

A LITTLE BIT DISABLED: INFERTILITY AND THE AMERICANS WITH DISABILITIES ACT

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INTRODUCTION

In a landmark and controversial 1998 decision, the Supreme Court, in *Bragdon v. Abbott*,¹ used the Americans with Disabilities Act of 1990 (ADA)² to uphold the civil rights of a woman who had been denied equal access to a dentist because of her HIV status. In *Bragdon*, the Court held that people with asymptomatic HIV were a protected class against discrimination under the ADA.³ However, the Court's counterintuitive reasoning—that the deterrent effect of HIV upon a *woman's* ability to reproduce, and not its debilitating impact upon a *person's* ability to fight off disease, constituted the basis for providing the protection of disability-status to persons with asymptomatic HIV—produced as many unintended beneficiaries as it did critics.⁴ Never before had the Supreme Court thought of the ability to reproduce as a major life activity equivalent to the ability to walk or breathe.⁵ Many procreative rights scholars and advocates hailed the decision as a watershed event validating the claims of infertile women to coverage for infertility treatments through employer-provided health benefit plans under the ADA.⁶ Once infertility was declared a

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1. 524 U.S. 624 (1998).

2. Equal Opportunity for Individuals with Disabilities, 42 U.S.C. §§ 12101–12213 (1994 & Supp. V 2000).

3. 524 U.S. at 631.

4. *Id.* at 638 (holding that “[r]eproduction falls well within the phrase ‘major life activity.’ Reproduction and the sexual dynamics surrounding it are central to the life process itself.”).

5. *Id.*

6. See Kimberly Horvath, *Does Bragdon v. Abbott Provide the Missing Link for Infertile Couples Seeking Protection Under the ADA?*, 2 DEPAUL J. HEALTH CARE L. 819, 840 (1999) (“Infertile couples may also receive greater protection for health care

disability, some scholars even predicted that mandatory insurance coverage for treatment of a variety of reproductive disorders was “a slam-dunk.”⁷

Since *Bragdon*, advocates for the infertile have looked to the courts as a way to obtain insurance coverage for their medical treatments.⁸ The legal battle to obtain insurance coverage for the infertile under the ADA has been waged on two fronts. First, advocates had to convince the courts that the inability to reproduce should be considered a disability under the ADA. Second, advocates had to convince the courts that all individuals with disabilities should obtain equal protection from discriminatory insurance practices under the ADA. This Note will address the efforts to find such protection through the first case to test the frontiers of the rights of the infertile: *Saks v. Franklin Covey*.⁹

Saks had its roots when, only a few months after *Bragdon*, the Equal Employment Opportunity Commission (EEOC) ruled that a publishing company violated the ADA by specifically excluding surgical impregnation procedures from its health benefits plan.¹⁰ On October 2, 2000, the District Court for the Southern District of New York weighed in on the agency’s ruling in *Saks*, the first post-*Bragdon* case brought by infertility advocates.¹¹ As predicted, the court followed *Bragdon* in holding that infertility was a protected disability, and, therefore, an infertile person is “a ‘person with a disability’ within the meaning of the ADA.”¹² However, the court found two independent grounds to dismiss the case. First, the court reasoned that the plan

coverage [as a result of the *Bragdon* decision].”); Peter K. Rydel, Comment, *Redefining the Right to Reproduce: Asserting Infertility as a Disability Under the Americans with Disabilities Act*, 63 ALB. L. REV. 593, 598 (1999) (“[S]elf-insured employers not subject to state regulation must be wary of denying infertility coverage to employees.”); RESOLVE, SUPREME COURT RULES: REPRODUCTION IS A MAJOR LIFE ACTIVITY (July 2, 1998), at <http://www.resolve.org/advabbt.htm> (“Are employers discriminating when they do not provide infertility insurance coverage? The Court decision strengthens the case for insurance coverage.”).

7. Kim H. Finley, Comment, *Life, Liberty, and the Pursuit of Viagra? Demand for ‘Lifestyle’ Drugs Raises Legal and Public Policy Issues*, 28 CAP. U. L. REV. 837, 852 (2000).

8. See, e.g., *Lehman v. Adecco N. Am.*, No. 00-C8137, 2001 U.S. Dist. LEXIS 6391 (N.D. Ill. Apr. 3, 2001) (deciding lawsuit based on denial of health care benefits for infertility).

9. 117 F. Supp. 2d 318 (S.D.N.Y. 2000) (holding that although infertility is disability under ADA, exclusion of medically necessary treatments for infertility does not discriminate against infertile).

10. Randy Kennedy, *U.S. Agency Says Employer Should Pay for a Woman’s Infertility Treatments*, N.Y. TIMES, Apr. 29, 1999, at B5.

11. 117 F. Supp. 2d 318.

