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SEX DISCRIMINATION AND INSURANCE FOR CONTRACEPTION

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Abstract: Unintended pregnancy is a serious problem in the United States. Most private insurance plans do not pay for contraception even though they pay for other prescription drugs and devices. This Article argues that this pattern constitutes sex discrimination and is prohibited by Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act. It discusses the reasons this issue has been neglected and suggests ways federal and state officials might remedy this common form of gender discrimination.

More U.S. women confront unintended pregnancy than women in nearly every other developed country. One reason is that most employment-based health insurance programs in the United States exclude payment for contraceptives from otherwise comprehensive coverage for prescription drugs and medical services. The Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act of 1978 (PDA), prohibits discrimination in the provision of employee health benefits "on the basis of pregnancy, childbirth, and related medical conditions."[1] This Article considers whether the exclusion and limitation of coverage for contraceptive services in employment-based insurance programs violates the PDA.

Part I explores the incidence of unintended pregnancy and the medical, fiscal, social, and personal costs associated with it, and considers the ways in which lack of insurance coverage for contraception contributes to the problem of unwanted pregnancy. Part II describes patterns of delivery and financing of contraceptive services in the United States. Part III argues that the PDA prohibits employers from

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This Article originated when Kathryn Kolbert, Vice President of the Center for Reproductive Law and Policy, asked me whether Title VII prohibits employee benefit plans from discriminating against contraception. I was surprised to discover that the issue had never been addressed in law review literature or case law. Professor Sue Ross, a principal architect of the Pregnancy Discrimination Act of 1978, generously shared her insight into the meaning of that law. Many other people provided me with information and insight, including Janet Benshoof, Cary LaCheen, Roberta Riley, Kathy Kneer, and Theresa Connor. Martha Field and Katherine Franke critiqued an earlier draft. Jessica Tsai and John Marshall Bellwoar provided magnificent research and editorial help. My assistant, Leslie Jenkins, provided invaluable aid throughout. The NYU Law School's Filomen D'Agostino and Max E. Greenberg Faculty Research Fund provided financial support. I am grateful for all their help.

1. 42 U.S.C. § 2000e(k) (1994).

discriminating against women by excluding or limiting coverage for contraceptive services. Part IV asks why, if excluding contraception from employment-based health insurance is pervasive, damaging, and illegal (in other words, a slam-dunk legal argument), no one has noticed or asserted it. Part V discusses the impact and limits of applying the PDA to prohibit discrimination against contraception. Finally, Part VI describes and evaluates alternative ways in which the PDA might be enforced and considers state and federal proposals to increase insurance coverage for contraception.

I. UNINTENDED PREGNANCY IN THE UNITED STATES

Almost sixty percent of the 6.3 million pregnancies that occur annually in the United States are unintended.[2] This rate is higher than that in any other developed country except France and much higher than most developed countries.[3] Many factors contribute to unintended pregnancy.[4] One important cause is the failure to use effective forms of birth control; more than half of all unintended pregnancies occur among the ten percent of American women who report that they do not use birth control.[5] One reason why women do not use birth control is that health insurance commonly excludes coverage for effective forms of contraception that physicians provide.[6] This Part explores the adverse consequences of unintended pregnancy that flow, in significant part, from the exclusion of contraception from private insurance. Unintended pregnancy: (1) increases infant mortality and morbidity; (2) generates financial costs for childbirth and the care of distressed newborns; (3) leads to high rates of abortion; and (4) limits women's abilities to

2. Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* 1 (Sarah S. Brown & Leon Eisenberg eds., 1995) [hereinafter *Best Intentions*].

3. Elise F. Jones et al., *Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries*, 20 Fam. Plan. Persp. 53, 55 (1988).

4. Among teens, research suggests that one of the most important factors explaining the very high rates of unintended pregnancy in the United States is a general lack of candor about sexuality and conception, reflected in weak school-based sex education programs and the absence of frank discussions of contraception in the media, particularly in advertising. *See* Elise F. Jones et al., *Teenage Pregnancy in Developed Countries: Determinants and Policy Implications*, 17 Fam. Plan. Persp. 53, 54–58 (1985).

5. Alan Guttmacher Institute, *Contraception Counts: State-by-State Information*, May 1997, at 1.

6. *See infra* Part II.

perform and contribute to society and undermines national economic stability.

A. Unintended Pregnancy Increases Infant Mortality and Morbidity

Like the rates of unintended pregnancy, U.S. infant mortality and morbidity rates are higher than those of any other developed country and, indeed, higher than rates in many developing countries.[7] Many studies find that unintended pregnancy is the major explanation for these harms that newborns suffer.[8] These studies also show that increasing access to contraception is an important step in reducing infant mortality and morbidity.

It is not surprising that unintended pregnancies are more likely to produce unhealthy babies.[9] Pregnancy produces tremendous burdens on a woman's body and life, and an infant makes even greater demands on the mother and family. When a woman and family plan a child, they are better prepared to make the necessary sacrifices to meet the infant's needs. But when pregnancy is unintended, responding to the demands of pregnancy and infancy is much more difficult.[10]

The adverse effects of unintended pregnancy do not end in infancy. Unwanted children and adolescents are nearly twice as likely as wanted children to receive psychiatric care for both mild and severe

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7. *Best Intentions*, *supra* note 2, at 66–72. In 1985, the U.S. infant mortality rate ranked nineteenth in the world, worse than countries such as Singapore and Spain. George J. Annas et al., *American Health Law* 924 (1990). When comparing only the white U.S. infant mortality rate with other nations, the United States ranked fourteenth, worse than Japan and Hong Kong. *Id.* The U.S. black infant mortality rate ranked twenty-eighth, behind countries with fewer medical and economic resources such as Cuba and Bulgaria, and equal to Costa Rica. *Id.*

In 1991, 7% of all infants in the United States were born too small, and 11% were born too soon. Patricia H. Shiono & Richard E. Behrman, *Low Birth Weight: Analysis and Recommendations*, 5 Future of Children 4, 4 (1995).

8. For example, the National Commission to Prevent Infant Mortality reported: "If all pregnancies were planned, infant mortality could be reduced by an estimated 10 percent and low birthweight by 12 percent." National Comm'n to Prevent Infant Mortality, *Troubling Trends: The Health of America's Next Generation* 38 (1990) [hereinafter *Troubling Trends*].

9. "The child of an *unwanted* conception especially (as distinct from a *mistimed* one) is at greater risk of being born at low birthweights, of dying in its first year of life, of being abused, and of not receiving sufficient resources for healthy development." *Best Intentions*, *supra* note 2, at 1.

10. *See* McRae v. Califano, 491 F. Supp. 630, 668–73, 690 (E.D.N.Y. 1980) (summarizing evidence that woman's attitude toward her pregnancy is extremely important factor in determining whether pregnancy poses threat to her life or health, and noting that woman who is unable and unwilling to bear children often experiences great stress in pregnancy, which adversely affects her medical condition).

psychological disorders.[11] In addition, they are twice as likely to have a record of juvenile delinquency and three times more likely to have a record of adult criminal activity.[12]

B. Unintended Pregnancy Generates Increased Financial Costs

Even if unintended pregnancy results in a healthy baby, the financial costs of childbirth are much greater than the costs of many years of contraception.[13] If the unintended pregnancy results in a distressed newborn, the costs are even greater. "For every low-weight birth that is averted, the health care system saves between $14,000 and $30,000 in hospitalization costs associated with low birth weight in the first year of life."[14] It was estimated that by 1990:

> [T]he nation will have spent at least $2.1 billion in first-year costs alone to care for the excess numbers of low-birth weight infants who need extensive medical care and whose tragic situations could have been averted had the nation moved more rapidly to reduce the incidence of low birth weight.[15]

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11. *See Born Unwanted: Developmental Effects of Denied Abortion* 41 (Henry P. David et al. eds., 1988).

12. *Id.* at 42.

13. In 1993, the cost of oral contraceptives and associated physical exams was $1500 for five years, while the cost of Norplant was $700 for the same period. The cost of an IUD, which remains effective for eight years, was about $500. Alan Guttmacher Institute, *Uneven & Unequal: Insurance Coverage and Reproductive Health Services* 4 (1995) [hereinafter *Uneven & Unequal*]. By contrast, the cost of maternity care for a normal vaginal delivery was $4334 in 1989, and the cost of a Caesarean-section was $7186. *Id.* at 3.

In a study comparing medical costs of 15 contraceptive methods with no contraceptive method, it was found that regardless of the contraceptive method used, contraception saves money. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 Am. J. Pub. Health 494, 494 (1995). Over five years, the most cost-effective methods were the copper-T IUD, vasectomy, the contraceptive implant, and the injectable contraceptive, saving $14,122, $13,899, $13,813, and $13,373 respectively. *Id.* Oral contraceptives saved $12,879, and barrier methods, spermicides, withdrawal, and periodic abstinence saved $8933 to $12,239. *Id.* The researchers found that "savings generally are realized by third-party payers. . . . [B]usinesses and individuals receive an economic benefit if these savings yield lower premiums and increased profits or wages." *Id.* at 500; *see also* Dona J. Lethbridge & Kathleen M. Hanna, *Promoting Effective Contraceptive Use* 12 (1997).

14. Annas et al., *supra* note 7, at 930 (citing Office of Technology Assessment, *Healthy Children: Investing in the Future* 85 (1988)).

15. Children's Defense Fund, *The Health of America's Children: Maternal and Child Health Data Book* 25 (1987).

Reducing unintended pregnancy is the single most effective means of reducing the number of distressed, low birth weight babies.[16]

C. *Unintended Pregnancy Often Ends in Abortion*

The U.S. abortion rate is higher than that of any Western European country.[17] Almost half (forty-four percent) of all unintended pregnancies in the United States end in abortion.[18] Abortion imposes enormous financial[19] and psychic[20] costs on women even when it is legal. President Clinton asserts that abortion should be "safe and legal, but rare."[21] But abortion cannot be rare unless women have access to contraception.

D. *Unintended Pregnancy Limits Women's Abilities to Perform and Contribute to Society and Undermines National Economic Stability*

In addition to its emotional, financial, and human costs, unintended pregnancy damages the national and world economies and communities. The adverse social and economic consequences of unintended pregnancy fall most harshly on women. The U.S. Supreme Court recognized that reality when it upheld a woman's right to choose abortion in *Planned*

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16. *Best Intentions*, *supra* note 2, at 70.

17. Jeannie I. Rosoff, *Not Just Teenagers*, 20 Fam. Plan. Persp. 52, 52 (1988). The U.S. abortion rate is exceeded only by that in the developed countries of Eastern Europe and developing countries with strong population control policies. Of the developed countries, only the following have abortion rates higher than the U.S. rate of 27.5 per 100 pregnancies: Albania (31.2); Bulgaria (45.4); Czech Republic (33.5); Hungary (40.7); and Slovak Republic (32.4). In contrast, the following Western European countries have abortion rates much lower than the United States: England and Wales (19.0); Finland (13.3); Netherlands (9.6); and Scotland (15.0). Alan Guttmacher Institute, *Number of Legal Abortions, Abortion Rate and Abortion Ratio: Countries with Accurate Abortion Statistics* tbl. 1 (Apr. 1997) (unpublished table, on file with Alan Guttmacher Institute); *see also* Stanley K. Henshaw, *Induced Abortion: A World Review*, 22 Fam. Plan. Persp. 76, 78 (1990).

18. Jacqueline Darroch Forrest, *Epidemiology of Unintended Pregnancy and Contraceptive Use*, 170 Am. J. Obstetrics & Gynecology 1485, 1485 (1994).

19. Most women pay for abortions with cash in advance. In 1993, clinics charged an average of $341 for an abortion at 10 weeks with local anesthesia; abortion costs generally ranged from $140 to $1700. Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54, 57 (1995). Furthermore, because 84% of U.S. counties have no abortion provider, women often must travel to obtain services. Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1991 and 1992*, 26 Fam. Plan. Persp. 100, 100 (1994).

