination," since they only indicate that cost may have been a motivating factor in IMMC's decision.²⁶⁴ It then noted that cost considerations do not violate Title VII because there was no sex-based classification under the PDA.²⁶⁵ The court failed to acknowledge evidence that the exclusion was motivated by the employer's belief that infertility benefits are used primarily, if not solely, by women, and its concerns that the effects of such treatment would result in pregnancy.²⁶⁶

In an equally cursory analysis, the court rejected the plaintiff's disparate impact claim.²⁶⁷ The plaintiff alleged that

257. *Id.*

258. *Id.* at 679-80.

259. *Id.*

260. *See id.* at 679.

261. *Id.* It also cited the lack of EEOC guidelines about infertility treatments as evidence that infertility was not covered by the PDA. *Id.* at 679.

262. *See id.* at 680.

263. *Id.* at 680.

264. *Id.*

265. *Id.*

266. *See id.*

267. *Id.* at 681.

infertility treatments have a greater impact on women because women are required more often than not to undergo treatment and extensive diagnostic testing and monitoring, even where the man is the infertile one.²⁶⁸ The plaintiff also alleged that women suffer a greater impact because they bear the larger portion of the costs for such treatments.²⁶⁹ These arguments were rejected on the grounds that the plaintiff offered insufficient statistical evidence for support.²⁷⁰

At least two other courts have cited to *Krauel* in support of granting an employer's motion to dismiss in similar complaints.²⁷¹ In *Alexander v. American Airlines*,²⁷² the plaintiff brought a Title VII and PDA-based challenge against the employer's infertility exclusion, in addition to the prescription contraception exclusion discussed above.²⁷³ In justifying its dismissal of the infertility claims, the court simply cited *Krauel* for the proposition that, as a matter of law, infertility or the inability to become pregnant is not "pregnancy related" within the meaning of the PDA.²⁷⁴

In the other case, *Niemeier v. Tri-State Fire Protection*,²⁷⁵ the Illinois Federal District Court rejected a Title VII challenge to an exclusion of infertility benefits by a former employee and his wife.²⁷⁶ The claims based on the original Title VII language were dismissed on procedural grounds, so only the PDA claim was addressed.²⁷⁷ The court cited *Krauel* in rejecting the plaintiff's PDA-based claim.²⁷⁸ It held that the PDA only requires employers to treat pregnancy, childbirth, or related medical conditions in a "neutral way."²⁷⁹ Once again, the disparate health and financial

268. *Id.*

269. *Id.*

270. *Id.* The Eighth Circuit Court of Appeals upheld the district court's grant of summary judgment in favor of IMMC. *Id.*

271. See *Alexander v. Am. Airlines, Inc.*, No. 4:02CV0052, 2002 WL 731815, at *3 (N.D. Tex. Mar. 1, 2002) (not reported in federal supplement); *Niemeier v. Tri-State Fire Protection*, No. 99 C 7391, 2000 U.S. Dist. LEXIS 12621 (N.D. Ill. Aug. 24, 2000).

272. 2002 WL 731815.

273. *Id.* at *1.

274. See *id.* at *2.

275. 2000 U.S. Dist. LEXIS 12621.

276. *Id.* at *2. In this case, Mr. Niemeier and his wife were covered under a health/medical benefits plan that had an express exclusion for coverage of artificial insemination and "treatment for other sexual dysfunctions not related to organic disease." *Id.* at *3.

277. *Id.* at *12, *14-*20.

278. See *id.* at *19.

279. *Id.* at *18-*20. The plaintiffs tried to assert that the plan only excluded infertility testing and treatment for females in support of their Title VII claim;

effects were not even considered.

Finally, in *Saks v. Covey*,²⁸⁰ the plaintiff brought a challenge against a policy that covered some infertility treatments, but had an express exclusion for IVF and surgical implantation procedures.²⁸¹ The plaintiff, Rochelle Saks, believed that she had a compelling claim of disparate treatment and impact based on the fact that the employer expressly excluded only surgical implantation procedures that were performed on women.²⁸² Saks claimed discrimination on the basis of sex under Title VII's original language because the policy provided comprehensive coverage for surgical procedures to treat male infertility, but incomplete coverage for surgical treatments to treat female infertility.²⁸³ She also argued that the exclusion violated the PDA because the plan's benefits for infertility treatments were inferior to its coverage for non-pregnancy-related illnesses.²⁸⁴ The district court granted summary judgment to the employer on both claims,²⁸⁵ which was affirmed by the Second Circuit Court of Appeals.²⁸⁶

The Second Circuit narrowly defined "the proper inquiry in reviewing a sex discrimination challenge to a health benefits plan [as] 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."²⁸⁷ According to the court,

however, the court disregarded this allegation since it was contrary to the Plan's express exclusion and since the plaintiff did not introduce any evidence to support the contention. *Id.* at *20 n.3.

280. 316 F.3d 337 (2d Cir. 2003).

281. *Id.* at 340-41.

282. *See id.* at 346-47. After the plaintiff attempted unsuccessfully to have a child, she pursued several medical courses of action. *Id.* at 341. These included ovulation kits, taking Clomid to induce and regulate ovulation, intrauterine inseminations (IUIs), in vitro fertilization (IVF), progesterone and estrogen, several injectable fertility drugs, and blood tests and ultrasounds which monitored the potential side effects of the drugs. *Id.* Saks became pregnant three times, but none made it to term. *Id.* She was denied reimbursement for the interuterine system (IUS), IVFs, injectable fertility drugs, and monitoring tests. *Id.* at 342. The plan denied reimbursement for the IUI and IVF based on an express exclusion for surgical impregnation techniques. *Id.* Under the terms of the plan, injectable drugs were usually covered; however, Saks was denied reimbursement for these drugs and the related monitoring because they were used in conjunction with the excluded impregnation procedures. *Id.*

283. *Id.* at 346-47.