12. *Id.* at 324.

exclusions did not constitute discrimination on the basis of disability because they applied uniformly to both disabled and nondisabled employees.¹³ Second, the court held that the plan's exclusions for infertility treatments, which predated passage of the ADA, "by definition" could not constitute subterfuge of the purposes of the ADA under the ADA's "safe harbor" provision.¹⁴

Prior to *Bragdon*, courts had articulated three general arguments for dismissing claims such as those brought in *Saks*: (1) reproduction was not a major life activity protected by the ADA; (2) exclusions against infertility treatments were not "disability-based;" and (3) exclusions predating the ADA fell under the "safe harbor" provision.¹⁵ However, *Saks* was the first case in which a court found that infertility treatments could be excluded *despite* the finding that infertility was a *per se* disability.¹⁶ *Saks* is significant because it is the first case applied to infertile individuals that relies *exclusively* upon the facial neutrality of insurance policy exclusions targeted against treatments, as opposed to diagnoses, as a sufficient basis to survive scrutiny under the ADA.

This Note will examine the consistency of the claim in *Saks* in the aftermath of *Bragdon* and in light of the influential Seventh Circuit decision, *Doe v. Mutual of Omaha*, that defined and limited the obligations of health insurers under the ADA.¹⁷ By refusing to engage in a meaningful disparate impact analysis of the effect of facially neutral benefit exclusions on the protected class of the reproductively disabled, the courts send a disturbing signal to all disabled people requiring insurance coverage. By reducing each disability to its specific diagnosis instead of seeing each disability as part of a wider class, the courts have essentially divided a once-unified coalition of disabled-rights advocates into issue- and symptom-specific movements. As a result, the fight against discrimination on the basis of disability will continue to be piecemeal and isolated, resulting in the anomaly that infertile women may only be considered "a little bit disabled" and thus only a "little bit entitled" to their legal rights under the ADA.

13. *Id.* at 327.

14. *Id.* at 328.

15. *See, e.g., Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102 (S.D. Iowa 1995), *aff'd*, 95 F.3d 674 (8th Cir. 1996) (citing all three grounds as reasons for denial of claim that failure to cover infertility violated ADA).

16. 117 F. Supp. 2d at 326–27.

17. 179 F.3d 557, 563 (7th Cir. 1999) (holding that health benefit plans that capped amount of permissible expenditures for treatment of AIDS did not violate ADA as long as all employees received same benefits.)

Part I of this Note outlines the medical and social aspects of infertility, focusing on the policies that the states and the federal government have enacted thus far to address the growing infertility crisis. Part II retraces the debate that most scholars and observers thought would define the issue of infertility and insurance coverage under the ADA: whether infertility is a disability or not. Part III explores whether and how the ADA relates to insurance coverage under its main provisions, Titles I and III. Although the *Saks* claim was denied because of this very question, that claim was only brought under Title I; other claims could possibly be brought under Title III. Part IV critically examines the *Saks* case in an effort to demonstrate how the outcome might have been different had the court engaged in a disparate impact analysis of the policy exclusion. Finally, Part V tests the internal consistency of the portion of the *Saks* decision that suggests that treatment-based exclusions having an adverse affect only upon the infertile are not disability-based distinctions constituting "subterfuge" of the purposes of the ADA. This Note concludes by noting that, while the analysis exercised in *Saks* is inconsistent with precedent, there may be ways to support the *Saks* holding other than those exercised by the *Saks* court.

I

THE PROBLEM OF INFERTILITY IN AMERICA

Infertility is a serious and growing concern in America. Estimates of the overall incidence of infertility among couples of reproductive age vary from two to six million.¹⁸ Due to environmental and social factors, infertility in the United States has been said to be at its highest rate ever.¹⁹ This Part of the Note briefly discusses the inci-

18. See D'Andra Millsap, *Sex, Lies, and Health Insurance: Employer-Provided Health Insurance Coverage of Abortion and Infertility Services and the ADA*, 22 AM. J. L. & MED. 51, 56 (1996); see also Anne T. Fidler & Judith Bernstein, *Infertility: From a Personal to a Public Health Problem*, 116 PUB. HEALTH REP. 494, 497 (1999) (discussing difficulty of defining infertility: "As for many diseases or disorders, there is no single objective test of infertility and no universally accepted definition, though typically it is defined in clinical practice as the inability to become pregnant after more than one year of unprotected intercourse.").

19. Deborah Dallman, Note, *The Lay View of What Disability Means Must Give Way to What Congress Says it Means: Infertility as a "Disability" Under the Americans with Disabilities Act*, 38 WM. & MARY L. REV. 371, 389 (1996) ("Of the millions of infertile couples in the United States, an increasing number seek treatment."); Philip Elmer-Dewitt, *Making Babies*, TIME, Sept. 30, 1991, at 56; see also Fidler & Bernstein, *supra* note 18, at 497 (reporting that "[t]he absolute number of women being treated with assisted reproductive technologies . . . rose dramatically" between 1995 and 1998); cf. Trip Gabriel, *High-Tech Pregnancies Test Hope's Limit*, N.Y. TIMES, Jan. 7, 1996, at A1 (discussing general growth in assisted reproductive technology).

dence and treatment of infertility in America; how information failures in the infertility market have been exacerbated by the government's inability to regulate it; and how insurance underwriters have generally excluded infertility treatments from their policies.