20. Often women seeking abortions must confront hostile and sometimes violent demonstrators. Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 Fam. Plan. Persp. 246, 250 (1991).

21. *President's Remarks on Signing Memorandums on Medical Research and Reproductive Health and an Exchange with Reporters*, 1 Pub. Papers 7 (Jan. 22, 1993).

Parenthood v. Casey, stating that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[22] Unplanned and unwanted pregnancies undermine women's abilities by precluding women from participating fully in the "marketplace and the world of ideas."[23]

In 1995, the President's Council on Sustainable Development identified six important factors in sustaining national economic growth; access to family planning services was one of those factors.[24] The Council recommended "[e]xpanding private insurance to cover the full range of reproductive health services"[25] and described the social and economic damages caused by unintended pregnancy:

> Because the United States has the world's third largest population and the largest economy, with an unparalleled scale of per capita consumption and waste generation, even slight changes in U.S. consumption patterns or population size can have a significant impact on sustainability.... [C]ontinued population growth steadily makes more difficult the job of mitigating the environmental impact of American resource use and waste production patterns.[26]

Thus, while unintended pregnancies are most damaging to the individual women who experience them, they also cause significant harm to society and the economy as a whole.

II. PATTERNS OF DELIVERY AND FINANCING CONTRACEPTIVE SERVICES IN THE UNITED STATES

Sterilization is the most commonly used form of contraception in the United States.[27] It is also the only medically prescribed and provided contraceptive service available to both men and women. In 1990, forty-two percent of all contraceptive users in the United States were protected

22. Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992).

23. Stanton v. Stanton, 421 U.S. 7, 14–15 (1975).

24. *See* The President's Council on Sustainable Development, *Sustainable America: A New Consensus for Prosperity, Opportunity, and a Healthy Environment for the Future* ch. 6 (1996).

25. *Id.* at 146.

26. *Id.* at 143.

27. Linda J. Piccinino & William D. Mosher, *Trends in Contraceptive Use in the United States: 1982–1995*, 30 Fam. Plan. Persp. 4, 5 (1998).

by sterilization (29.5% by female sterilization and 12.6% by vasectomy).[28] While sterilization is a safe and effective method of contraception, it has serious disadvantages. It requires surgery and is, as a practical matter, irreversible.[29] Nevertheless, surgical sterilization is the form of contraception most commonly covered by private insurance.[30] Women in the United States confront significant barriers to access to other effective forms of reversible contraception.[31] Perhaps this explains why so many more people in the United States choose sterilization than in any other country.

The contraceptive pill is one of the most commonly used forms of reversible contraception,[32] used by twenty-seven percent of women who practice contraception in the United States.[33] The pill is safe and highly effective when used properly.[34] Except for health maintenance

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28. William D. Mosher & Christine A. Bachrach, *Understanding U.S. Fertility: Continuity and Change in the National Survey of Family Growth, 1988–1995*, 28 Fam. Plan. Persp. 4, 6 (1996).

29. Many women, especially younger women, who are sterilized come to regret their decision. Institute of Medicine, *Contraceptive Research and Development: Looking to the Future* 192 (Polly F. Harrison & Allan Rosenfield eds., 1996) [hereinafter *Looking to the Future*].

30. Across the range of insurance plans, on average 86% cover all forms of surgical sterilization, while 90% of point-of-service networks cover both male and female sterilization. *Uneven & Unequal*, *supra* note 13, at 9.

The Alan Guttmacher Institute's 1995 study, *Uneven & Unequal*, was the first large-scale, comprehensive study of private insurance coverage of reproductive health care services in the United States. *Id.* at 5. The researchers distinguished four types of private health insurance. First, conventional indemnity plans reimburse a patient or a provider for covered services up to a specified dollar amount and account for 58% of insured employees. Second, a preferred provider organization (PPO) gives enrollees the option either to obtain care from a designated "preferred" provider or from an outside provider. An enrollee obtaining care from an out-of-network provider typically pays a higher cost-sharing amount. Third, in point-of-service plans, a primary physician acts as a gatekeeper to a network of specialists. Twenty-three percent of insured employees are enrolled in PPOs and similar point-of-service plans. Fourth, "[h]ealth maintenance organizations (HMOs) provide a defined, comprehensive set of health services to an enrolled population within a specified geographic service area. Providers are typically reimbursed on a capitated or other 'at risk' arrangement." *Id.* Nineteen percent of employees were enrolled in HMOs. *Id.*

31. *See* Rosoff, *supra* note 17, at 52.

32. Roberto Rivera, *Oral Contraceptives: The Last Decade*, in *Contraceptive Research and Development: 1984 to 1994: The Road from Mexico City to Cairo and Beyond* 24 (P.F.A. Van Look & G. Pérez-Palacios eds., 1994) [hereinafter *Contraceptive Research and Development*].

33. *See* Piccinino & Mosher, *supra* note 27, at 5.

34. The contraceptive pill has been subject to more studies to identify serious side effects than any other medicine in history. Sharon Snider, *The Pill: 30 Years of Safety Concerns*, FDA Consumer, Dec. 1990, at 8, 9. Over the years, scientists and drug companies have developed new formulations with lower doses. Pills marketed today have little effect on the risks of heart disease or stroke in healthy women who do not smoke. *Id.* While the relation between any drug and cancer is difficult to evaluate, the pill appears not to increase the risk of breast cancer and reduces the risk of cancer of the

organizations (HMOs), about two-thirds of private insurance plans exclude coverage for contraceptive pills, even though virtually all private insurance plans include coverage for other prescription drugs.[35] There is no FDA-approved contraceptive pill for men.[36]

Barrier methods, including the diaphragm and male and female condoms, are the third most popular contraceptive in the United States, used by 20.3% of contraceptive users.[37] Barrier methods have the added advantage of providing some protection against sexually transmitted diseases. However, they are much less effective in preventing pregnancy than other forms of contraception.[38] The male condom is available over the counter, while the diaphragm must be prescribed and fitted by a physician. Except for HMOs, over three-quarters of all U.S. private insurers exclude coverage for female diaphragms.[39]

Intrauterine devices (IUDs) are largely unavailable in the United States today, even though in Europe they are used by more than one quarter of all women using contraception.[40] The IUD is highly effective, has few adverse side effects in most women, and is the least expensive

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ovaries and of the endometrium; it may, however, increase the risk of uterine cancer. Rivera, *supra* note 32, at 30–32. The pill is less effective in actual use than in controlled settings because women must remember to use it every day. Robert A. Hatcher et al., *Contraceptive Technology* 119 (16th rev. ed. 1994).

35. Only 31% of non-HMO insured plans with less than 15 employees include coverage for pills. Only 32% of plans with less than 100 employees, and 33% of plans with more than 100 employees include coverage. *Uneven & Unequal*, *supra* note 13, at 9. However, between 95% and 97% of these plans include coverage for other prescription drugs. *Id.* By contrast, 89% of HMOs include prescription drug coverage and 84% of them cover contraceptive pills. *Id.*

36. Christina Wang et al., *Male Contraception: 1993 and Beyond*, in *Contraceptive Research and Development*, *supra* note 32, at 121, 122–28. Both national and international agencies have conducted clinical trials on the suppression of sperm production by hormonal methods. These methods, however, have several problems, including lower efficiency in Caucasian men, the need for several months of treatment before the effects are induced, and relatively high cost. *Id.* at 125.

37. The National Academy of Science reports that among couples who are married or in "union," 14.6% rely upon condoms and 5.7% use diaphragms. *Looking to the Future*, *supra* note 29, at 172–73.

38. Stanley K. Henshaw & Kathryn Kost, *Abortion Patients in 1994–1995: Characteristics and Contraceptive Use*, 28 Fam. Plan. Persp. 140, 146 (1996). Among typical users in 1988, 16% of couples using condoms experienced an unwanted pregnancy within the first year of use. Hatcher et al., *supra* note 34, at 115. A 1996 study by the Institute of Medicine reports an average one-year failure rate of 3% for combined oral contraceptives and 12% for condoms. *Looking to the Future*, *supra* note 29, at 96, 98.

39. Between 19% and 21% of indemnity plans cover diaphragms, while 23% of PPOs and 81% of HMOs do so. *Uneven & Unequal*, *supra* note 13, at 9.

40. Katherine Treiman et al., *IUDs—An Update*, Population Rep., Dec. 1995, at 1, 25.

form of contraception.[41] IUDs are unavailable to most women in the United States in part because doctors are not trained to provide them.[42] In addition, three-quarters of indemnity insurers and preferred provider organizations (PPOs) exclude coverage for IUDs.[43]

Norplant, a recent contraceptive alternative, consists of six plastic matchstick size capsules containing the hormone progestin implanted under a woman's skin.[44] By 1995, nearly one million U.S. women used Norplant.[45] Norplant has been subject to extensive testing and appears to be highly effective and safe.[46] Three-quarters of indemnity insurers and PPOs exclude coverage for Norplant.[47] Even though IUDs and Norplant are more economical than pills because they remain effective for many years, the cost for many years of protection must be paid up front.[48] This one-time cost creates a price barrier for women who do not have insurance coverage for contraception and hence must pay out of pocket.[49]

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41. *See* Irving Sivin, *IUDs: A Look to the Future*, in *Contraceptive Research and Development*, *supra* note 32, at 37, 39–44.

42. Patricia Cohen, *The IUD: Birth-Control Device That the U.S. Market Won't Bear*, Wash. Post, Aug. 6, 1996, at A1. The unavailability of the IUD is influenced by the fact that an early version of the device, the Dalkon Shield, was marketed aggressively and later found highly defective. Many women were injured, suits ensued, and the manufacturer declared bankruptcy. *See generally* Richard B. Sobol, *Bending the Law: The Story of the Dalkon Shield Bankruptcy* (1991).

43. *Uneven & Unequal*, *supra* note 13, at 9.

44. *See* Sheldon Segal, *A New Delivery System for Contraceptive Steroids*, 157 Am. J. Obstetrics & Gynecology 1090 (1987).

45. Albert George Thomas Jr. & Stephanie M. LeMelle, *The Norplant System: Where Are We in 1995*, 40 J. Fam. Prac. 125, 125 (1995).

46. *See* Rosemarie Thau & Ann Robbins, *New Implant Systems for Men and Women*, in *Contraceptive Research and Development*, *supra* note 32, at 91, 92.

47. Only 23% of insured plans with less than 100 employees cover Norplant, while 27% of self-insured plans and PPOs do so. *Uneven & Unequal*, *supra* note 13, at 9.

48. *See supra* note 13 (discussing costs).

49. *Birth Control Implant Gains Among Poor Under Medicaid*, N.Y. Times, Dec. 17, 1992, at A1. Women who do not qualify as poor generally obtain contraceptive services from private physicians. Poorer women rely upon clinics. In 1994, almost 6.6 million women received contraceptive services from more than 7000 subsidized family planning clinics. Jennifer J. Frost, *Family Planning Clinic Services in the United States, 1994*, 28 Fam. Plan. Persp. 92, 92 (1996). A variety of programs provide public financial support for family planning: Medicaid, federal funds provided under Title X of the Public Health Service Act, and state and local grants.

Title X is the popular name for the Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1506 (codified at 42 U.S.C. §§ 300–300a-8 (1994)). Through block grants to states, Title X allocates funds to qualified family planning providers. The congressional purpose behind Title X was "to make comprehensive, voluntary family planning services, and information relating thereto, readily available to all persons." 116 Cong. Rec. 24,094 (1970).