284. *Id.* at 345.

285. *Id.* at 342.

286. The judgment was affirmed on grounds different from the reasoning of the district court. *See id.* at 343.

287. *Id.* at 344 (emphasis added).

“for a condition to fall within the PDA’s inclusion of ‘pregnancy . . . and related medical conditions’ as sex-based characteristics, that condition must be unique to women.”²⁸⁸ The court then held that the exclusion did not violate either the PDA or Title VII because while fertility is obviously related to pregnancy in the medical sense, it is not a sex-based characteristic unique to women.²⁸⁹ In fact, the court noted that because infertility afflicts men and women with equal frequency, a disparate impact claim could not even be made.²⁹⁰

Finally, the court rejected the plaintiff’s claim that Title VII was violated because the policy only excluded infertility treatments which are performed on women.²⁹¹ While it acknowledged that in certain contexts exclusion of women-only surgical treatments “might arguably constitute a violation of Title VII,” it rejected this argument here because surgical impregnation procedures are necessary as a result of male and female infertility.²⁹² Thus, every court to address this issue to date has rejected plaintiffs’ attempts to even bring such claims. In every case, courts fail to find a sufficient link between gender and the excluded treatment, and they do not consider the PDA relevant at all.²⁹³

In each case discussed above, the courts found that no prima facie case was made out because of the gender-neutral aspects of infertility. Consequently, these courts never scrutinized the employers’ justifications for the exclusion to determine if there was a legitimate medical or policy reason for the exclusion or if it was merely a pretext for discrimination.²⁹⁴ Under this dominant approach, the courts ignore all of the information set forth in Parts II and III of this Article about the different health effects of

288. *Id.* at 346.

289. *Id.* (citing to *Int’l Union v. Johnson Controls, Inc.*, 499 U.S. 187, 198 (1991)).

290. *Cf. id.* at 346.

291. *Id.* at 349.

292. *Id.* at 347.

293. *See id.* at 346.

294. There has been one case in which the court denied the defendant’s motion to dismiss plaintiff’s Title VII challenge to infertility exclusions. *See Bielicki v. City of Chicago*, No. 97 C 1471, 1997 U.S. Dist. LEXIS 6880 (N.D. Ill. May 5, 1997). In a very brief decision, the court stated that the allegation that the City denied coverage for plaintiff’s infertility treatments, while paying for infertility treatments for males covered under the same health plan, was enough to raise sufficient evidence of an inference of discriminatory intent for purposes of defeating a summary judgment motion. *Id.* at *10. However, this claim appears to be challenging disparate treatment in the administration of a policy that ordinarily covers infertility treatment, not the express policy exclusion itself. *Cf. id.* at *2-*3, *9-*10.

infertility on men and women and the likely stereotyping and gender bias motivating such exclusions. Under the dominant approach, plaintiffs appear to have no recourse under Title VII absent the most obvious cases of intentional discrimination or disparate treatment.

V. Critique of the Dominant Approach: Why Courts Resist Title VII Challenges to Benefits Exclusions

Part IV demonstrates that in several ways courts continue to resist the notion that reproductive health exclusions implicate Title VII. First, they interpret the PDA narrowly to only protect exclusions of sex-specific conditions, regardless of any relationship between the excluded treatment and pregnancy. Second, they focus exclusively on the gender-neutral aspects of the exclusion in finding that the plaintiff has not made out a prima facie case. Finally, they do not apply a meaningful disparate impact analysis that considers the disparate health and financial effects on women that result from the exclusion.

A look at the benefits cases within the larger context of civil rights litigation suggests that this resistance stems in part from a fear that plaintiffs are using the PDA to try to obtain special protection or entitlements for pregnancy, which would undermine the equality principles underlying Title VII and the PDA. Evidence of this fear is found throughout the prescription contraception and infertility cases described in Part IV. For example, in rejecting the plaintiffs' PDA-based claim, *Krauel* and *Niemeir* emphatically noted that the PDA *only* requires employers to treat pregnancy, childbirth, or related medical conditions in a neutral way. In *Saks*, the court rejected the plaintiff's claims based on its interpretation of the PDA as only protecting conditions unique to women.²⁹⁵ While not fully fleshed out in the cases, this fear seems rooted in two long-standing and related tensions in civil rights law: the courts' tendency to view reproductive rights issues as implicating privacy rights, not gender equality, and a debate between equal and special treatment theorists in defining the proper legal framework for ensuring equality under Title VII and the PDA.²⁹⁶

295. *Saks v. Covey*, 316 F.3d 337 (2d Cir. 2003).

296. See *infra* notes 297-313 and accompanying text.

A. *A Privacy Versus Equality Paradigm for Reproductive Rights*

The first problem underlying the dominant approach stems from courts' tendency to view reproductive rights cases as a privacy issue as opposed to one of gender equity. Early movements to protect reproductive health focused on fighting active government interference in the form of criminal prohibitions on abortion and the dissemination of birth control.²⁹⁷ Success was limited, however, because while courts removed formal, legal barriers to such treatment, there were still economic barriers for many women without adequate resources. For example, the federal government and some states expressly prohibited using Medicaid funds for abortions, even ones that were medically necessary, except in very limited circumstances.²⁹⁸ Some public facilities refused to provide abortion services at all.²⁹⁹

These limits on access to public resources were challenged as a violation of privacy rights and equal protection for women, but in an important series of cases, the Supreme Court made clear that the Fourteenth Amendment does not obligate the government to subsidize abortion through funding or access to public facilities.³⁰⁰ The Court did not consider such claims as implicating gender equality, rather it seemed to focus on the implication of a privacy right. As such, the Court characterized plaintiffs' claims as requests for the subsidization of a fundamental right or special entitlements inconsistent with protections of the 14th Amendment.