A. *Infertility Incidence and Treatment of Infertility*

Couples seeking to achieve pregnancy often discover their infertility after a year of unsuccessful, contraception-free intercourse.²⁰ Of the sixty million women of reproductive age, roughly fifteen percent have had an infertility-related medical appointment at some point in their lives.²¹ The causes of infertility can be traced either to a man or a woman.²² Upon diagnosis, many couples fall into a treacherous psychological cycle of hope, despair, and desperation.²³ Although some characterize the decision to have children as a "lifestyle choice," a diagnosis of infertility can be as psychologically devastating as a diagnosis of a terminal illness.²⁴

Most couples seeking treatment are able to utilize noninvasive therapies that range from hormone-altering drug treatments to wearing looser shorts.²⁵ Most couples are able to achieve a successful pregnancy with conventional treatments.²⁶ However, approximately five percent require more advanced assisted reproductive technologies

20. See AM. SOC'Y OF REPROD. MED., FREQUENTLY ASKED QUESTIONS ABOUT INFERTILITY, at <http://www.asrm.org/Patients/faqs.html> (last visited Nov. 18, 2001) [hereinafter ASRM, FAQ]. A normally fertile couple has a nearly ninety percent chance of achieving pregnancy over that same time period. Sharon Begley, *The Baby Myth*, NEWSWEEK, Sept. 4, 1995, at 38, 45.

21. DIV. OF REPROD. HEALTH, CTRS. FOR DISEASE CONTROL & PREVENTION, 1998 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS, COMMONLY ASKED QUESTIONS ABOUT THIS REPORT, at <http://www.cdc.gov/nccdphp/drh/art98/faq.htm> (last modified Aug. 14, 2001).

22. Male infertility is the cause roughly 33% of the time, female infertility is the cause roughly 33% of the time, and both male and female infertility is the cause the remaining 33% of the time. See ASRM, FAQ, *supra* note 20.

23. See Begley, *supra* note 20, at 47 (comparing psychological pressure on couples to keep trying to achieve pregnancy despite past failures as "their own private Vietnams. Having spent \$10,000 . . . they can't quit until they have a victory—a baby").

24. See Fidler & Bernstein, *supra* note 18, at 497.

25. See ASRM, FAQ, *supra* note 20; see also RESOLVE, GETTING STARTED: HOW DO I KNOW I HAVE AN INFERTILITY PROBLEM?, at <http://www.resolve.org/started.htm> (last visited Nov. 18, 2001).

26. ASRM, FAQ, *supra* note 20.

(ARTs), such as in vitro fertilization (IVF).²⁷ The average cost of an IVF cycle in the United States is between \$7,800 and \$10,000.²⁸

Even in the case of male infertility, it is the woman who must undergo the time-consuming impregnation procedures alone.²⁹ A recent report issued by a special task force for New York State revealed a failure rate of over eighty percent of the twenty-seven thousand reported IVF cycles in 1994.³⁰

B. Information Failures in the Infertility Market

In order for markets to efficiently allocate goods and services, economics assumes that consumers have sufficient information to weigh the costs and benefits of a particular purchase. One could scarcely imagine a functioning market without price tags to convey costs to the buyer. Similarly, without a proper understanding of the value or benefit of the good or service for sale, consumers are likely to make poor choices that do not maximize their own welfare.

Health care markets generally exhibit strong information asymmetries, since many consumers of health care services are not repeat

27. *Id.* ARTs include in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). See Horvath, *supra* note 6, at 823 n.35. Both GIFT and ZIFT are variations on the IVF procedure, which is designed to bypass the fallopian tubes through a multi-stage procedure involving ovulation induction, blood tests, follicle growth monitoring, egg retrieval (using a laproscope inserted through a woman's vagina), the mixing of eggs with sperm in a petri dish, and the implantation of two to four embryos. See ABINGTON REPROD. MED., PATIENT INFORMATION: IVF AND FROZEN EMBRYO TRANSFER, at <http://www.abington-reprod.com/ivfconsent.html> (last visited Nov. 18, 2001) (discussing various types of infertility treatment). With ZIFT, embryos are placed in the fallopian tubes. *Id.* GIFT involves the surgical placement of retrieved eggs and sperm into a woman's fallopian tubes through a needle inserted near the navel, and is sometimes more acceptable to patients who have ethical objections to fertilization outside the body. *Id.*

28. See Thomas D. Flanigan, Note, *Assisted Reproductive Technologies and Insurance Under the Americans with Disabilities Act of 1990*, 38 BRANDEIS L.J. 777, 780 (2000) ("The cost of a typical IVF cycle is between \$8,000 and \$10,000."); ASRM, FAQ, *supra* note 20 ("The average cost of an IVF cycle in the United States is \$7,800.").