In summary, only fifteen percent of traditional indemnity plans cover all of the most commonly used reversible prescription contraceptives, and forty-nine percent of plans cover none of these methods.[50] This data reveals several patterns of discrimination. Most insurance plans treat all forms of reversible contraception disfavorably relative to other medical services, drugs, and devices.[51] Furthermore, most insurance plans treat prescription contraception used only by women (i.e., pills, diaphragms, IUDs, and Norplant) less favorably than medical forms of contraception used by men (i.e., sterilization).[52] Condoms, which both men and women may purchase and use, are, like other forms of non-prescription drugs, not typically covered by health insurance.[53]

Insurance coverage patterns also reveal a preference for irreversible sterilization over reversible forms of contraception.[54] The reasons for this preference are not clear. Indeed, treating permanent sterilization more favorably than reversible forms of contraception seems perverse. One possible explanation is that insurance has traditionally favored surgical services over other medical services. Today, however, virtually all insurance plans cover prescription drugs other than contraception.[55]

III. THE PREGNANCY DISCRIMINATION ACT AND INSURANCE DISCRIMINATION AGAINST CONTRACEPTIVE USERS

This Part considers the meaning of discrimination in the context of employee benefit plans that offer employees comprehensive coverage for

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In 1994, more than 85% of all U.S. counties had a least one clinic providing subsidized family planning services, and nearly three-quarters had at least one Title X-funded provider. Frost, *supra* at 97. Nonetheless, subsidized family planning clinics serve, on average, only 44% of all low-income, sexually-active women who need subsidized contraceptive services. In some states, family planning clinics serve more than 75% of all women in need, whereas in other states, they serve fewer than 30% of such women. *Id.* at 100.

50. *Uneven & Unequal*, *supra* note 13, at 12.

51. Ninety-seven percent of indemnity plans cover prescription drugs, but only 33% of such plans cover oral contraception. Ninety-nine percent of PPOs cover prescription drugs, but only 41% cover contraception. *Uneven & Unequal*, *supra* note 13, at 16.

52. *See supra* notes 30 (sterilization), 35 (oral contraception), 39 (diaphragms), 43 (IUDs), 47 (Norplant) and accompanying text.

53. Further, while condoms are useful in preventing sexually transmitted diseases, as a form of birth control they are far less reliable than pills, Norplant, or IUDs. Among abortion patients who were using a method of contraception during the month they became pregnant, the condom was the method most commonly used. Henshaw & Kost, *supra* note 38, at 146.

54. *See supra* note 30 and accompanying text.

55. *See supra* note 51.

medically necessary physician services, and drugs and devices prescribed by a physician and approved by the FDA, but exclude coverage for reversible forms of contraceptive services, drugs, and devices. As explained in Part II, this pattern is common.[56] Apart from HMOs, the typical insurance plan offered by U.S. employers and insurers excludes coverage for reversible forms of contraception.[57] The typical policy provides men coverage for all physician services and prescription drugs and devices, but denies women coverage for medical services and prescribed drugs and devices for reversible contraception.[58] These plans thus discriminate against women.

A. The Basic Title VII Claims

Title VII of the Civil Rights Act of 1964 makes it unlawful for an employer "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."[59] This prohibition applies to the benefits an employer provides its employees, including health insurance coverage, because "[h]ealth insurance and other fringe benefits are 'compensation, terms, conditions, or privileges of employment.'"[60]

Title VII prohibits employer policies that discriminate against women intentionally or explicitly. In the hiring context, explicit sex-based

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56. Typical employment-based health insurance plans of all forms exclude coverage for services, drugs, and devices that are for "pre-existing conditions," Rand E. Rosenblatt et al., *Law and the American Health Care System* 282–83 (1997), or are "experimental," *id.* at 211–15, 238–44, or "not medically necessary," *id.* at 147–59, 224–29. Obviously, insurance plans that cover prescription drugs do not pay for over-the-counter drugs and cosmetics not prescribed by a physician. In addition, these plans typically impose deductibles and co-insurance requirements. *See* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. Rev. 1, 8 n.34 (1986). This Article does not address these common limitations on insurance coverage, except insofar as employers and insurers impose greater limits on payment for contraceptive services than are imposed on other medical services.

57. *See supra* Part II.

58. For example, General Electric's insurance plan included coverage for services "such as prostatectomies, vasectomies, and circumcisions that are specific to the reproductive system of men." General Elec. Co. v. Gilbert, 429 U.S. 125, 152 (1976) (Brennan, J., dissenting).

59. 42 U.S.C. § 2000e-2(a)(1) (1994).

60. Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 682 (1983). *See generally* Arizona Governing Comm. v. Norris, 463 U.S. 1073, 1079 (1983) (finding that there is "no question" that deferred compensation plan constitutes condition or privilege of employment, and retirement benefits are compensation under Title VII).

discrimination can be justified only if the employer demonstrates that gender is a "bona fide occupational qualification," which requires the employer to show that "the essence of the business operation would be undermined" by hiring either women or men.[61] Title VII also prohibits employer policies that are neutral in form but discriminatory in effect. To establish a prima facie disparate impact claim, a plaintiff must show that the challenged employment practices "in fact fall more harshly on one group than another, without justification."[62]

Many reasons support the claim that excluding contraceptives from otherwise comprehensive coverage for physician services and prescription drugs disproportionately impacts women. The current state of technology permits prescription contraceptives only for women. Thus, when an employer covers all prescription drugs except for contraception, the discrimination against women is explicit. Because this characterization is based on technological limitations, however, treating the exclusion of coverage for prescription contraceptives as a facially neutral policy that has a discriminatory impact upon women seems more appropriate.[63]

Insurance policies that exclude coverage for contraception disproportionately impact women for two reasons. First, because all of the medically prescribed reversible methods of contraception must be obtained and used by women, they bear all of the physical risks and hassles that accompany obtaining and using reversible contraception. Second, because employment-based insurance plans that ordinarily cover prescription drugs single out and exclude coverage for contraception, women bear a disproportionate share of the out-of-pocket financial costs of health care services. Women spend approximately sixty-eight percent more in out-of-pocket health care costs than men.[64] More than twice as many women (7.4 million compared with 3.4 million men) had out-of-

61. *See, e.g.*, Diaz v. Pan Am. World Airways, Inc., 442 F.2d 385, 388 (5th Cir. 1971).

62. Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 681 (8th Cir. 1996); *see also* Dothard v. Rawlinson, 433 U.S. 321, 331–32 (1977) (invalidating height and weight requirements for prison guards that disproportionately excluded women and were not correlated to amount of strength "essential to good job performance").

63. The Reagan Administration argued that claims of discrimination on the basis of pregnancy could not be based on a theory of disparate impact, but courts have rejected that claim. *See, e.g.*, Scher v. Woodland Sch. Community Consol. Dist. No. 50, 867 F.2d 974 (7th Cir. 1988) (finding disparate impact where employer applied rule against combination of paid sick leave and unpaid leave more strictly to pregnant workers than non-pregnant workers).

64. Women's Research and Education Institute, *Women's Health Insurance Costs and Experiences* 2 (1994).

pocket expenditures for health care services that exceeded ten percent of their income.[65] The costs of prescription contraceptives, excluded from general insurance coverage, account for the largest portion of this disparity.[66]

Even if technology were to make effective prescription contraception available to men, excluding contraception from insurance coverage would still disproportionately impact women. Women, and only women, bear all of the *physical* burdens of unwanted pregnancy.

Once a plaintiff has established a prima facie case that a policy has a disproportionate adverse impact upon women, the employer may defend the policy by showing it is justified by business necessity.[67] It is difficult to imagine how an employer could show that "business necessity" requires excluding prescription contraceptive services from insurance coverage.

Historically, employment-based health insurance plans excluded vaginal deliveries and neonatal care from coverage.[68] In 1974, the U.S. Supreme Court held that denying medical and disability insurance for medical problems related to pregnancy was not a form of sex discrimination prohibited by the Equal Protection Clause.[69] Two years later, the Court held in *General Electric Co. v. Gilbert* that an otherwise-comprehensive insurance program that excluded pregnancy-related disabilities from disability coverage did not constitute sex discrimination prohibited by Title VII of the Civil Rights Act of 1964.[70] In upholding the policy, the Court stated:

> [The policy] does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities. While it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification . . . .
>
> The program divides potential recipients into two groups—pregnant women and nonpregnant persons. While the first group is

65. *Id.* at 6.

66. *Id.* at 10–11.

67. *Dothard*, 433 U.S. at 331–32.

68. *See* Law & Ensminger, *supra* note 56, at 59–60.

69. Geduldig v. Aiello, 417 U.S. 484 (1974).

70. General Elec. Co. v. Gilbert, 429 U.S. 125, 145–46 (1976).

> exclusively female, the second includes members of both sexes. . . . [T]here is no risk from which men are protected and women are not . . . [and] no risk from which women are protected and men are not.[71]

Applying this rationale to insurance coverage for reversible contraception, employers could argue that excluding reversible contraception from reimbursable services "does not exclude anyone from benefit eligibility because of gender but merely removes one" service from the list of compensable items. "While it is true that only women can become pregnant," so the argument would go, it does not follow that every insurance policy classification touching on pregnancy is a sex-based classification. The common U.S. insurance programs under consideration here merely "divide potential recipients into two groups"—those who seek to avoid pregnancy and those who do not. Thus, employers could argue that this division is not sex-based discrimination because both men and women might seek to avoid pregnancy. Because contraceptive services are denied to both men and women equally, employers might argue as in *Gilbert* that "there is no risk from which men are protected and women are not . . . [and] no risk from which women are protected and men are not."[72]

B. The Pregnancy Discrimination Act

Congress rejected *Gilbert*'s assertion that discrimination against pregnant women was not discrimination based on sex by adopting the Pregnancy Discrimination Act of 1978 (PDA).[73] The PDA prohibits covered employers from discriminating "on the basis of pregnancy, childbirth, or related medical conditions" and requires that "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."[74] Thus, the

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71. *Id.* at 134–38 (quoting *Geduldig*, 417 U.S. at 496–97).

72. *Id.* at 138 (quoting *Geduldig*, 417 U.S. at 496–97).

73. Pub. L. 95-555, 92 Stat. 2076 (codified as amended at 42 U.S.C. § 2000e(k) (1994)); *see also* California Fed. Sav. & Loan Ass'n v. Guerra, 479 U.S. 272, 277 n.6 (1987); Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 670–71 n.1 (1983).

74. 42 U.S.C. § 2000e(k). The full text of subsection (k) states:

> 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

legitimacy of denying employees coverage for reversible contraception hinges upon the meaning of the PDA.

Consider some defenses employers might offer to the assertion that excluding contraception from an otherwise comprehensive benefit program constitutes discrimination on the basis of sex. First, an employer might argue that excluding contraception from coverage is not sex discrimination because the exclusion is not made "on the basis of pregnancy, childbirth, or related medical conditions."[75] Second, an employer might assert that because insurance policies available in the commercial market typically exclude contraceptive services from coverage, the employer should not be required to include such coverage. Finally, some employers might assert that freedom of religious conscience allows them to deny coverage for contraception. These arguments will be considered in turn.

1. The Language of the PDA Excludes Contraception Coverage

The first likely response to the claim that the PDA prohibits excluding contraception from coverage is that the PDA requires equality only in relation to "pregnancy, childbirth, and related medical conditions."[76] Contraception is not included in this list. Contraception is about *avoiding* pregnancy and childbirth, employers could argue, not about protecting pregnant women from discrimination.

This argument, that the only effect of the PDA is to reverse *Gilbert*'s narrow holding that discrimination against pregnant workers is not sex discrimination, was advanced by the employers in *Newport News Shipbuilding and Dry Dock Co. v. EEOC*.[77] The plaintiffs challenged an employee benefit program that provided comprehensive benefits to

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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, and nothing in section 2000e-2(h) of this title shall be interpreted to permit otherwise. 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 for an abortion: *Provided*, that nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

42 U.S.C. § 2000e(k).

75. 42 U.S.C. § 2000e(k).