297. See, e.g., *supra* notes 177-182 and accompanying text (describing the legal barriers to the dissemination of information about birth control). See also *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the government may not ban abortions prior to the time at which the fetus can survive on its own outside the womb).

298. See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980) (challenge to the Hyde Amendment which prohibited Medicaid funding for abortions, except those necessary to save the life of the mother and in cases of rape).

299. See, e.g., *Webster v. Reprod. Health Svcs.*, 492 U.S. 490 (1989) (challenge to a state law prohibiting state employees from performing abortions and the use of public facilities for performing abortions).

300. See *Harris*, 448 U.S. 297 (holding that the prohibition of Medicaid funds for abortions does not violate the Fourteenth Amendment); *Maher v. Roe*, 432 U.S. 464 (1980) (holding that exclusion of funding for non-therapeutic abortions does not violate the constitutional right of a woman to decide to terminate her pregnancy); *Williams v. Zbarez*, 448 U.S. 358 (1980); *Webster*, 492 U.S. 490 (upholding a state law prohibiting state employees from performing abortions and the use of public facilities for performing abortions). The Court in dicta has also suggested that this applies to other non-abortion reproductive health services. See *Williams*, 448 U.S. at 318 ("It cannot be that because government may not prohibit the use of contraceptives . . . government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives . . .").

This framework, established in *Geduldig* in 1976, allowed pregnancy-benefits exclusions in public employment benefits plans, and was ultimately adopted by the *Gilbert* majority as the framework for Title VII challenges.³⁰¹ The PDA is so important because it makes clear that this is not the only framework for considering claims related to reproductive rights, and that reproductive health exclusions do implicate gender equity under Title VII.

B. The Special versus Equal Treatment Debate: The Proper Role of the PDA in Ensuring Equality Between the Sexes

Title VII's fundamental purpose is to guarantee equality between the sexes in employment, and the PDA was designed to further this purpose by making it clear that employers cannot use women's differences as a basis for discrimination. In fact, differential treatment related to sex-specific characteristics, such as pregnancy-related classifications, must be scrutinized closely because reproduction has been the focal point of a long history of employment discrimination against women.³⁰² The "special" versus "equal treatment" debate represents two contrasting theories about the relationship between equality and difference and the proper approach to guaranteeing gender equality.³⁰³

In short, equal treatment theorists argue that equality is accomplished by ignoring the differences between men and women and treating them the same; special treatment theorists argue that certain differences between men and women must be acknowledged and accommodated in order to ensure equality.³⁰⁴ The difference in the two approaches becomes visible where there is a gender-neutral policy or structure that may be more burdensome to women because of their unique ability to become

301. *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976); *Geduldig v. Aiello*, 417 U.S. 484 (1974).

302. See *supra* notes 43-83 and accompanying text.

303. See, e.g., Herma Hill Kay, *Equality and Difference: The Case of Pregnancy*, 1 BERKELEY WOMEN'S L.J. 1, 24-30 (1985).

304. Cf. Williams & Segal, *supra* note 20, at 351-80. See generally Kay, *supra* note 303 (arguing against an equal treatment type model in situations of biological differences between men and women); Sally J. Kenney, *Pregnancy Discrimination: Toward Substantive Equality*, 10 WIS. WOMEN'S L.J. 351 (1995) (discussing the advances and gaps in the movement toward accommodation of pregnancy); Colette G. Matzzie, *Substantive Equality and Antidiscrimination: Accommodating Pregnancy Under the Americans with Disabilities Act*, 82 GEO. L.J. 193 (1993) (arguing for pregnancy accommodation under the ADA rather than the traditional Equal Protection or Title VII analysis).

pregnant, such as employers' facially neutral leave policies.³⁰⁵

Take the case of an employer that does not provide leave for any disability or illness. The issue is whether the failure to provide pregnancy leave discriminates against women. Equal treatment theorists focus on how the employer treats pregnancy as compared to medical conditions suffered by men. If the employer does not provide leave for other illnesses, then men and women are being treated the same, and there is no discrimination. Special treatment theorists would evaluate such policies from a different framework. They would argue that even if no disability leave is provided for other illnesses, leave should still be provided for women during pregnancy to equalize women and men's ability to be successful employees while engaging in reproductive activity. Because of women's unique ability to become pregnant and the different reproductive consequences for men versus women, only women are temporarily physically disabled as a result of reproduction. The employer should accommodate these differences by providing pregnancy leave because only this approach would put men and women on truly equal footing in terms of their ability to engage in reproductive activity and advance professionally.³⁰⁶

This debate is illustrated in a non-benefits case from the Seventh Circuit, *Troupe v. May Department Stores Co.*³⁰⁷ In *Troupe*, a woman who was placed on probation for repeated tardiness due to severe morning sickness was ultimately fired the day before she was due to start her maternity leave.³⁰⁸ She alleged a Title VII and PDA violation on the grounds that she was fired because of her pregnancy.³⁰⁹ In rejecting the plaintiff's claim, Judge Posner framed the issue as whether the discharge of a pregnant employee to avoid paying the costs of maternity leave is discrimination under the PDA. Posner asserted that such a financially motivated dismissal alone does not violate Title VII, since employers "can treat pregnant women as badly as they treat similarly affected but non-pregnant employees."³¹⁰ In other words, if other employees who were repeatedly tardy or about to take a long leave were fired, then the firing of the plaintiff would not

305. See, e.g., Kay, *supra* note 303, at 24-30.

306. See *id.* at 30-31.

307. 20 F.3d 734 (7th Cir. 1994).