29. See Cintra D. Bentley, Note, *A Pregnant Pause: Are Women Who Undergo Fertility Treatment to Achieve Pregnancy Within the Scope of Title VII's Pregnancy Discrimination Act?*, 73 CHI.-KENT L. REV. 391, 399 (1998) ("The process can become all encompassing, compelling some women to leave their employment temporarily because undergoing fertility treatment can be a full-time job."); Larry Thompson, *Fertility With Less Fuss*, TIME, Nov. 14, 1994, at 79 ("Making a test-tube baby is a test of human endurance—especially for the would-be mother.").

30. Maryann Napoli, *Infertility Treatments: New Report*, HEALTH FACTS, May 1, 1998, at 3.

players in a given market.³¹ Kenneth Arrow, in a now classic analysis of health care economics, pointed out that, from a patient's perspective, "Uncertainty as to the quality of the product is perhaps more intense [in the health care context] than in [the market for] any other important commodity."³²

The market for ARTs and other infertility services in particular suffer from this market failure given the expense, discomfort, and shame surrounding each failed cycle.³³ Moreover, the complexity of the procedures can often confuse and overwhelm prospective patients.³⁴ Consumers of infertility treatments tend to be highly vulnerable to aggressive marketing tactics and medical experimentation, unable to quit trying the latest innovation despite previous failures and unwilling to listen to more skeptical second opinions.³⁵

Finally, the lack of standardization in the reporting of the "success rates" of various fertility treatments has led to overoptimistic presentations of the efficacy of different treatments, reducing the ability of consumers to comparison shop between clinics in terms of quality care.³⁶ Clinics often boast of success rates between twenty-five and fifty percent, yet those rates might be determined by measuring the rate of pregnancy per cycle, as opposed to the live-birth rate, which can grossly distort the statistic in which infertile couples are actually interested.³⁷

Since reproductive endocrinology is a relatively new field, the underlying causes of reproductive disorders and infertility are not well understood, resulting in frequent misdiagnoses.³⁸ Moreover, due to a general lack of data, it is not always settled which procedures work best to address any given disorder when a correct diagnosis is made.³⁹ If the doctors are left guessing as to what the proper diagnosis or treatment is, then the market cannot function properly.

31. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 948-49 (1963).

32. *Id.* at 951.

33. See Begley, *supra* note 20, at 40.

34. Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 HARV. L. REV. 2092, 2102 (1996).

35. See Begley, *supra* note 20, at 45-47 (comparing compulsion to try new, untested therapies to gambling).

36. See Note, *supra* note 34, at 2102 (discussing various methods used by fertility clinics to inflate their success rates).

37. Robert Pear, *Fertility Clinics Face Crackdown*, N.Y. TIMES, Oct. 26, 1992, at A15.

38. See Begley, *supra* note 20, at 44-45.

39. *Id.* at 45.

Currently, there is no national program for certification of fertility clinics and no national standards for performance of laboratory procedures, clinical testing of new procedures, maintenance of records, qualifications for lab personnel, or quality inspection.⁴⁰ Breakthroughs in medicine and technology surrounding embryology in the past twenty years have outpaced attempts by the law to address the unique and complex industry that has arisen in the interim.⁴¹

Congress attempted to address this information failure through the Fertility Clinic Success Rate and Certification Act of 1992.⁴² The law called upon the Centers for Disease Control and Prevention (CDC) to create a model program for states to use in certifying embryo laboratories and fertility clinics.⁴³ It also required the annual publication of ART clinics' success rates through the CDC beginning in 1994.⁴⁴

However, few states have signed onto the pilot certification program, leaving the federal attempt to create a centralized standard-setting agency a mere "legislative curiosity."⁴⁵ In 1998, the CDC finally released a model certification program that set up quality standards for states to adopt at their discretion.⁴⁶ In 1999, the CDC completed its final report, providing a comprehensive survey of current practices and laboratory procedures at ART embryo clinics.⁴⁷ This survey was designed to establish a baseline against which future attempts at regulation could be measured. In the meantime, regulation of fertility clinics and infertility has been left largely to private entities and the judiciary.

40. See Note, *supra* note 34, at 2106 ("At present, the federal attempt to create a certification agency [for infertility treatment programs] is therefore little more than a legislative curiosity.")