76. 42 U.S.C. § 2000e(k).

77. 462 U.S. 669 (1983).

workers and spouses, but denied pregnancy benefits to workers' wives. Justice Rehnquist, joined by Justice Powell, dissented. They embraced a strict reading of the PDA and urged that the first clause of the PDA, prohibiting discrimination on the basis of "pregnancy, childbirth, or related medical conditions," must be read as limited by the statute's second requirement that "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.*"[78] According to the dissent, the PDA "speaks only of female employees affected by pregnancy and says nothing about spouses of male employees."[79]

According to the majority, however, neither the words of the statute nor its legislative history supported the dissent's narrow reading of the statute. The majority recognized instead that the language of the PDA reflects a broad remedial purpose. "The 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions."[80] "[F]or all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex."[81] "The meaning of the first clause [of the PDA] is not limited by the specific language in the second clause, which explains the application of the general principle to women employees."[82] In short, the PDA broadly requires employers to treat equally pregnancy and pregnancy-related conditions for which benefits are provided to an employee or his or her otherwise qualified dependents.

The Court also has recognized repeatedly that the protection of Title VII, as amended by the PDA, is not limited to women who are already pregnant. For example, in *International Union, UAW v. Johnson Controls, Inc.*,[83] the Court held that an employer's policy excluding women from certain jobs because of concern for the health of the employee's potential fetus violated Title VII as amended by the PDA.[84] The Court found that the PDA's prohibition on pregnancy discrimination

78. *Id.* at 687–88 (Rehnquist, J., dissenting) (quoting 42 U.S.C. § 2000e(k)) (emphasis added).

79. *Id.* at 686 (Rehnquist, J., dissenting).

80. *Id.* at 684.

81. *Id.*

82. *Id.* at 678 n.14.

83. 499 U.S. 187 (1991).

84. *Id.* at 206.

applies both to policies that affect pregnant women and those that affect women's abilities to become pregnant.[85] A policy that explicitly classifies employees by their potential for pregnancy "[u]nder the PDA . . . must be regarded, for Title VII purposes, in the same light as explicit sex discrimination."[86]

Likewise, the dissent in *General Electric Co. v. Gilbert* explained that when evaluating a claim of discrimination by an insurance program, the relevant classification is not between pregnant women and non-pregnant individuals.[87] Rather, the relevant classification is "between persons who face a risk of pregnancy and those who do not."[88] Similarly here, an insurance program that excludes contraception from coverage discriminates against people "who face a risk of pregnancy and those who do not."[89] By adopting the PDA, Congress explicitly affirmed the reasoning and analysis of the *Gilbert* dissent.[90] Courts have consistently reaffirmed that the PDA protects not only pregnancy, but the risk of pregnancy as well.[91]

The PDA's explicit abortion exclusion also supports the conclusion that the Act's prohibition against discrimination on the basis of "pregnancy, childbirth, or related medical conditions"[92] includes a prohibition against unfavorable treatment of contraceptive services. The PDA specifically provides that the Act "shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion."[93] The abortion exclusion makes plain that Congress understood that a law prohibiting discrimination against benefits related to "pregnancy, childbirth, or related medical conditions"[94] would require coverage for

85. *Id.* at 199.

86. *Id.*

87. General Elec. Co. v. Gilbert, 429 U.S. 125, 161 n.5 (1976) (Stevens, J., dissenting).

88. *Id.* at 161–62 n.5 (Stevens, J., dissenting).

89. *Id.* (Stevens, J., dissenting).

90. For a summary of the legislative history expressly approving the views of the dissenting Justices, see *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 679 n.17 (1983).

91. *See id.* at 684 ("The 1978 Act makes clear that it is discriminatory to treat pregnancy-related conditions less favorably than other medical conditions."); *see also* cases cited *infra* notes 96–97, 107.

92. 42 U.S.C. § 2000e(k) (1994).

93. 42 U.S.C. § 2000e(k).

94. 42 U.S.C. § 2000e(k).

abortion unless Congress specified otherwise. The abortion exclusion confirms that Congress understood that discrimination against pregnancy and related medical conditions encompassed discrimination against measures taken to avoid pregnancy. If Congress had intended to leave employers free to disfavor contraceptive services in employee benefit plans, Congress could have easily added the words "or contraception" to the abortion exclusion. Congress did not do so.

Cases involving discrimination against women who seek treatment for infertility also confirm that the PDA's prohibition against discrimination on the basis of "pregnancy, childbirth, or related medical conditions"[95] must be read broadly to include insurance plans that treat contraception disfavorably. In *Pacourek v. Inland Steel*[96] and *Erickson v. Board of Governors*,[97] female employees were fired because they used sick leave time to obtain infertility treatment.[98] In both cases, the plaintiffs alleged sex discrimination, while the employers argued that discrimination on the basis of infertility did not constitute discrimination on the basis of sex within the meaning of the PDA.[99] The *Pacourek* court found in favor of the plaintiffs, noting:

> The basic theory of the PDA may be simply stated: Only women can become pregnant; stereotypes based on pregnancy and related medical conditions have been a barrier to women's economic advancement; and classifications based on pregnancy and related medical conditions are never gender-neutral. Discrimination against an employee because she intends to, is trying to, or simply has the potential to become pregnant is therefore illegal discrimination. It makes sense to conclude that the PDA was intended to cover a woman's intention or potential to become pregnant, because all that conclusion means is that discrimination against persons who intend to or can potentially become pregnant is discrimination against women . . . .[100]

The legislative history of the PDA supports the *Pacourek* court's conclusion. The House Report on the PDA stated, "In using the broad

95. 42 U.S.C. § 2000e(k).

96. 858 F. Supp. 1393 (N.D. Ill. 1994).

97. 911 F. Supp. 316 (N.D. Ill. 1995).

98. *Erickson*, 911 F. Supp. at 317–18; *Pacourek*, 858 F. Supp. at 1396.

99. *Erickson*, 911 F. Supp. at 319; *Pacourek*, 858 F. Supp. at 1400–02.

100. *Pacourek*, 858 F. Supp. at 1401.

phrase 'women affected by pregnancy, childbirth and related medical conditions,' the bill makes clear that its protection extends to the whole range of matters concerning the childbearing process."[101] Similarly, Senator Harrison Williams, the chief sponsor of the Senate bill leading to the PDA, observed, "[T]he overall effect of discrimination against women because they might become pregnant, or do become pregnant, is to relegate women in general, and pregnant women in particular, to a second-class status."[102] Representative Ronald Sarasin expressed a similar sentiment when he remarked that the PDA gives a woman "the right . . . to be financially and legally protected before, during, and after her pregnancy."[103]

The language of the PDA is expansive, covering "pregnancy, childbirth, or *related medical conditions*."[104] Furthermore, the legislative history demonstrates that the language of the PDA—particularly because of the phrase "related medical conditions"—was meant to be expansive. The *Pacourek* court agreed when it stated that "'[r]elated' is a generous choice of wording, suggesting that interpretation should favor inclusion rather than exclusion in the close cases."[105] Insurance coverage for contraception should be included under this broad interpretation.

That the PDA prohibits discrimination against women who seek to avoid pregnancy, as well as those who are pregnant, is confirmed by the Act's prohibition of discrimination against women who have had an abortion. The Equal Employment Opportunity Commission (EEOC) Guidelines, adopted at the time of the PDA's enactment, interpret the PDA to mean that an employer may not discharge, refuse to hire, or otherwise discriminate against a woman because she had an abortion.[106] Similarly, in *Turic v. Holland Hospitality, Inc.*,[107] the Sixth Circuit held that Title VII, as amended by the PDA, prohibits an employer from discriminating against an employee who has, or contemplates having, an abortion. The court said, "Since an employer cannot take adverse employment action against a female employee for her decision to have an

101. H.R. Rep. No. 95-948, at 5 (1978), *reprinted in* 1978 U.S.C.C.A.N. 4745, 4753.

102. 123 Cong. Rec. 29,385 (daily ed., Sept. 15, 1977) (statement of Sen. Williams).

103. 124 Cong. Rec. 38,574 (daily ed., Oct. 14, 1978) (statement of Rep. Sarasin).

104. 42 U.S.C. § 2000e(k) (1994) (emphasis added).

105. *Pacourek*, 858 F. Supp. at 1402.

106. 29 C.F.R. app. § 1604 (1997) ("An employer cannot discriminate in its employment practices against a woman who has had an abortion.").

107. 85 F.3d 1211, 1214 (6th Cir. 1996).

abortion, it follows that the same employer also cannot take adverse employment action against a female employee for merely thinking about what she has a right to do."[108] Because the discrimination prohibited by the PDA encompasses discrimination against women who have abortions, *a fortiori*, it encompasses discrimination against women who seek services designed to prevent conception.

A final difficulty with the argument that the PDA does not prohibit discrimination against measures to avoid pregnancy is that medical treatment is also about avoiding undesired consequences.[109] Virtually all employment-based insurance plans include coverage for preventive services such as screening exams to detect problems in healthy people,[110] as well as coverage for treatments that can delay or avoid adverse consequences.[111] Much of what standard medical practice does, and much of what health insurance pays for, is avoiding damaging consequences to the patient that will be more costly in the long run. Excluding contraception—also a preventive measure—from coverage effectively discriminates against employees who want to avoid the undesired consequence of pregnancy.

In sum, an employee benefit plan that provides comprehensive coverage for all prescription drugs and devices except those used to avoid unwanted pregnancy discriminates against women and violates

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108. *Id.*

109. Primary care providers have long sought the opportunity to intervene early in the course of diseases or even before their onset, and the benefits of incorporating prevention into medical practice have become increasingly apparent over the past 20 to 30 years. *See generally* U.S. Dep't of Health & Human Servs., *Healthy People 2000: Midcourse Review and 1995 Revisions* 3 (1996) (summarizing measures to avoid premature death, serious illness, and chronic disability).

110. *See* Paul S. Frame et al., *U.S. Preventive Services Task Force: Highlights of the 1996 Report*, 55 Am. Fam. Physician 567 (1997). For example, most employment-based insurance plans cover mammography to detect breast cancer, although different policies pay on different terms based on cost-benefit assessments. *See generally* David M. Eddy, *Rationing Resources While Improving Quality: How to Get More for Less*, 272 J. Am. Med. Ass'n 817 (1994) (assessing costs and benefits of covering various preventive services).

111. Estrogen replacement therapy to forestall osteoporosis and other diseases is the most commonly prescribed treatment in the United States. *See* IMS America, *IMS Reports New Products, Patent Expirations and DTC Advertising Prompt Shifts in 1997 U.S. Pharmaceutical Rankings* (Feb. 26, 1988) <http://www.ims-america.com/communications/pr_rank.htm> ("In terms of prescriptions dispensed, American Home's estrogen replacement drug, Premarin, held its lead spot in 1997...."). For other discussions of estrogen's role in disease prevention, see OnHealth, *Estrogen, Bones & Breast Cancer* (Nov. 26, 1996) <http://www.healthnet.ivi.com/hnews/9611/htm/estrogen.htm>, OnHealth, *Hormone Replacement and Alzheimer's* (Sept. 20, 1996) <http://www.healthnet.ivi.com/hnews/9609/htm/hormone.htm>, and OnHealth, *Hormone Therapy: A Lifesaver?* (Feb. 13, 1995) <http://www.healthnet.ivi.com/hnews/9602/htm/lifesave.htm>.

Title VII, as amended by the Pregnancy Discrimination Act. Employers' claims that the PDA should be read narrowly to exclude coverage for contraception are inconsistent with the language of Title VII and with the U.S. Supreme Court's interpretation of the Act.