308. *Id.* at 735-36.

309. 20 F.3d at 734. She also alleged that her supervisor claimed she was being fired because the company did not expect her to return after she had the baby. *Id.* at 735-36.

310. 20 F.3d at 738 (noting, however, that this might violate other employment or contract laws).

constitute gender discrimination.

Judge Posner believed this result was dictated by the equal treatment principle underlying the PDA, which he interpreted as requiring the employer to ignore an employee's pregnancy. In fact, he went even further and expressly warned plaintiffs against trying to use a disparate impact claim based on the PDA to get special treatment for pregnancy:

The Pregnancy Discrimination Act does not, despite the urgings of feminist scholars . . . require employers to offer maternity leave or take other steps to make it easier for pregnant women to work Employers can treat pregnant women as badly as they treat similarly affected but nonpregnant employees. . . . [D]isparate impact is a permissible theory of liability under the Pregnancy Discrimination Act, as it is under other provisions of Title VII. But, properly understood, disparate impact as a theory of liability is a means of dealing with the residues of past discrimination, rather than a warrant for favoritism.³¹¹

Under the dominant approach, courts view plaintiffs' PDA-based argument as one for special treatment.³¹² Courts seem to assume that a blanket exclusion of infertility or contraceptive methods used by men and women is analogous to an employer's gender-neutral policy of denying any sick or disability leave or terminating an employee for a gender-neutral reason such as tardiness.³¹³ Consequently, using the PDA to analyze the claim would effectively be a mandate to employers to provide medical treatment related to a woman's ability to control her fertility, privileging women over men or creating special protection for reproductive treatment generally.

311. *Id.* (citations omitted). *Troupe* has been criticized on several grounds. While *Troupe* has been cited for the notion that the PDA only requires equal or comparable treatment, and not special treatment for pregnancy-related conditions, *Troupe* does not give any guidance about finding an appropriate comparison point where the challenge is to exclusions of sex-specific benefits. Posner expressly acknowledged that in some situations a comparison group may not exist, but did not elaborate on what to do in those instances. *Id.* *Troupe's* approach has also been criticized for enabling employers to fire employees based on a gender stereotype about the likelihood of pregnant women returning to work, which is exactly the type of discrimination the PDA was designed to prevent. See generally Ann C. McGinley & Jeffrey W. Stempel, *Condescending Contradictions: Richard Posner's Pragmatism and Pregnancy Discrimination*, 46 FLA. L. REV. 193 (1994).

312. See *Troupe*, 20 F.3d at 738 (noting PDA is not about favoritism for female reproductive rights).

313. *Id.* ("Employers can treat pregnant women as bad as they treat [non-pregnant employees]."). See *supra* Part IV.B. (discussion of infertility cases).

B. Why the Dominant Approach is Not Faithful to the Equality Principles of Title VII and the PDA

For purposes of this Article, I do not take issue with the notion that Title VII and the PDA require equal treatment, as opposed to special treatment, for women.³¹⁴ What I argue, however, is that courts' concerns about special treatment in these cases is misplaced. Rather, the dominant approach undermines the equality principles of Title VII due to several flawed assumptions that appear to be underlying the courts' fear.

1. Distinguishing Inaction from Deliberate Line-Drawing by Employers

First, the assumption that special treatment necessarily follows from considering the relationship between the excluded treatment and pregnancy is wrong. The problem identified with the "special treatment approach" is that it creates an affirmative obligation on the employer to identify and acknowledge differences between the sexes, and to accommodate those differences by treating one sex differently. An employer's inaction or policies governing adverse actions that truly do have the same harmful effect on men and women, such as a policy of terminating employees for repeated tardiness, would violate the statute because of the employer's failure to accommodate pregnancy.³¹⁵ Courts using the dominant approach incorrectly assume that apparently neutral benefit exclusions present the same problem.

There are important distinctions between policy exclusions of reproductive health benefits and the cases of adverse actions, such as termination or denial of promotion.³¹⁶ In insurance exclusion cases, employers are affirmatively acting to exclude (or adopt an exclusion) directly related to reproductive health, which can and does result in less comprehensive coverage for women's

314. A discussion of whether the special or equal treatment approach is normatively better is beyond the scope of this Article. I assume for purposes of this Article that the equal treatment approach is the limiting principle of Title VII. See, e.g., *Cal. Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 286-87 (1987) (citing the legislative history to support the interpretation that "the PDA does not require employers to extend any benefits to pregnant women that they do not already provide to other disabled employees").

315. See *id.* at 1027 (noting concern over whether sex difference ever should be considered when determining the propriety of considering pregnancy to achieve equal employment opportunity, and that the equal treatment approach requires treating pregnancy as any other disability, whereas the special treatment approach would perpetuate paternalism and patriarchy).

316. See *supra* notes 32-83 and accompanying text.

reproductive health. Moreover, an assumption that such classifications are based on a gender-neutral assignment of risk ignores the pervasive history of discrimination against women in reproductive health matters and employment generally.