41. See Gregory A. Triber, *Growing Pains: Disputes Surrounding Human Reproductive Interests Stretch the Boundaries of Traditional Legal Concepts*, 23 SETON HALL LEGIS. J. 103, 103 (1998) ("In the last twenty years, human reproductive technology has advanced more briskly than the ability of the law to address the unique and complex issues involved.")

42. Pub. L. No. 102-493, 106 Stat. 3146 (codified at 42 U.S.C. §§ 263a-1 to 263a-7 (1994)).

43. 42 U.S.C. § 263a-2.

44. *Id.* § 263a-1.

45. See Note, *supra* note 34, at 2106.

46. Implementation of the Fertility Clinic Success Rate and Certification Act of 1992: A Model Program for the Certification of Embryo Laboratories, 64 Fed. Reg. 39,374 (July 21, 1999).

47. DIV. OF REPROD. HEALTH, CTRS. FOR DISEASE CONTROL & PREVENTION, FINAL REPORT: SURVEY OF ART: EMBRYO LAB. PROCEDURES & PRACTICES (Jan. 29, 1999), at <http://www.cdc.gov/nccdphp/drh/pdf/ARTsurvey.pdf>.

C. Insurance Exclusion of Infertility Treatments

Insurance coverage for ARTs and other infertility treatments tends to be the exception rather than the rule.⁴⁸ According to a benefits study done in 1997, only twenty-five percent of employers provided some form of infertility insurance coverage to their employees.⁴⁹ Additionally, most of those plans that provided some coverage offered only a few infertility options, and many covered only the diagnosis.⁵⁰

Although thirteen states mandate some form of coverage for infertility treatments, such mandates do not apply to employer self-funded health benefit plans because of the Employee Retirement Income Security Act (ERISA), a federal law which preempts state laws relating to employee benefit plans.⁵¹ In some states, more than half of all employees work for, and receive their health benefits from, exempted employers.⁵² In the thirty-seven other states without mandated benefit laws for infertility treatments, infertile couples have few options other than what little they and their families may be able to afford out of pocket.

In the late 1980s and early 1990s, several courts held that, absent specific exclusions, infertility treatments were to be covered as medically necessary treatments under standard health insurance coverage.⁵³ Insurers could no longer simply assert that IVF was too experimental or medically unnecessary to cover. In response, many insurers specifically moved to exclude or limit provision of infertility treatments.⁵⁴ A recent survey of health plans found ninety-three percent contain

48. See Millsap, *supra* note 18, at 52 (describing current infertility coverage as “erratic” at best”).

49. Diane D. Aronson, *Should Health Insurers Be Forced To Pay For Infertility Treatments?*, INSIGHT ON THE NEWS, Feb. 8, 1999, at 24, 26.

50. *Id.*

51. Rydel, *supra* note 6, at 594–95. For more on ERISA preemption of state mandated benefit laws, see *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

52. Aronson, *supra* note 49, at 27.

53. See *Egert v. Conn. Gen. Life Ins.*, 900 F.2d 1032, 1039 (7th Cir. 1990) (holding that if plaintiff could demonstrate that her infertility was sickness or injury under her insurance plan, insurer was obligated to reimburse her for necessary IVF treatment); *Ralston v. Conn. Gen. Life. Ins.*, 617 So. 2d 1379, 1382 (La. Ct. App. 1993) (holding IVF as “essential for the necessary care and treatment” of infertility under insurance policy).

54. See Millsap, *supra* note 18, at 59 (“As a result of these court decisions concluding that those insurance policies included coverage of infertility treatments, insurers began to include specific exclusionary clauses. . . . As a result, the vast majority of private insurance policies do not cover IVF or many other types of infertility treatments.”).

specific exclusions denying coverage for medication and services related to infertility.⁵⁵

The rise of HMOs and managed care has also driven the trend towards even more explicit refusals to cover infertility treatments.⁵⁶ Consequently, many couples are forced to accept childlessness due to a lack of insurance coverage, high cost, and low success rates.⁵⁷ Not surprisingly, those currently able to afford ARTs tend to be white, upper-middle class, and married.⁵⁸

The lack of insurance coverage exacerbates the information failure in the market for ARTs, as third party payers represent important quality and cost-control monitors due to their repeated interactions with health care providers.⁵⁹ As a result, infertile couples often seek treatment in a haphazard and potentially dangerous manner, serving as guinea pigs for untested procedures and powerful hormone therapies that some studies have shown increase the risk of ovarian cancers, multiple births, prematurity, and low birth weight.⁶⁰

If insurance policies must cover infertility diagnosis and treatment under the ADA, their price will obviously increase to some degree, based on how much additional cost the insurer will incur as a result of covering infertility. Overall, IVF and other ARTs account for only three hundredths of one percent (0.03%) of U.S. health care costs.⁶¹ Some studies show that the addition of infertility treatments to a group health plan has a marginal effect on premiums. In Massachusetts, a state with comprehensive mandatory coverage laws, the

55. Flanigan, *supra* note 28, at 777.

56. See Lisa M. Kerr, Note, *Can Money Buy Happiness? An Examination of the Coverage of Infertility Services Under HMO Contracts*, 49 CASE W. RES. L. REV. 599, 617, 620 (1999); see also Anne Adams Lang, *For Infertility Treatments, Now You're Covered, Now You're Not*, N.Y. TIMES, June 21, 1998, § 15 (Women's Health), at 12.