2. *Commercial Market Health Insurance Policies Exclude Contraception Coverage*

A second employer response to the claim that the PDA prohibits excluding contraception from coverage is that health insurance policies available in the commercial market typically exclude contraception. The U.S. Supreme Court considered and decisively rejected this defense in *Arizona Governing Committee v. Norris*.[112] According to the Court:

> It would be inconsistent with the broad remedial purposes of Title VII to hold that an employer who adopts a discriminatory fringe benefit plan can avoid liability on the ground that he could not find a third party willing to treat his employees on a nondiscriminatory basis. An employer who confronts such a situation must either supply the fringe benefit himself, without the assistance of any third party, or not provide it at all.[113]

Title VII directly prohibits discrimination only by employers, not by insurance companies.[114] Some states, however, have created an additional cause of action against insurance companies that aid and abet employer discrimination prohibited by state or federal law.[115] In *Colorado Civil Rights Commission v. Travelers Insurance Co.*,[116] for instance, a state court considered a claim against both an employer *and* an insurance company for denying coverage for normal-birth deliveries in violation of the PDA. The insurance company had offered the employer the choice between policies excluding and including coverage for normal delivery.[117] The company selected the more limited policy, excluding

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112. 463 U.S. 1073 (1983).

113. *Id.* at 1090.

114. Title VII applies to employers with 15 or more employees and "any agent" of the employer. 42 U.S.C. § 2000e(b) (1994).

115. *See, e.g.*, Colo. Rev. Stat. Ann. § 24-34-402(1)(e) (West 1990). ("It shall be a discriminatory or unfair employment practice: for any person, whether or not an employer . . . [t]o aid, abet, incite, compel, or coerce the doing of any act [that violates the employment discrimination laws].").

116. 759 P.2d 1358 (Colo. 1988).

117. *Id.* at 1360.

coverage for pregnancy.[118] The court found the insurance company liable, explaining that the company "could not disclaim responsibility for aiding and abetting a discriminatory practice . . . simply because it offered [the employer] the option of selecting a policy providing comprehensive coverage for pregnancy."[119]

3. *Religious Convictions Permit Excluding Contraception Coverage*

Finally, some employers might assert that the employers' or other employees' religious convictions that contraception is immoral justify excluding contraception from general coverage for prescription drugs and medical services. Religious opposition to contraception has been a central factor in recent debates on proposed state laws requiring insurance coverage for contraception.[120] Title VII includes a special exemption for religious organizations, which provides that the prohibition against discrimination on the basis of race or gender does not apply "to a religious corporation, association, educational institution, or society 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."[121] In addition, Title VII provides:

> Notwithstanding any other provision of this subchapter, (1) it shall not be an unlawful employment practice for an employer to hire and employ employees . . . on the basis of . . . 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 . . . .[122]

Despite the language of Title VII, courts have interpreted these exemptions narrowly to prohibit invidious discrimination on the basis of gender. For example, a Jesuit university was allowed to require that a

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118. *Id.*

119. *Id.* The court stated further, "Travelers cannot avoid responsibility for conduct aiding and abetting a discriminatory act on the ground that it had no intent to discriminate." *Id.* at 1369.

120. *See infra* notes 160–61 and accompanying text.

121. 42 U.S.C. § 2000e-1(a) (1994).

122. 42 U.S.C. § 2000e-2(e)(1).

faculty member in the philosophy department be Jesuit,[123] but a Christian school was not entitled to fire a pregnant, unmarried teacher, even though the school claimed that the teacher's actions violated the church's moral and doctrinal precepts.[124] Moreover, the Ninth Circuit has held that the religious-based exemptions from Title VII's prohibition against discrimination apply only to hiring and firing decisions, and not to benefit determinations.[125]

Courts also hold that requiring people to contribute, through taxes or employee benefit contributions, to activities they consider immoral is not a burden on freedom of religious conscience. For example, an Amish farmer could not avoid paying social security tax simply because the tax violated his religious belief.[126] This general principle is not limited to taxation. Students who asserted that their religious beliefs prevented them from contributing to their university's health care system because it financed abortion services failed to state a claim under the Religious Freedom Restoration Act.[127]

Although federal law and the laws of many states protect health care workers who refuse to perform abortions for reasons of conscience,[128]

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123. Pime v. Loyola Univ., 585 F. Supp. 435, 441–43 (N.D. Ill. 1984), *aff'd*, 803 F.2d 351 (7th Cir. 1986).

124. Dolter v. Wahlert High Sch., 483 F. Supp. 266 (N.D. Iowa 1980). The court also noted that there was a triable question whether males who engaged in premarital intercourse in violation of the church's moral code were likewise discharged. *Id.* at 270 n.5; *see also* EEOC v. Pacific Press Publ'g Ass'n, 482 F. Supp. 1291, 1300 (N.D. Cal. 1979) (rejecting defense made by religious publishing house against unlawful retaliation claim that discharge was effected because plaintiff was "unresponsive to spiritual counsel"), *aff'd*, 676 F.2d 1271 (9th Cir. 1982).

125. Barbara Lindemann & Paul Grossman, 1 *Employment Discrimination Law* 255 (3d ed. 1996). For example, in *EEOC v. Fremont Christian School*, the court invalidated a health insurance benefit plan that, because of a religious belief that the male was the head of household, provided benefits only to single persons and married men. 781 F.2d 1362, 1366 (9th Cir. 1986). The court found that this policy did not fit within Title VII's narrow religious exemption and emphasized that Title VII exempts religious employers "only with respect to discrimination based on religion, and then only with respect to persons hired to carry out the employer's 'religious activities.'" *Id.* The court also held that the BFOQ exception "does not apply to the full range of possibly discriminatory employment actions," as the statute uses only the terms "hire" and "employ." *Id.*

126. United States v. Lee, 455 U.S. 252, 260 (1981); *see also* Droz v. Commissioner, 48 F.3d 1120 (9th Cir. 1995) (denying self-employed social security tax exemption to taxpayer who had religious objections to social security), *cert. denied*, 516 U.S. 1042 (1996).

127. Goehring v. Brophy, 94 F.3d 1294 (9th Cir. 1996), *cert. denied sub nom.* Goehring v. del Junco, 117 S. Ct. 1335 (1997); *see also* St. Agnes Hosp. of Baltimore v. Riddick, 748 F. Supp. 319 (D. Md. 1990) (holding withdrawal of hospital accreditation for refusal to provide family planning training did not violate hospital's religious freedom).

128. *See* Bruce G. Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 3 Det. C.L. Rev. 847, 868 (1986).

these laws provide no support for a religious employer who seeks to exclude contraception from an employee benefit plan. First, such conscience clauses are limited to abortion and do not include contraception.[129] Further, neither employers who provide coverage for contraceptive services nor their employees are required as a result of that financial contribution to use contraception themselves. Thus, the religious conviction justification for excluding contraceptive services from employer-based insurance plans carries little weight.

IV. FACTORS EXPLAINING THE PERSISTENCE OF UNFAVORABLE TREATMENT OF CONTRACEPTION IN HEALTH INSURANCE PLANS

Two main factors explain why no one has raised a Title VII challenge to the common exclusion of contraceptives from otherwise comprehensive health insurance coverage. First, women affected by this exclusion, and indeed responsible employers, have difficulty obtaining even basic information about insurance coverage. Second, there are few lawyers available who are willing to take the financial risk necessary to raise these claims.

A. The Selection and Negotiation of Health Insurance Coverage

Typically, an employer either selects a health insurance plan for employees or offers employees a choice of plans with different features at different costs.[130] Unfortunately, both employees and employers confront great difficulty in obtaining information about what is covered and what is excluded from health insurance plans. Following the Alan Guttmacher Institute's 1995 study revealing that most U.S. health insurers exclude contraception from otherwise comprehensive coverage for prescription drugs,[131] some employers and employees sought more detailed information about coverage in their own plans. They confronted great difficulty, however, obtaining detailed information about what their plans covered and excluded.[132]

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129. *Id.* at 853–54; *see also* Pierce v. Ortho Pharm. Corp., 417 A.2d 505 (1980) (holding that physician's moral refusal to work on drug developed by Ortho was not justified).

130. *See, e.g.*, Rosenblatt et al., *supra* note 56, at 243–44.

131. *Uneven & Unequal*, *supra* note 13, at 12.

132. Rosenblatt et al., *supra* note 56, at 243–44. For example, Susan C. Rosenfeld, former general counsel of the Memorial Sloan Kettering Cancer Center and a breast cancer patient and prospective

An employer or insurer that fails to provide information about what an insurance plan does or does not cover violates the law. Under the Employee Retirement Income Security Act (ERISA), the federal law governing employee benefits,[133] and under the laws of several states,[134] employees must receive understandable information about their insurance coverage. But these laws are frequently ignored.[135] Women

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HMO enrollee, telephoned six major HMOs in New York City in 1994 to ascertain their policies regarding breast cancer treatment. One eventually responded. The others refused to supply contracts or to disclose exclusions. One representative volunteered: "You don't know [what is covered] until you actually hand in that claim form." *Id.* at 244 (citing Susan C. Rosenfeld, *So You Want to Join an H.M.O.? Good Luck*, N.Y. Times, Aug. 9, 1994, at A23).

When Janet Benshoof, President of the Center for Reproductive Law and Policy, read the 1995 Alan Guttmacher Institute study, she asked the Center's insurer to give her information about coverage for contraception and other reproductive health services. Even as an employer, she discovered information was still hard to obtain. Eventually, Benshoof learned that her organization's health insurer excluded coverage for all contraception except three generic formulas for birth control pills only available by mail order. The Center has set up a self-insured program to cover these costs. Interview with Janet Benshoof, President, Center for Reproductive Law and Policy, New York (May 5, 1997).

In 1997, Cary LaCheen, who joined the NYU Law Faculty after a career fighting insurance discrimination against people with disabilities, attempted to obtain information about the benefits package provided to NYU employees by Oxford Health Plans. Despite the fact that managed care plans in New York are required by N.Y. Pub. Health Law § 4408(1) to provide extensive information to both enrollees and prospective enrollees on their benefits packages, she was unable to obtain this information after oral and written requests to both NYU and Oxford. Only after filing complaints with the New York State Department of Insurance and the New York State Department of Health did she receive such information. The New York State Department of Health subsequently issued a Statement of Deficiencies to Oxford based on her complaint. If a seasoned advocate had such difficulty obtaining basic information on a health plan's coverage limits and exclusions, it is fair to assume that most individuals, who have less knowledge of the law requiring such disclosure, do as well. Interviews with Cary LaCheen, Lawyering Instructor, NYU Law School, New York (June 3, 1997 & Sept. 9, 1997); *see also infra* note 134.

133. Under ERISA, employees are entitled to a summary describing their employee benefit plans "written in a manner calculated to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1) (1994). Employers who fail to comply with this requirement "may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper." 29 U.S.C. § 1132(c)(1) (1994).

134. In 1996, for example, the New York State Legislature passed an act providing:

> Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information . . . . The information to be disclosed shall include at least the following: (a) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered.

N.Y. Pub. Health Law § 4408(1) (McKinney Supp. 1998).

135. *See supra* note 132.

often learn that contraception is excluded when they receive a booklet from the insurance plan, after they have enrolled, or when they submit a claim and it is denied.[136] At that point, a woman's protest may be met with the response that she has "chosen" a plan that does not cover contraception.[137] Unfortunately, although employees are legally entitled to information about what their health plan covers, and although plans that exclude coverage for contraception may violate Title VII, few individual women or employers have sufficient financial incentive to address these legal violations. Both employers and employees are concerned with a wide range of complex factors in selecting a health insurance plan, and coverage for contraception may not be on the top of anyone's list.