2. Disparate Impact Claims Serve the Equality Principles of Title VII and the PDA

Troupe's warning about using disparate impact and the PDA as a weapon to obtain special treatment of pregnancy is misleading and incomplete; it does not give an example of the proper use of disparate impact in pregnancy-related claims.³¹⁷ Contrary to *Troupe's* warnings, disparate impact claims have been embraced by equal treatment theorists as critical in furthering the equality principles under Title VII and the PDA.³¹⁸

In the equal-versus-special-treatment debate, each side has refined its position as it has engaged in thoughtful dialogue about the perceived limitations or dangers of each approach.³¹⁹ For example, both sides worry about the negative effects that focusing on pregnancy and difference can have in the long term—especially with a history of employers treating women adversely on the basis of pregnancy. On the other hand, both sides agree that too much deference to an employer's facially neutral policy can mask discriminatory treatment.³²⁰

The equal treatment approach has been criticized as not being protective enough because it requires us to find a point of comparison between men and women upon which to determine differential treatment or impact.³²¹ Practically, however, if a male norm or standard of comparison is used, it can operate as hidden discrimination and be dressed up in a legal framework that prevents plaintiffs from ever getting their cases heard.³²² Equal

317. See *Troupe*, 20 F.3d at 738.

318. See *Griggs v. Duke Power Co.*, 401 U.S. 424, 430 (1971) (using disparate impact approach where employer applies facially neutral policies that have an adverse affect on some because of gender); see also *Nashville Gas Co. v. Satty*, 434 U.S. 136, 139-43 (1977) (using a disparate impact test to invalidate a policy denying women accumulated seniority because of child birth-related absences, which was facially neutral but placed an undue burden on women).

319. See, e.g., Christine A. Littleton, *Reconstructing Sexual Equality*, 75 CAL. L. REV. 1279; see also *Kay*, *supra* note 303.

320. See *Kay* *supra* note 303, at 32-37; Littleton, *supra* note 319, at 1325-27.

321. See *Kenney*, *supra* note 304, at 355 ("Feminists have called into question the core of the concept of discrimination contained in both antidiscrimination legislation and the equal protection clause of the U.S. Constitution. Having rights and privileges depends upon the extent to which women are like men.")

322. See Littleton, *supra* note 319, at 1280-82 (offering a vision of an equal

treatment advocates have recognized this problem and answered it by embracing a disparate impact claim to allow plaintiffs to challenge facially neutral policies that adversely affect women.³²³

However, discussion of disparate impact is almost non-existent in reproductive health benefits cases. When courts do discuss it, they seem to collapse the disparate treatment and impact analysis, assuming no disparate impact from the fact that there is no disparate treatment.³²⁴ This was one of the key mistakes the Court made in *Gilbert*. Where courts do go further and discuss disparate impact claims in the infertility cases, they quickly cite statistics showing that the condition of infertility affects men and women equally.³²⁵ This analysis is woefully lacking, however, because there is a qualitative aspect to the harm that is being neglected. Typically, disparate impact claims focus on how many women as compared to men are affected, which is a quantitative analysis. This makes sense in most cases because the nature of the harm is the same for men and women, such as a denial of a job or promotion. As shown in Part III, however, benefits exclusions can have qualitatively different gender-specific effects.³²⁶ For example, because reproductive health treatment is sex-specific, a facially neutral exclusion may effectively exclude forms of treatment used exclusively by women or may exclude more forms of female-specific treatment. Because the excluded treatment directly relates to a women's ability to become pregnant, an exclusion can also result in adverse health effects suffered only by women.³²⁷

treatment approach called "Equality as Acceptance" that is not dependent on a male norm and arguing in favor of the statute challenged in *Guerra* on these grounds).

323. See, e.g., Williams & Segal, *supra* note 20, at 364.

324. This mistake was made by the majority in *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976). See *supra* discussion Part I.B.1.

325. See Lynne M. Thomas, *Abandoned Frozen Embryos and Texas Law of Abandoned Personal Property: Should There Be a Connection?*, 29 ST. MARY'S L.J. 255 (1997) (noting decreased fertility, while most often associated with women, strikes men and women equally).

326. See *supra* notes 161-232 and accompanying text.

327. This neglect of the qualitative aspect to disparate impact is also evident from the fact that the key infertility cases cited to *International Union v. Johnson Controls, Inc.*, 499 U.S. 187 (1991), a challenge to a fertility classification in an adverse action, for support in rejecting the plaintiff's prima facie case. In *Johnson Controls*, the defendant employer excluded fertile women from certain jobs with high exposure to lead. *Id.* at 190. The employer argued that the exclusion should be viewed as a classification based on fertility and should be treated as gender neutral. *Id.* The plaintiff, on the other hand, argued that since the policy only excluded fertile women, it constituted facially disparate treatment. *Id.* at 198-99. The Supreme Court held that because the "policy classifies on the basis of gender

There is support for an approach that considers the qualitative impact of facially neutral policies in Title VII claims. For example, in *Garcia v. Spun Steak Co.*,³²⁸ plaintiffs challenged an employer's policy requiring its workers to speak only English while working. The plaintiffs argued that the facially neutral English-only policy violated Title VII because it had a per se discriminatory impact on all Spanish-speaking employees.³²⁹ The district court granted plaintiffs' summary judgment, and Spun Steak appealed.³³⁰