57. The average success rate for IVF is only 15.2% per cycle. See Dallman, *supra* note 19, at 392.

58. Fidler & Berstein, *supra* note 18, at 497; Lang, *supra* note 56.

59. See Arrow, *supra* note 31, at 961-64 (discussing role insurance plays in health care market).

60. Napoli, *supra* note 30, at 3.

[I]nvestigators found that there was widespread inappropriate use of Clomid [a common fertility drug]. For example, there is no scientific evidence to show that this drug can benefit women without ovulatory dysfunction, yet medical records show that 52% of the infertile women who took Clomid in the Seattle study had normally functioning ovaries. Twelve earlier studies also showed an increased ovarian cancer rate among the women given the infertility drug, but only among those who didn't get pregnant.

Id.

61. ASRM, FAQ, *supra* note 20.

additional cost of comprehensive infertility coverage is estimated at \$1.71 per month.⁶² Another analysis showed that the cost effect on premiums is slight when spread out over a large enough group, only raising premiums between \$0.60 to \$2.00 per month.⁶³ One commentator concluded that, "One may certainly wonder what the ruckus is all about—these prices do not appear prohibitive, nor does it appear that there will be a 'drastic' increase in the cost of the coverage."⁶⁴

A 1997 National Center for Policy Analysis (NCPA) report alleged a much higher premium increase as a result of mandated benefits for infertility, raising the cost of a policy from \$105 to \$175 per year, or a 3% to 5% increase in premiums over a standard family policy.⁶⁵ The difference in estimates may reflect the difference between group and individual insurance policies. Group insurance policies are generally more comprehensive and their rates are lower because they are able to spread risk across a larger pool of members. However, group policies also tend to have more restrictions and utilize managed care principles. Individual insurance policies, on the other hand, tend to attract less healthy members and have much higher premiums as a consequence.⁶⁶

The cost of any type of mandate will also depend on how such a mandate is structured. Of the thirteen states that have some form of infertility insurance mandate, three states (California, Connecticut, and Texas) merely require that insurance companies offer policies that contain infertility benefits, allowing individuals to opt into the group without requiring that all individuals share the costs, rather than mandating that all policies provide coverage for infertility.⁶⁷ Of the states that require coverage of infertility treatments, variations exist in both

62. Wendy Kaminer, *Reproductive Entitlement*, AM. PROSPECT, Mar. 27, 2000, at 14, 15.

63. Rhonda Tischler, Note, *Infertility: A Forgotten Disability*, 41 WAYNE L. REV. 249, 268 (1994).

64. *Id.*

65. NAT'L CTR. FOR POLICY ANALYSIS, BRIEF ANALYSIS NO. 237: THE COST OF HEALTH INS. MANDATES (August 13, 1997), at <http://www.ncpa.org/ba/ba237.html>.

66. See INSURANCE BUYER'S GUIDE, BASIC TYPES OF HEALTH INSURANCE, at <http://www.insbuyer.com/healthinsurance.htm> (last visited Nov. 18, 2001) ("Group coverage is generally more comprehensive and group rates generally lower because their [*sic*] is strength in numbers."); RESOLVE, HEALTH INSURANCE COVERAGE OF INFERTILITY TREATMENT, at <http://www.resolve.org/advstlaws.htm> (last visited Nov. 18, 2001) ("[I]t is often difficult and very expensive to purchase individual insurance policies.").

67. CAL. HEALTH & SAFETY CODE § 1374.55(a) (West 2000); CONN. GEN. STAT. ANN. § 38a-536 (West 2000); TEX. INS. CODE ANN. § 3.51-6 (3A)(a) (Vernon Supp. 2001).

specificity and scope as to whether HMOs are included,⁶⁸ whether coverage must include IVF,⁶⁹ how infertility is defined,⁷⁰ whether benefit caps are used,⁷¹ and whether small businesses are exempt.⁷² Clearly, a mandate to offer coverage costs less to employers than a mandate to cover, but the overall cost of even the most ambitious mandates seems to be small. However, as the NCPA study shows, a mandate to offer coverage may result in policies that cost individuals slightly more per year because they do not have the benefit of spreading costs over the largest risk pool.

II

IS INFERTILITY A DISABILITY?