B. The Availability of Attorneys to Enforce Title VII Claims

The general unavailability of lawyers to enforce Title VII claims also prevents the initiation of more claims against employers for excluding contraception from health insurance. First, private attorneys press claims under the Civil Rights Act for individual clients who believe they have suffered discrimination. These attorneys are the most important actors enforcing U.S. civil rights laws.[138] Clients seek the help of these lawyers

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136. *See supra* note 132.

137. *Cf., e.g.*, Bushman v. State Mut. Life Assurance Co. of Am., 915 F. Supp. 945, 953 (N.D. Ill. 1996) (lamenting that court was forced to deny coverage for respected, mainstream, life-saving medical care because it was excluded in health insurance policy that claimant had never been able to see). In *Bushman*, the insurance company did not send the policy to the employer until three months after it went into effect. *Id.*; *see also* Hilliard v. BellSouth Med. Assistance Plan, 918 F. Supp. 1016 (S.D. Miss. 1995) (denying preliminary injunction forcing insurance company to pay for high dose chemotherapy for multiple myeloma when plaintiff had chosen plan that did not cover procedure, even though that choice had not been explained to him).

While the issue has not been addressed specifically, it seems that the fact that some of the plans offered by an employer do not discriminate on the basis of sex should not defeat a challenge to an employment-based health insurance plan that does discriminate. Despite the fact that a particular plan includes discriminatory coverage provisions, the plan might be attractive to an employee for a variety of reasons, such as because a long-time physician is a member of the plan's network. Title VII does not include a general defense based on the employee's ability to avoid sex discrimination by picking a different job or a different benefit program. *See supra* notes 115–19 and accompanying text (explaining that insurance company cannot defend against state law violation of aiding and abetting employer discrimination on ground that insurer offered employer both discriminatory and non-discriminatory policies).

138. Title VII relies "on the private suit as a principal enforcement vehicle." Samuel Estreicher & Michael C. Harper, *Cases and Materials on the Law Governing the Employment Relationship* 868 (1990).

when they have suffered a serious injury such as the loss of a job or a promotion. While Title VII provides attorneys' fees for lawyers who are successful in civil rights claims,[139] private civil rights lawyers customarily ask clients to pay out of pocket for the costs of litigation. Moreover, the U.S. Supreme Court has interpreted attorney fee statutes to mean that lawyers may not receive enhanced fees for bringing claims that are novel or uncertain.[140] Given the costs of contraception and the costs of litigation, individuals are unlikely to seek or find a lawyer to raise challenges to discriminatory insurance plans that do not cover contraception.

Second, civil rights organizations could bring suits arguing that excluding contraceptive services violates the Pregnancy Discrimination Act. But their resources are limited and many other serious issues demand their attention.[141] Third, the EEOC, which has primary executive

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139. 42 U.S.C. § 2000e-5(k) (1994) ("In any action or proceeding under this subchapter the court, in its discretion, may allow the prevailing party . . . a reasonable attorney's fee . . . .").

140. Pennsylvania v. Delaware Valley Citizens' Council for Clean Air, 483 U.S. 711, 730 (1987). The risk of losing a lawsuit is not "an independent basis for increasing the amount of any otherwise reasonable fee for the time and effort expended in prevailing." *Id.* at 725.

141. For example, the Center for Reproductive Law and Policy (CRLP) has challenged dozens of state restrictions on Medicaid funding and restrictive informed consent laws, particularly for minors. It persuaded the FDA to recognize the emergency use of contraceptive pills, defended testing for RU-486, and challenged restrictions on birth control information on the internet. *See* Center for Reproductive Law & Policy, *Press Advisory* (Mar. 9, 1998) (challenging Florida partial-birth abortion bill) (on file with *Washington Law Review*); Center for Reproductive Law & Policy, *Reproductive Freedom News* (visited Apr. 2, 1998) <http://www.echonyc.com/~comstop/> (citing CRLP articles discussing internet issues); Center for Reproductive Law & Policy, *Women of the World: Formal Laws and Policies Affecting Their Reproductive Lives* (1995) (visited Apr. 2, 1998) <http://www.echonyc.com/~jmkm/wotw/> (discussing women's reproductive rights issues in United States and abroad).

During the 1996 U.S. Supreme Court term, the NOW Legal Defense and Education Fund (LDEF) filed over a dozen briefs on issues including anti-abortion violence, child support enforcement, employment discrimination, and peer sexual harassment in schools. *See* NOW Legal Defense & Education Fund, *1996–1997 Legal Docket* (1997). NOW LDEF has devoted enormous resources to protecting access to abortion clinics and challenging laws that penalize poor women who have children.

The National Abortion and Reproductive Rights Action League (NARAL) worked to discourage Congress from adopting a criminal prohibition on late-term abortions. *See* National Abortion & Reproductive Rights Action League, *Abortion Rights: Late Term Abortion Ban* (visited Apr. 2, 1998) <http://www.naral.org/issues/lateterm.html> (listing NARAL sites addressing late-term abortions); *see also* National Abortion & Reproductive Rights Action League, *1998 Summary of Findings on Reproductive Rights in the States* (visited Apr. 2, 1998) <http://www.naral.org/publications/whod98summary.html> (summarizing state-by-state review of abortion and reproductive rights).

responsibility for enforcing U.S. civil rights laws, could initiate litigation or other efforts to discourage employers from discriminating against women by excluding contraception from health insurance benefits programs. In recent years, however, the small EEOC staff has struggled with a backlog of bread-and-butter race and sex discrimination claims, sought to address the problems of sexual harassment in the workplace, and attempted to respond to a significant public and judicial backlash against affirmative action programs.[142] With its energies focused on simply maintaining its already established caseload, expecting the EEOC to take on the new issue of employee benefit plan discrimination against contraception seems unrealistic. Furthermore, Title VII does not authorize the EEOC to issue regulations clarifying and implementing the meaning of the statute.[143]

Despite these fiscal and statutory limitations, the EEOC could do more than it is currently to prevent employers from discriminating against women by excluding contraceptives from coverage. For instance, the EEOC could issue a general "enforcement guidance" memo[144] to clarify that the PDA's prohibition against discrimination on the basis of pregnancy and related conditions condemns employer policies that treat contraception less favorably than other physician services and prescription drugs. Alternatively, in response to a request by an

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Other groups, including the Reproductive Freedom Projects of the American Civil Liberties Union and the New York Civil Liberties Union have worked to assure that medical students and Ob.-Gyn. residents have opportunities to learn how to perform abortions, and monitored hospital mergers so abortion services would not disappear from a particular community or state. *See* ACLU Reproductive Freedom Project, *Biennial Report 1996–97*, at 11 (on file with *Washington Law Review*); *see also* American Civil Liberties Union, *The ACLU Reproductive Freedom Project* (visited Mar. 9, 1998) <http://www.aclu.org/issues/reproduct/about.html> (describing Reproductive Freedom Project work); New York Civil Liberties Union, *NYCLU Reproductive Rights Project* fact sheet (on file with *Washington Law Review*) (describing project).

142. At the end of 1994, the EEOC had about 100,000 unresolved claims of race and sex discrimination lawsuits pending, twice its 1992 backlog. Peter T. Kilborn, *A Family Spirals Downward in Waiting for Agency to Act*, N.Y. Times, Feb. 11, 1995, at A1. In recent years, the EEOC has won substantial settlements in sexual harassment suits against Mitsubishi and Del Laboratories. *See* Carey Goldberg, *Company to Pay Record Amount in L.I. Sexual Harassment Case*, N.Y. Times, Aug. 3, 1995, at A1; Andrew Pollck, *Mitsubishi Wants Settlement of U.S. Sexual Harassment Suit*, N.Y. Times, Apr. 25, 1996, at D1.

143. Congress explicitly limited the EEOC's regulation-issuing powers to procedural matters. *See* 42 U.S.C. § 2000e-12(a) (1994); *see also* General Elec. Co. v. Gilbert, 429 U.S. 125, 141–42 (1976) ("Congress, in enacting Title VII, did not confer upon the EEOC authority to promulgate rules or regulations pursuant to that Title.") (citation omitted).

144. For an excellent discussion of this commonly used EEOC process, see Alfred W. Blumrosen, *The Binding Effect of Affirmative Action Guidelines*, 1 Lab. Law. 261 (1985).

employer, state human rights commissioner, or interested party, the EEOC could issue an opinion letter making the principle clear.[145] Given that the EEOC's resources are miniscule relative to its responsibilities, however, no inference about the meaning of the PDA should be drawn from EEOC silence or inaction.

Further, the nature of the legal claim at issue here—the right of women who seek to avoid pregnancy to obtain employee insurance benefits that include contraceptive services—contributes to the lack of incentive to assert the claim in court. However important the issue is in the aggregate, the impact on individual women may be less significant. For example, when a woman is fired as a result of sex discrimination, she has a powerful incentive to sue: to get her job back and collect back pay. In contrast, the regular cost of buying oral contraceptives, or even the one-time cost of obtaining Norplant or an IUD, is smaller than the cost of hiring a lawyer to enforce the legal claim. These facts affect the incentives of both individual women and the attorneys who might represent them.[146]

V. THE POTENTIAL IMPACT OF FEDERAL JUDICIAL ENFORCEMENT OF THE PDA

Although enforcing the PDA to require that contraception be treated like other medical treatments would not increase access to birth control for all women,[147] it would make a significant difference in making contraception more accessible and less costly to many women. First, it would make contraceptive services more accessible to large numbers of working women. Second, it would make such coverage available to the wives of men employed in companies that provide coverage for workers' dependents.[148] Third, although a somewhat less certain argument,

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145. *See* 29 C.F.R. § 1601.91 (1997) ("Any interested person desiring a written Title VII interpretation or opinion from the Commission may make such a request.").

146. The out-of-pocket costs of contraceptives are most burdensome for poor women. In recent years, advocates for the poor have had a full plate of work seeking Medicaid and Title X funding for family planning services. Nonetheless, these programs are limited and most women with incomes below the federal poverty line do not qualify for federally financed contraceptives. Frost, *supra* note 49, at 98; *see also supra* note 49 (discussing Title X).

147. Title VII only applies to employment-related insurance policies. *See, e.g.*, Lutcher v. Musicians Union Local 47, 633 F.2d 880, 883 (9th Cir. 1980) (explaining that Title VII applies only where there is some connection with employment relationship).

148. *See* Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669 (1983). The court held that employers are not required to provide any coverage for spouses, but to the extent that they

applying the PDA to contraception would make services available to the teenaged dependents of workers employed in jobs that offer coverage for dependents.[149] Treating contraception the same as other medical services might also help to make such services more socially acceptable to impressionable teenagers.[150]

Although it is not possible to document precise connections between insurance coverage for contraception, contraceptive use, unwanted pregnancy, and the tragic harms described in Part I, people who use effective forms of contraception are less likely to get pregnant than those who do not.[151] Common sense suggests that if physician services and prescription drugs for contraception are included in insurance plans on the same terms as other medical services and prescription drugs, more

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do, they may not discriminate against pregnancy-related conditions. *Id.* at 683–84. Disfavorable treatment of a spouse's pregnancy-related condition would constitute prohibited sex-based discrimination against the male worker. *Id.*; *see also* 29 C.F.R. app. § 1604.10 (1997).