The court noted that this case was atypical and one of first impression because it did not involve a policy that created a barrier to hiring or promotion.³³¹ Rather, the claim was that the policy created disparities in the "terms, conditions, and privileges of employment" by prohibiting the vast majority of workers at Spun Steak from speaking their first language.³³² The Ninth Circuit made clear that a disparate impact claim may be used to challenge policies that have an adverse impact on the "terms, conditions, or privileges" of employment, even where no barrier to employment exists.³³³

and childbearing capacity, *rather than fertility alone*," the defendant could not even make a credible gender-neutral argument. *Id.* at 198 (emphasis added). Both *Krauel* and *Saks* relied heavily on this distinction in finding that no prima facie case was made out for the infertility exclusions. *Saks v. Covey*, 316 F.3d 337 (2d Cir. 2003); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 680 (8th Cir. 1996). However, the Court only used this distinction to find that the policy discriminated on its face and therefore was an obvious disparate treatment claim. A more reasonable implication from the Court's holding is that where a classification is based on fertility "alone", a disparate impact claim would be more appropriate. *Johnson Controls*, 499 U.S. at 198-99. Moreover, the Court's distinction between fertility and childbearing capacity/gender must be read in conjunction with the Court's ultimate holding that "Johnson Controls' policy is not neutral because it does not apply to the reproductive capacity of the company's male employees in the same way as it applies to that of the females." *Id.* at 199. It is necessary to determine whether an employer's policy does truly apply to the reproductive capacity of men and women "in the same way" in order to determine whether the prima facie case is made out. As already demonstrated in Parts II and III, this analysis can be very different in the case of denying reproductive health benefits than in the case of an adverse action, such as firing. See *supra* notes 84-232 and accompanying text.

328. 998 F.2d 1480 (9th Cir. 1993).

329. See *id.* at 1484.

330. See *id.*

331. See *id.* at 1486.

332. See *id.*

333. *Id.* at 1484; see also *Colby v. J.C. Penney Co.*, 811 F.2d 1119 (7th Cir. 1987) (finding that both disparate impact and disparate treatment Title VII proof theories are applicable in compensation discrimination cases); *Wambheim v. J.C. Penney Co.*, 705 F.2d 1492 (9th Cir. 1983), *cert. denied*, 467 U.S. 1255 (1984) (rejecting the argument that § 2000e-2(a)(1) does not permit disparate impact cause

More significantly, however, the court affirmed the viability of a disparate impact claim based on qualitative rather than quantitative effects.³³⁴ While the court rejected the plaintiffs' argument that there was a per se disparate impact, the court affirmed that a disparate impact claim could be based on qualitative effects.³³⁵ The dispositive issue was whether the plaintiff could in fact prove that a significant, adverse impact resulted from the policy.³³⁶ The court provided guidance for how a plaintiff could prove disparate impact when it is difficult to quantify:

When the alleged disparate impact is on the conditions, terms, or privileges of employment . . . determining whether the protected group has been adversely affected may depend on subjective factors not easily quantified. The plaintiff may not merely assert that the policy has harmed members of the group to which he or she belongs. Instead, the plaintiff must prove the existence of adverse effects of the policy, must prove that the impact of the policy is on terms, conditions, or privileges of employment of the protected class, must prove that the adverse effects are significant, and must prove that the employee population in general is not affected by the policy to the same degree.³³⁷

Thus, while plaintiffs do appear to have a more difficult hurdle to overcome in qualitative disparate impact claims, such claims can and should be used to challenge facially neutral benefits exclusions that have adverse effects on women. Legal scholars and health advocates have already amassed evidence of these effects—from medical studies documenting the relationship between lack of insurance coverage and increased health risks, to surveys documenting the extent to which women versus men are actually in need of and unable to get treatment for infertility or

of action). Despite the fact that there is nothing in the statute or regulations that restricts disparate impact to hiring and firing, some question whether disparate impact applies to claims of discrimination in other contexts. See, e.g., *Garcia*, 998 F.2d at 1485-86 (noting that the Supreme Court had expressly reserved deciding the issue whether disparate impact is available to challenge discrimination in the "terms, conditions, or privileges" of employment (citing *Nashville Gas Co. v. Satty*, 434 U.S. 136, 144 (1977))).

334. See *Garcia*, 998 F.2d at 1489.

335. See *id.* at 1486.

336. See *id.*

337. *Id.* The problem in this particular case turned on whether adverse effects could be proved. The court ultimately held that the bilingual employees did not make out the prima facie case and remanded with instructions to grant summary judgment in favor of Spun Steak. *Id.* However, for the claim by plaintiff-employees with limited proficiency in English, the case was remanded for further proceeding on the issue as to whether these employees were adversely impacted by the policy. *Id.* at 1490.

contraceptive services, to evidence of the extent to which employers' and insurers' biases about women's sexuality and value as pregnant employees motivate such decisions.³³⁸ This evidence should, at a minimum, satisfy the prima facie case for disparate impact, which the employer can then try to rebut.

3. Employer's Rebuttal as a Limit on Special Treatment

There is also an important check on courts' and employers' fears that the PDA will be used to require special treatment for prescription contraception or infertility. A finding that a prima facie violation is shown merely shifts the burden to the employer; it does not mean an automatic win for the plaintiff.³³⁹ In the case of a disparate impact claim, the employer has the opportunity to rebut the plaintiff's allegations of the presence and significance of the disparities.³⁴⁰ Alternatively, employers can offer a legitimate, neutral reason for the classification that supports the claim that men and women really do receive comprehensive coverage.³⁴¹

Shifting the burden in these cases is consistent with the purpose of Title VII and the PDA. This gives courts the chance to do a meaningful examination of the employer's reasons and plaintiff's claims of pretext, or in a disparate impact case, to meaningfully assess the overall impact of the employer's coverage of sex-specific conditions and treatment. Burden shifting is critical in ferreting out policies that are in reality discriminatory but that can be easily manipulated because of gender-neutral aspects. As I will show below, the plaintiffs in *Erickson v. Bartell Drug Co.* were able to demonstrate disparate treatment and effects based on the relationship of the excluded treatment to pregnancy.³⁴² However, they won because they were able to successfully challenge the employer's reasons—reasons which were not consistent with its other policy decisions or with accepted medical practice, leaving only an inference that gender bias motivated the exclusion.