Oliver Wendell Holmes famously observed, “The life of law has not been logic: it has been experience.”⁷³ What is the law to do, then, when logic dictates one result, and experience another? Experience tells us that infertility is not a disability in the same sense as the loss of a limb or a degenerative disease. Infertility poses no threat to the patient’s physical health if left untreated.⁷⁴ Aside from the psychological trauma that might accompany diagnosis, it does not directly affect the participation of men or women in the economy or in public life.⁷⁵

68. Compare ARK. STAT. ANN. §§ 23-85-137(a), 23-86-118(a), 23-76-104 (Lexis 1999 & Supp. 2001) (providing for infertility coverage by insurance companies but exempting HMOs from most insurance industry regulations), with MASS. GEN. LAWS ANN. ch. 175 § 47H (West 1998) (allowing inclusion of HMOs).

69. Compare MD. CODE ANN., INS. § 15-810(b)(1) (Supp. 2001) (specifically prohibiting exclusion of benefits for IVF), with CAL. HEALTH & SAFETY CODE § 1374.55(a) (West 2000) (exempting IVF benefits from requirement to offer infertility treatment coverage).

70. Compare MASS. GEN. LAWS ANN. ch. 175, § 47H (West 1998) (defining infertility as “the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year”), with CONN. GEN. STAT. ANN. § 38(a)-536 (West 2000) (defining infertility to also include inability to retain pregnancy during period of one year).

71. Compare 215 ILL. COMP. STAT. 5/356m(b)(1)(B) (West 2000) (limiting number of egg retrievals to six), with Ark. Ins. Rules and Reg. 1, WL AR ADC INS 1 (requiring lifetime maximum benefit cap of no less than fifteen thousand dollars).

72. Compare 215 ILL. COMP. STAT. 5/356m(a) (West 2000) (limiting mandate to policies covering more than 25 people), with MASS. GEN. LAWS ANN. ch. 175, § 47H (West 1998) (tying mandate to provide infertility coverage only to policies that provide other pregnancy-related benefits, but not specifically exempting small businesses).

73. OLIVER WENDELL HOLMES, JR., *THE COMMON LAW* 1 (1881).

74. Kaminer, *supra* note 62, at 14.

75. However, it is often noted that a woman’s reproductive capacity is partially to blame for the persistence of the “glass ceiling” for female business executives. See, e.g., Margaret Littman, *Where the Girls Aren’t*, CHICAGO MAG., Mar. 2001, at 83, 126–27 (quoting Linda Stroh, Professor of Human Resources at Loyola University in

All told, infertility treatments can be fairly criticized as a luxury item in a health care market that leaves millions without basic services.

At the same time, however, the desire to bear children and raise a family is deeply ingrained across all cultures of the world and throughout history. Femininity has long been symbolically associated with fertility.⁷⁶ Theologians,⁷⁷ philosophers,⁷⁸ authors,⁷⁹ and popular icons⁸⁰ have all played a part in the social construction of women as mothers. The courts have, for the most part, paid deference to the notion that “pregnancy is different” in their jurisprudence on reproductive health issues, although not always with advantages redounding to the women involved.⁸¹ Although patriarchal assumptions of women’s roles have strongly influenced this social construction of fertility, it is impossible to deny that the distinction between genders is largely defined by the reproductive capacities and roles of women and men, and that infertility uniquely interferes with the self-identity of many women. However, it is still a leap to equate this psychological

Chicago as saying, “[T]here still is that perception that women who have children are less serious about their careers. As long as there is still that perception, these types of [on-site childcare and flextime] programs don’t help women climb the ladder.”).

76. See Paula Abrams, *The Tradition of Reproduction*, 37 ARIZ. L. REV. 453, 461 (1995) (“Nonprocreative intercourse was viewed as illicit. It is no accident that contraception was first regulated in this country as obscenity.”).

77. *Id.* at 475 (“Women are saved from Eve’s original transgression by bearing children. The women in the Old Testament were ruled by their wombs.”).

78. *Id.* at 459 (“According to Aristotle, children were among the ‘fewest possible parts’ of the family; thus a childless marriage was not a true *oikos* because it lacked the dynamic of self-renewal.”).

79. SIMONE DE BEAUVOIR, *THE SECOND SEX* 523 (H.M. Parshley trans., Vintage Books 1989) (1952) (“[I]t is often said of a woman that she is coquettish, or amorous, or lesbian, or ambitious, ‘for lack of a child;’ her sexual life, the aims, the values she pursues, would in this view be substituted for a child.”).

80. MADONNA, *Little Star, on RAY OF LIGHT* (Warner Bros. Records 1998) (“God gave a present to me/Made of flesh and bones/My life/My soul/You make my spirit whole.”). *Ray of Light* is often described as Madonna’s “maternity album,” which she recorded after giving birth to her first child.