149. One of the issues in *Newport News* was a colloquy in the legislative history of the PDA. *Compare Newport News*, 462 U.S. at 678–82, with *id.* at 691–93 (Rehnquist, J., dissenting). While no one in Congress opposed the basic concept of the Act, some Senators, led by Senator Hatch, offered limiting amendments. Senator Hatch observed that the language of the first section, prohibiting discrimination against "women affected by pregnancy, childbirth or related medical conditions" was very broad. *Id.* at 692 (Rehnquist, J., dissenting) (citing 123 Cong. Rec. 29,643 (1977)). Senator Hatch asked, "[W]hat about the status of a woman coworker who is not pregnant but rides with a pregnant woman and cannot get to work once the pregnant female commences her maternity leave or the employed mother who stays home to nurse her pregnant daughter? Are they women 'affected by' pregnancy?" *Id.* at 681 (citing Cong. Rec. 29,644). Senator Williams, the lead sponsor of the bill, protested that the PDA would not cover those situations. Senator Hatch concluded by asking, "[T]his act only applies to the particular woman who is actually pregnant, who is an employee and has become pregnant after her employment?" *Id.* at 693 (Rehnquist, J., dissenting) (citing Cong. Rec. 29,644). Senator Williams responded, "Exactly." *Id.* (Rehnquist, J., dissenting) (citing Cong. Rec. 29,644).

Apparently relying upon this legislative history, the EEOC guidelines do not require equal treatment of workers' male and female children. They provide: "[I]nsurance does not have to cover the pregnancy-related conditions of other dependents as long as it excludes the pregnancy-related conditions of the dependents of male and female employees equally." 29 C.F.R. app. § 1604.10 Thus, EEOC guidelines appear to allow an employer to provide comprehensive health insurance for workers' dependent male children and no coverage for female children, or visa versa, so long as the children of male and female *workers* are treated in an equally discriminatory way.

This interpretation of Title VII and the PDA seems inconsistent with the larger remedial purpose of the law. All women are hurt when female dependents are denied coverage for pregnancy-related services. The fact that the daughters of male workers as well as female workers are equally disadvantaged does not make the sex-based discrimination acceptable.

150. Teenagers in the United States experience higher rates of unintended pregnancy than those in most other developed countries. *See* Jones et al., *supra* note 4, at 54. While mass media and culture encourage sex, U.S. teens have less access to contraceptive information and services than teens in other countries. *Id.*

151. *See* discussion *supra* Part II.

people will use effective forms of contraception. In part, the effect is economic. If the drug or service is covered by insurance, people on tight budgets are more likely to use them. But the effect is not simply economic. When an insurance program that provides broad coverage for physician services and prescription drugs excludes coverage for contraception, that exclusion conveys a message that discourages contraception.

VI. THE CONTRACEPTION DISCRIMINATION PROBLEM: ALTERNATIVES TO FEDERAL ENFORCEMENT OF THE PDA

Federal regulatory or judicial enforcement of the PDA is only one means by which discrimination against women seeking coverage for contraceptive services might be addressed. In the 1990s, a growing number of pro-choice women's organizations and individuals have begun to address the problem of insurance coverage for contraception as well.[152] Employers should be educated to understand that excluding coverage for contraception burdens women and generates financial costs that are significantly greater than those of providing insurance for contraception.

A. State Legislation

In the late 1990s, several states have considered measures to remedy the common problem of insurance plans treating contraceptive services unfavorably. These legislative approaches, debated in California,[153]

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152. *See, e.g., Uneven & Unequal, supra* note 13; Center for Reproductive Law & Policy, *Improving Access to Contraception: A Plan for Action* (1997) (on file with author); Center for Reproductive Law & Policy Contraceptive Conference, New York, N.Y. (July 18–20, 1997).

153. *See* Dana Wilkie, *Birth Control Benefits Bill Vetoed: Measure Sought to Reduce Unwanted Pregnancies*, San Diego Union-Tribune, Oct. 18, 1995, at A3. In 1997, one newspaper reported that contraceptives:

> remain the one class of federally approved drug benefits most frequently refused coverage by health insurers across the country. That omission has inspired legislation supported by more than two dozen women's groups and medical associations who want to make contraceptive coverage universal in every group or individual policy issued in California.

Catherine Bridge, *Contraceptive Drug Coverage Could Be a Health-Plan "Must,"* Sacramento Bee, June 30, 1997, at IB10.

Some California legislators have asserted that contraceptives are cheap and women can always pay for them out of pocket. Interview with Kathy Kneer, Executive Director, Planned Parenthood Affiliates of California (Apr. 20, 1998). Others have suggested that women could pay for contraceptives with credit cards. Any medical service can, of course, be charged to a credit card, but most people prefer insurance. Yet others suggested that contraception is similar to hair spray and

Virginia,[154] New York,[155] and Connecticut,[156] would prohibit insurance plans that treat contraception less favorably than other medical services or prescription drugs. The debates in these states illuminate the substantive issues at stake in considering whether basic health insurance coverage should include payment for contraception. Three arguments have been offered against mandatory equal coverage for contraception.

First, those who oppose legal requirements that treat contraception equally with other physician services and prescription drugs have relied on general arguments opposing laws requiring employers or health insurers to provide coverage for particular benefits.[157] Second, opponents of state laws requiring equal coverage for contraception further assert that "a mandate would put too great a burden on small businesses."[158] Given that contraception costs much less than abortion, delivery, or the

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should be financed out of pocket. But contraception costs much more than hair spray. Moreover, contraceptives are prescription drugs, while hair spray is not. Finally, the adverse consequences of unwanted pregnancy are much greater than the consequences of un-sprayed hair. *Id.*

In 1995 and 1998, Governor Pete Wilson vetoed bills that would have required coverage for contraception. *See* Dan Bernstein, *Contraceptive Coverage Mandate Vetoed*, Sacramento Bee, Feb. 12, 1998, at A3.

154. *See* David Ress, *Birth Control Insurance Bill Dealt Setback; State Study Commission Votes Against Mandating Coverage*, Richmond Times Dispatch, Sept. 20, 1996, at B6. In 1996, one house of the Virginia legislature passed laws to require both public and private employers to provide insurance coverage for contraception. In 1997, however, Virginia adopted weakened laws requiring public and private employers simply to *offer* coverage for contraception if the woman is willing to pay an additional premium. *See* Va. Code Ann. §§ 2.1-20.1, 38.2-3407.5:1 (Michie Supp. 1997); *see also* Patrick Lee Plaisance, *Insurance Law on Birth Control Raises Questions*, Newport News Daily Press, Sept. 4, 1997, at 1.

155. In 1996 and 1997, the New York State Assembly passed a bill requiring that all insurers providing prescription coverage also provide equal coverage for contraceptive prescriptions. Although a similar bill was introduced in the State Senate, it was never considered. Planned Parenthood of New York City, *Planned Parenthood of New York City Supports the Equity in Prescription Insurance and Contraceptive Coverage Act of 1998* (on file with *Washington Law Review*).

156. *See* Jonathan Rabinovitz, *Connecticut Lawmakers Try Again to Force Health Insurers to Pay for Birth Control*, N.Y. Times, Feb. 25, 1998, at B5.

157. For example, in Virginia, George H. Heilig, Jr., Chair of the House Corporations, Insurance and Banking Committee and of a commission on mandated benefits, said, "[I]t does take away [the] choice the employer has in designing policies and from individuals in buying policies." Ress, *supra* note 154, at B6.

158. This was the principal reason cited by Governor Pete Wilson when he vetoed the California bill that would have required insurers to cover contraceptives to the same extent they cover other prescription drugs. *Statelines California: Women's Groups Denounce Contraception Veto*, Health Line (Am. Political Network), Oct. 23, 1995, available in Westlaw (10/23/95 APN-HE 8).

treatment of newborns, which are typically covered by health insurance,[159] this cost argument is difficult to understand.

Third, opponents contend that contraceptive coverage would violate the religious freedom of those who believe contraception is immoral. For example, Catholic organizations led opposition to a proposed mandate in California that required equal treatment for prescription contraception, arguing that "religious hospitals and Catholic employers must abide by ethical directives forbidding the use of contraceptive drugs to regulate births."[160] Most U.S. employers and hospitals, however, do not share religious convictions forbidding the use of contraceptive devices. Even Catholic employers who regard contraception as a sin cannot justify discriminating against women on the basis of pregnancy or contraceptive use.[161]

B. ERISA Limitations on State Authority

ERISA[162] severely limits the traditional power of the states to regulate insurance, prohibit discrimination, and promote health and welfare. One goal of ERISA is to protect employers from conflicting commands of state and federal law.[163] ERISA prohibits states from mandating benefits or defining discrimination in self-insured employee benefit plans more broadly than federal law.[164] In areas where state and federal laws do not conflict, ERISA preserves state authority to regulate insurance. States, therefore, retain significant power to mandate benefits and prohibit

159. *See supra* notes 13 (contraception), 19 (abortion), and text accompanying note 15 (low birth weight babies).

160. Wilkie, *supra* note 153, at A3; *see also* Planned Parenthood Affiliates of California, *AB 160—Action Alert!!! Tell the Governor: "Sign AB 160—My Conscience Needs Protection, Too!,"* Jan. 29, 1998 (on file with *Washington Law Review*).

161. *See supra* Part III.B.3.

162. 29 U.S.C. §§ 1001–1461 (1994).

163. A central purpose of ERISA preemption is to protect employee benefit plans "by eliminating the threat of conflicting and inconsistent State and local regulation." Shaw v. Delta Airlines, 463 U.S. 85, 99 (1983) (citation omitted).

164. ERISA provides that it "shall [not] be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d). It also prohibits states from requiring employee benefit plans to cover particular medical conditions or services. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985).

insurance discrimination in all health insurance programs other than those of self-insured employee benefit plans covered by ERISA.[165]

Since 1995, the U.S. Supreme Court has interpreted ERISA narrowly to allow states greater flexibility to regulate health insurance plans traditionally within the scope of ERISA.[166] Despite this new federal recognition of state power to regulate health insurance, this section assumes that ERISA still prohibits states from imposing mandatory benefit requirements or anti-discrimination rules that go beyond what is required by federal law.

C. *State Authority to Enforce Title VII*

Even though ERISA prohibits states from imposing mandatory benefit requirements or anti-discrimination rules that go beyond what is required by federal law, states continue to play an important role in interpreting and enforcing Title VII. As the enforcer of federal law, a state may—and indeed it must—interpret Title VII as amended by the PDA.

Washington State leads the nation in legislation addressing insurance coverage for contraception. In 1973, prior to the adoption of the Pregnancy Discrimination Act, the state Human Rights Division adopted a rule requiring the following: "Insurance benefits provided by the employer must be equal for male and female employees. For example: (a) If full health insurance coverage is provided for male employees, then

165. *Metropolitan Life*, 471 U.S. at 744.

166. In 1995, a unanimous U.S. Supreme Court held that ERISA does not preempt state laws, including hospital rate regulations, that have only an "indirect" impact on ERISA plans. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 660–62 (1995). While *Travelers* gives an important green light to state regulation of ERISA plans, that case and those that followed have consistently suggested that state laws mandating the inclusion of particular benefits in employee benefit plans are not similarly free from ERISA preemption. In *Travelers*, the Court distinguished state "mandates affecting coverage," suggesting that ERISA would preempt such laws. *Id.* at 657. In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, the Court rejected an ERISA challenge to a New York law that imposed a special tax on the gross receipts of hospitals. The Court noted in dicta that the law was not one that "required employers to provide certain benefits." 117 S. Ct. 1747, 1752 (1997) (citation omitted). Similarly, *Napoletano v. Cigna Healthcare of Conn., Inc.* rejected an ERISA challenge to a claim against an employee benefit plan under the Connecticut Unfair Trade Practices Act. 680 A.2d 127 (Conn. 1996), *cert. denied*, 117 S. Ct. 1106 (1997). The court noted that state law did not "dictate the benefits that the employer must offer." *Id.* at 138; *see also* Safeco Life Ins. Co. v. Musser, 65 F.3d 647, 653 (7th Cir. 1995) (holding that state fees imposed on insurer selling stop-loss coverage to self-funded employee welfare benefits plans did not relate to those plans, and therefore, were not preempted by ERISA).

full coverage, including maternity and abortion, must be provided for female employees."[167]

In 1991, Washington voters affirmed this commitment to reproductive choice, adopting Initiative 120, which provides:

> (1) Every individual has the fundamental right to choose or refuse birth control;
>
> (2) Every woman has the fundamental right to choose or refuse to have an abortion . . . ;
>
> (3) Except as specifically permitted by [this Act], the state shall not deny or interfere with a woman's fundamental right to choose or refuse to have an abortion; and
>
> (4) The state shall not discriminate against the exercise of these rights in the regulation or provision of benefits, facilities, services, or information.[168]

Insofar as these Washington provisions affirm, clarify, and enforce the requirements of the PDA, they constitute state implementation of federal anti-discrimination requirements and are not preempted by ERISA. But to avoid federal ERISA preemption, Washington lawmakers must act to implement the federal law, and not rely simply on their own local sense of justice.