C. Viewing the PDA as an Independent Source of Special Treatment for Pregnancy is a Red Herring

The bottom line is that the notion of the PDA as a tool for special treatment in these cases is a red herring. Relying on the

338. See *supra* notes 137-160 and accompanying text.

339. See *Garcia*, 998 F.2d at 1486.

340. See *id.*

341. See *id.*

342. See *infra* note 366-368 and accompanying text.

PDA and the relationship between the classification and pregnancy to help define the kinds of classifications that make out a Title VII prima facie case is not using the PDA to mandate special treatment for pregnancy. The limitations established under the equal treatment theory still apply, as made clear in *Newport News* and by the EEOC.³⁴³ For example, the PDA could not be used to require an employer to provide pregnancy-related health benefits where no other medical benefits are provided. However, where the employer has chosen to provide benefits and expressly excludes a pregnancy-related condition or treatment, the employer's classification should be scrutinized carefully.³⁴⁴

Using the PDA in this manner is consistent with its open-ended language covering not only pregnancy and childbirth, but "related medical conditions" as well.³⁴⁵ It is also consistent with the legislative history of the PDA documenting Congress's desire to protect "the whole range of matters concerning the childbearing process"³⁴⁶ and to recognize "the right of women to have families and to work" by giving them "the right to choose both, to be financially and legally protected before, during, and after pregnancy."³⁴⁷ The courts' preoccupation with the notion that the PDA is being used as an independent basis of protection is probably due as much to inartful pleadings by plaintiffs as to the courts' own confusion and resistance to Title VII challenges to benefits exclusions. However, once a meaningful disparate impact model is used, it should be clear that a PDA-based claim is not even necessary.

VI. *Erickson*: A Roadmap for Change or an Empty Promise?

In *Erickson*, a class action was brought under Title VII as amended by the PDA challenging the exclusion of prescription contraceptives from its otherwise comprehensive prescription

343. See *supra* notes 72-83 and accompanying text.

344. See Williams, *supra* note 48, at 333, 335. Williams writes:

The legal distinctions flowed from the central premise that men and women were destined for separate social roles because of innate differences between them, most centrally women's reproductive function . . . Implicit [in many of these rules] was not only a factual but a normative judgment: when wage-earning women became pregnant they did, and should, go home.

Id.

345. See 42 U.S.C. §2000e (2000).

346. H.R. REP. NO. 95-948, at 5 (1978), reprinted in 1978 U.S.C.C.A.N. 4745, 4753.

347. 124 CONG. REC. 38, 574 (daily ed. Oct. 14, 1978) (statement of Rep. Sarasin).

benefits plan.³⁴⁸ The court seemed to find this an easy case of facial disparate treatment in light of the framework established in *Newport News*, because the employer excluded medical treatment which was only available to women.³⁴⁹ The court could have stopped here, but it went further in using the PDA and the excluded benefit's relationship to pregnancy to support its holding. Specifically, the court highlighted the sex-specific purpose of contraception and the unique adverse health effects women suffer from the denial of access to such treatment due to their capacity to become pregnant.³⁵⁰ It then held that "classifying employees on the basis of their childbearing capacity, regardless of whether they are, in fact, pregnant, is sex-based discrimination" and "the law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception."³⁵¹

The employer attempted to rebut the plaintiff's prima facie case by offering several apparently neutral reasons for the exclusion.³⁵² The plaintiff successfully challenged the legitimacy of each of these reasons, further supporting an inference of discrimination.³⁵³ Briefly, the employer cited many of the common justifications set out in Part III of this Article—that medication to prevent pregnancy is not medically necessary since pregnancy is not an illness or disease, that preventive treatment is not considered medically necessary, and that prescription

348. *Erickson*, 141 F. Supp. 2d 1266, 1266 (W.D. Wash. 2001). The plan excluded prescription contraceptives such as birth control pills, Norplant, Depo-Provera, intra-uterine devices, and diaphragms. *Id.* at 1268. The claim was brought on behalf of the non-union female employees of Bartell. *Id.*

349. *Id.* at 1270-71.

350. *Id.* at 1271-73.

351. *Id.* at 1271. The *Erickson* decision reinforced the EEOC's interpretation of such exclusions in a decision issued the prior year. In December 2000, the EEOC issued a decision that the failure to offer insurance coverage for prescription contraceptive drugs and devices may be a violation of Title VII, as amended by the PDA. Equal Employment Opportunity Commission Decision (Dec. 14, 2000), available at <http://www.eeoc.gov/policy/docs/decision-contraception.html> (last visited Mar. 31, 2005) [hereinafter *EEOC Decision*]. The EEOC considered two types of exclusions: (1) a categorical exclusion of oral contraceptives for birth control, to alleviate the symptoms of dysmenorrhea and pre-menstrual syndrome, and to prevent the development of ovarian cancer, and (2) exclusion of Depo Provera for birth control purposes. *Id.* The EEOC used the same disparate treatment analysis as *Erickson* in finding that both exclusions violated Title VII. *See id.*; see also *Erickson*, 141 F. Supp. 2d at 1271. However, the EEOC also found that exclusions of prescription contraceptives used for birth control purposes violate the express terms of the Pregnancy Discrimination Act. *EEOC Decision*.

352. *See Erickson*, 141 F. Supp. 2d at 1272.