Shaw v. Delta Air Lines, Inc.[169] is the central case addressing the relationship between state implementation of Title VII and federal preemption of state laws that relate to employee benefit plans. *Shaw* arose in 1976 when, two weeks after the U.S. Supreme Court's *Gilbert* decision holding that Title VII did not prohibit discrimination against pregnant women,[170] the New York Court of Appeals held that an "employer whose employee benefit plan treats pregnancy differently from other nonoccupational disabilities engages in sex discrimination

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167. Wash. Admin. Code 162-30-020(7) (1973), *reprinted in* Wash. Admin. Code, vol. 6 (1959–1976). Note that the regulation does not mention contraception. Is this a significant omission or did the legislature assume that contraception coverage was obvious? It seems to the author that a legislature willing to mandate coverage for abortion in 1973 probably would have assumed that contraception was routinely covered.

168. Reproductive Privacy Act, Wash. Rev. Code § 9.02.100(1)–(4) (1996).

169. 463 U.S. 85 (1983).

170. General Elec. Co. v. Gilbert, 429 U.S. 125 (1976). The *Shaw* Court notes the two-week coincidence. *Shaw*, 463 U.S. at 88–89.

within the meaning of the [New York] Human Rights Law."[171] Thus, the New York law prohibiting health insurance discrimination against pregnant women came into direct conflict with the U.S. Supreme Court's interpretation of Title VII in *Gilbert*. While New York was free to apply a concept of discrimination broader than that defined by Title VII to actors other than ERISA plans, the Court in *Shaw* held that the ERISA preemption prohibited the state from applying the broader law to ERISA plans during the period after the U.S. Supreme Court held in 1976 that Title VII did not prohibit discrimination on the basis of pregnancy and before the effective date of the PDA in 1978.[172]

In its analysis of this claim, the Court began by recognizing that "[s]tate laws obviously play a significant role in the enforcement of Title VII."[173] Title VII expressly preserves state anti-discrimination laws that do not conflict with it.[174] Moreover, Title VII requires recourse to available state administrative remedies, and the EEOC accords "substantial weight" to state administrative determinations.[175] Thus, the *Shaw* Court concluded, "Given the importance of state fair employment laws to the federal enforcement scheme, [federal ERISA] pre-emption of the [state] Human Rights Law would impair Title VII to the extent that the Human Rights Law provides a means of enforcing Title VII's commands."[176] Therefore, the Court held that ERISA prevented New York from imposing a rule that was flatly inconsistent with Title VII as then interpreted.[177]

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171. *Shaw*, 463 U.S. at 88 (citing Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd., 359 N.E.2d 393 (N.Y. 1976)).

172. *Id.* at 108.

173. *Id.* at 101.

174. *Id.* (citing 42 U.S.C. § 2000e-7). This section of Title VII states:

> Nothing in this subchapter shall be deemed to exempt or relieve any person from any liability, duty, penalty, or punishment provided by any present or future law of any State or political subdivision of a State, other than any such law which purports to require or permit the doing of any act which would be an unlawful employment practice under this title.

42 U.S.C. § 2000e-7 (1994).

175. *Shaw*, 463 U.S. at 101–02 (citing 42 U.S.C. § 2000e-5(b)).

176. *Id.* at 102.

177. "We hold that New York's Human Rights Law is pre-empted with respect to ERISA benefit plans only insofar as it prohibits practices that are lawful under federal law." *Id.* at 108 (emphasis added).

At the same time, the *Shaw* Court recognized that states play a vital role in interpreting and implementing Title VII. In dealing with ERISA plans that may not be subject to state regulation:

> Courts and state agencies, rather than considering whether employment practices are unlawful under a broad state law, will have to determine whether they are prohibited by Title VII. If they are not, the state law will be superseded and the agency will lack authority to act. It seems more than likely, however, that state agencies and courts are sufficiently familiar with Title VII to apply it in their adjudicative processes."[178]

The Court here underscores that, under Title VII, state courts and agencies must consider, interpret, and enforce federal Title VII law as well as state anti-discrimination laws. If a practice is not regulated by Title VII, then ERISA precludes the state from regulating it in the context of employee benefit plans. If, however, a practice is prohibited by Title VII, the state may act and state authority is not preempted by ERISA.

The only other case addressing the conflict between anti-discrimination rules and ERISA preemption of state regulation is *Champion International Corp. v. Brown*.[179] In *Brown*, the Montana Human Rights Commission found that an ERISA employer pension plan violated the Montana age discrimination law, because it gave no credit for service after age sixty-five.[180] The pension plan challenged by the state regulators in *Brown* was "in compliance with ERISA provisions and the treasury regulations interpreting them."[181] As in *Shaw*, federal law specifically addressed the issue,[182] but the state sought to apply a rule inconsistent with federal law. The Ninth Circuit held that ERISA does not allow states to subject employers to rules that are flatly inconsistent with federal law.[183]

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178. *Id.* at 105–06.

179. 731 F.2d 1406 (9th. Cir. 1984).

180. *Id.* at 1407.

181. *Id.*

182. Federal law provides: "The term 'normal retirement age' means the earlier of: (A) the time a plan participant attains normal retirement age under the plan, or, (B) the later of: (i) the time a plan participant attains age 65, or (ii) the 5th anniversary of the time a plan participant commenced participation in the plan." 29 U.S.C. § 1002(24) (1994).

183. *Brown*, 731 F.2d at 1409.

In relation to contraception, Washington's rules are the most reasonable interpretation of the PDA. Insofar as state rules implement and enforce the federal PDA, they are not preempted by ERISA. This analysis suggests that Washington and other states are free to interpret the federal PDA to prohibit health insurance plans from discriminating against contraception and to apply such an anti-discrimination rule to plans governed by ERISA. Washington's regulation[184] prohibits plans that disfavor maternity and abortion services, but does not explicitly address the question of coverage for contraception. The Washington Reproductive Privacy Act[185] prohibits insurance plans that disfavor either birth control or abortion. The analysis offered here suggests that ERISA precludes states from applying these *state* rules to plans governed by ERISA. Under Title VII, a state may interpret Title VII and apply those interpretations to ERISA plans, but may not apply state law that is inconsistent with Title VII to ERISA plans.

Washington's prohibition against insurance plans that do not cover abortion is inconsistent with Title VII and is preempted by ERISA. The federal PDA explicitly authorizes insurance plans to exclude abortion from coverage,[186] except in narrow circumstances. Under *Shaw* and *Brown*, therefore, Washington may not apply its discrimination rules regarding abortion to ERISA plans. In contrast, under the analysis of the PDA in this Article, the Washington prohibition against excluding contraception from coverage would simply be implementing Title VII as amended by the PDA, and would not be preempted by ERISA.[187]

Because ERISA preempts so much of states' traditional authority to regulate the content of benefits provided by employment-based health insurance programs, federal approaches—either through interpretation and enforcement of the existing provisions of Title VII or through new federal legislation—are particularly important.

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184. *See supra* text accompanying note 167.

185. *See supra* text accompanying note 168.

186. 42 U.S.C. § 2000e(k) (1994).

187. Catherine L. Fisk advances a similar analysis, arguing that ERISA does not preempt state authority to require employers to provide benefits for same-sex domestic couples because the federal Defense of Marriage Act has recognized state power to regulate in this area. *See* Catherine L. Fisk, *ERISA Preemption of State and Local Laws on Domestic Partnership and Sexual Orientation Discrimination in Employment*, 8 UCLA Women's L.J. (forthcoming June 1998).

D. Federal ERISA Amendment

In yet another approach to this issue, in May 1997, a bipartisan coalition of senators introduced the Equity in Prescription Insurance and Contraceptive Coverage Act of 1997 (EPICC), which would prohibit discrimination against contraception in insurance coverage.[188] A federal law such as EPICC would avoid ERISA preemption of state efforts to define discrimination or mandate benefits. EPICC is modeled after the Newborns' and Mothers' Health Protection Act of 1996, which amended ERISA to require that health insurance plans allow doctors and women to decide how long the woman needs to stay in the hospital following the birth of a child.[189]

From a policy perspective, one could question the wisdom of Congress making health insurance coverage decisions on a condition-by-condition basis.[190] Moreover, as this Article has argued, the proposed federal regulation may be superfluous in that the PDA already requires coverage of contraception.[191] But as this Article has also pointed out, the PDA's application to insurance coverage for contraception has been widely ignored; an additional federal law clarifying that excluding contraception from insurance coverage may be salutatory. It is not uncommon for Congress to adopt "redundant" legislation.[192] In these

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188. S. 766, 105th Cong. (1997). The proposed act contains the following factual findings:

> Congress finds that—(1) each year, approximately 3,600,000 pregnancies, or nearly 60 percent of all pregnancies, in this country are unintended; (2) contraceptive services are part of basic health care, allowing families to both adequately space desired pregnancies and avoid unintended pregnancy; (3) studies show that contraceptives are cost effective: for every $1 of public funds invested in family planning, $4 to $14 of public funds is saved in pregnancy and health care-related costs; (4) by reducing rates of unintended pregnancy, contraceptives help reduce the need for abortion; (5) unintended pregnancies lead to higher rates of infant mortality, low-birth weight, and maternal morbidity, and threaten the economic viability of families . . . .

Id. § 2.

189. Pub. L. No. 104-204, 110 Stat. 2935 (to be codified at 29 U.S.C. § 1185, 42 U.S.C.S. §§ 300gg-4, 300gg-51).

190. Commentators have observed that several factors supported this legislation. Eugene Declercq & Diana Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 Milbank Q. 175, 184–85 (1997). The early discharge laws are incremental and simple. The issue unites physicians and consumers against insurance companies. *Id.* at 186–87. Perhaps most important, the laws require no public spending. *Id.* at 187–88. The authors ask whether "the passage of early discharge legislation [was] the forerunner of an outpouring of incremental, largely symbolic health legislation targeted at key constituencies." *Id.* at 197.

191. *See supra* Part III.B.

192. For example, in 1994 Congress adopted the Freedom of Access to Clinic Entrances Act (FACE) to provide criminal penalties and civil remedies against "whomever—by force or threat of

circumstances, an ad hoc congressional effort to address real human problems may make sense.

VII. CONCLUSION

Unintended pregnancy is a serious problem in the United States. Insurance policies that exclude contraception from otherwise comprehensive coverage for prescription drugs and medical services contribute to this problem. Excluding contraception from employment-based insurance violates the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act. Women, employers, the EEOC, private lawyers, and states should use the analysis presented here to do all that they can to seek equal coverage for contraceptive services.

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force or by physical obstruction, intentionally injures, intimidates or interferes with" any person who is or has been "obtaining or providing reproductive health services." 18 U.S.C. § 248 (1995). This law is "redundant" in that state common law and criminal statutes prohibit the conduct addressed by FACE, and a unanimous U.S. Supreme Court held in *National Organization for Women, Inc. v. Scheidler*, 510 U.S. 249 (1994), that anti-choice violence and harassment could be prosecuted under the federal anti-racketeering statute.