353. *See id.*; see also *supra* notes 161-232 and accompanying text.

contraception is a luxury or lifestyle choice.³⁵⁴ For the reasons given in Parts II and III, the plaintiff was able to show that such justifications were either not based on sound medical practice or were inconsistent with the employer's other coverage decisions.³⁵⁵ Finally, the employer also asserted a cost defense,³⁵⁶ however, the court relied on *Manhart* in holding that there was no cost defense in Title VII cases.³⁵⁷ The court also interpreted the legislative reversal of *Gilbert* as "requir[ing] employers to provide women-only benefits or otherwise incur additional expenses on behalf of women in order to treat the sexes the same."³⁵⁸

It may not be immediately clear whether *Erickson* offers an alternative model to that of the dominant approach or whether the plaintiffs were successful precisely because this was an easy case of disparate treatment. Indeed, the court makes it clear that it does not rely solely on the PDA when it notes that "regardless of whether the prevention of pregnancy falls within the phrase 'pregnancy, childbirth, or related medical conditions,' Congress' [sic] decisive overruling of *General Elec. Co. v. Gilbert* . . . evidences an interpretation of Title VII which necessarily precludes the choices [the employer] has made in this case."³⁵⁹ The court certainly does not claim to be doing anything novel or distinct. For several reasons, however, I believe that the court's reasoning suggests a bolder move that would allow plaintiffs a meaningful opportunity to bring disparate treatment and impact claims under Title VII.³⁶⁰

First, the court did not stop at the obvious link between the form of treatment and gender. It embraced the PDA-based claim and seemed to rely heavily on the relationship of prescription contraception to pregnancy in supporting its conclusion that gender inequality would result from this exclusion.³⁶¹ While this came primarily in analyzing the employer's justifications for the exclusion, the court's reliance on the PDA is a striking contrast to the dominant approach, which treated the PDA as irrelevant. Moreover, while the *Erickson* court did not have to address the disparate impact claim, it used language consistent with a

354. *Id.*

355. *Id.* 1272-75. For example, many types of preventive medication and treatment were covered. *Id.*; see also *supra* notes 84-232 and accompanying text.

356. *Id.* at 1275.

357. *Id.* at 1274; see also *Gen. Elec. Co. v. Gilbert*, 429 U.S. 125 (1976).

358. *Id.* at 1270; see also *Gilbert*, 429 U.S. at 125.

359. *Erickson*, 141 F. Supp. 2d at 1274 (citations omitted).

360. See *supra* notes 84-160 and accompanying text.

361. See *Erickson*, 141 F. Supp. 2d at 1275.

qualitative disparate impact analysis, highlighting the unique nature of the harm suffered by women as a result of such exclusions.³⁶² Finally, although the court did not have to deal with infertility exclusions, in dicta it seemed to view even such neutrally drawn categories with suspicion.³⁶³

In sum, *Erickson* seems to construct a model for a more powerful Title VII and PDA due to several reasons: its willingness to view reproductive health exclusions as likely proxies for gender discrimination; its willingness to consider the relationship between the excluded benefit and pregnancy in determining the unique cost and health effects suffered by women as a result of the exclusions; and its refusal to defer to employers' purported justifications and managerial discretion in light of the pervasive history of pregnancy-based discrimination.

Conclusion

Medicine can never be completely divorced from our social and moral judgments about the proper role of medical treatment in our lives or whether scarce resources should be used to provide such treatment. The role that morality plays is most prominent in the reproductive health area, especially for treatment that enables women to control their fertility. However, society has decided that discrimination based on certain kinds of assumptions is unacceptable because of the harm it can cause socially, psychologically, physically, and economically. Actions that exclude women or treat them differently based on gender stereotypes are such examples, and Title VII and the PDA were enacted precisely to combat this type of discrimination.³⁶⁴ Nonetheless, many courts have failed to embrace Title VII and the PDA as a means to eliminate discriminatory patterns in the allocation of employment-based health benefits.³⁶⁵

362. It is noteworthy that the court relied heavily on the substantive arguments made by Sylvia Law who used a disparate impact analysis in challenging exclusions of prescription contraception. See *Erickson*, 141 F. Supp. 2d at 1272-73; see also Ernest F. Lidge III, *An Employer's Exclusion of Coverage for Contraceptive Drugs is Not Per Se Sex Discrimination*, 76 TEMPLE L. REV. 533, 560 (2003) (characterizing the *Erickson* decision as confusing disparate treatment and disparate impact theories because of its discussion of the unique burdens suffered by women due to unwanted pregnancies).

363. For example, in a measured acknowledgement of the challenge of applying Title VII to exclusions of infertility treatment, the court noted that "there is at least an argument that the exclusion of infertility drugs applies equally to male and female employees . . ." *Erickson*, 141 F. Supp. 2d at 1275.

364. See *supra* notes 32-83 and accompanying text.

365. See *supra* notes 233-294 and accompanying text.

Erickson provides a model for salvaging Title VII as a tool for challenging the discriminatory allocation of benefits. This decision appears to embrace a more meaningful disparate impact analysis by looking beyond the employer's purported neutral classification scheme to consider how women are uniquely harmed by the exclusions and by closely scrutinizing the employer's justification.³⁶⁶ Practically, *Erickson* also demonstrates the importance of marrying health and civil rights law effectively. Health lawyers need to understand the fears driving the current civil rights framework because these fears have created an inherent resistance to benefits challenges. In this Article, I have tried to offer a tool to help counter this resistance by answering courts' fears of special treatment for pregnancy and by educating courts about the discriminatory patterns and effects that women face in reproductive health care.

I am hopeful that with the increasing medical and sociological evidence of the harmful effects on women and the growing outrage about insurance disparities because of high profile drugs like Viagra, the importance of Title VII and the PDA for challenging such exclusions will become more apparent. At least for now, *Erickson* has provided a good roadmap for using Title VII and the PDA to ensure true equality in employment-based health care.

366. See *supra* notes 348-363 and accompanying text.