81. Elizabeth A. Reilly, *The Rhetoric of Disrespect: Uncovering the Faulty Premises Infecting Reproductive Rights*, 5 AM. U. J. GENDER & L. 147, 186 (1996) (“Defining women through their reproductive capacity, the Court then uses it [in various cases] to isolate them, authorizing special rules that disadvantage women, but seldom upholding schemes that assist women in achieving equality in an unequal world.”); see also *Rust v. Sullivan*, 500 U.S. 173, 196–203 (1991) (upholding “gag rule” on physicians in federally funded abortion clinics as consistent with state’s power to encourage childbirth); *Muller v. Oregon*, 208 U.S. 412 (1908) (upholding restrictive labor laws on women designed to protect their childbearing capacity); *Bradwell v. Illinois*, 80 U.S. (16 Wall.) 130, 139–41 (1873) (reasoning that because woman’s “paramount destiny and mission” is to be wife and mother, she is incompetent to have separate career).

interference with other disabilities that have more tangible and frequent manifestations, such as paralysis, hearing loss, or blindness.

Nonetheless, the law appears relatively clear that infertility is indeed a disability and that people with reproductive disorders do have standing to sue for workplace accommodations and even insurance coverage for their maladies under the ADA.⁸² Enacted “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities,”⁸³ the ADA was hailed as “the greatest expansion of civil rights protections since the 1964 Civil Rights Act”⁸⁴ and the “20th Century Emancipation Proclamation” for the disabled by its supporters in Congress.⁸⁵ Modeled after the Civil Rights Act of 1964, the ADA served as both a remedial measure creating civil rights for the disabled suffering from discrimination, and a prospective mandate upon society to accommodate and mainstream millions of disabled Americans into society.⁸⁶ The mandate of the ADA went beyond simply removing barriers that hindered the disabled. The ADA promised “equality of opportunity, full participation, independent living, and economic self-sufficiency” for people with disabilities.⁸⁷

The ADA is divided into five titles intended to make various parts of society more accessible to people with disabilities.⁸⁸ Title I prohibits disability-based discrimination in the “terms, conditions, and privileges of employment” against any “qualified individual with a disability.”⁸⁹ Employer fringe benefits, including employer-provided health insurance, are covered by this clause.⁹⁰ Moreover, the prohibition in Title I extends to “selection criteria that screen out or tend to screen out an individual with a disability” unless such criteria are

82. 42 U.S.C. §§ 12101–12213 (1994 & Supp. V 2000).

83. *Id.* § 12101(b)(1) (1994).

84. 136 CONG. REC. 17,368 (July 13, 1990) (statement of Sen. David Durenburger).

85. *Id.* at 17,369 (statement of Sen. Tom Harkin).

86. *Id.*

87. 42 U.S.C. § 12101(a)(8); *see also* Timothy D. Johnston, Note, *Reproduction Is Not a Major Life Activity: Implications for HIV Infection as a Per Se Disability Under the Americans with Disabilities Act*, 85 CORNELL L. REV. 189, 196 (1999) (discussing primary goals of ADA).

88. The first four titles (codified as “subsections” in the United States Code) include prohibitions of disability-based discrimination in employment, public services and transportation, places of public accommodation operated by private entities, to services offered by the telecommunications industry. The fifth title governs “miscellaneous provisions.” *See* 42 U.S.C. §§ 12101–12213 (1994 & Supp. V 2000).

89. *Id.* § 12112(a).

90. *Id.* § 12112(b)(2); *see also* Stephen T. Kaminski, *Must Employers Pay for Viagra? An Americans with Disabilities Act Analysis Post-Bragdon and Sutton*, 4 DEPAUL J. HEALTH CARE L. 73, 83 (2000).

shown to be job-related and are justified by business necessity.⁹¹ Title III prohibits disability-based discrimination in the “full and equal enjoyment” of goods, services, and other advantages provided by places of public accommodation.⁹² Such discrimination includes denial of participation, participation in an unequal benefit, or provision of a separate benefit.⁹³

Because it is a federal statute, the ADA reaches self-funded health plans normally exempted from state laws by ERISA. Moreover, the ADA also explicitly holds employers accountable for any disability-based discrimination against their disabled employees by third parties, such as traditional insurers, with whom it has contractual relationships concerning those employees.⁹⁴

One of the questions raised by the language prohibiting discrimination based on “disability” is how “disability” is to be defined under the ADA. The definition of “disability” under the ADA is “a physical or mental impairment that substantially limits one or more of the major life activities of such individual.”⁹⁵ An individual must establish each of the three elements of this definition of disability in order to have standing under the ADA: (1) the presence of an impairment, (2) a major life activity affected by that impairment, and (3) a showing that the major life activity is substantially limited by the impairment. In cases involving infertility claims, the major battles have primarily been fought over the question of whether infertility interferes with a “major life activity.” However, for the case of infertility in particular, it is worth examining both whether infertility constitutes an “impairment,” and whether it impacts a “major life activity.”

A. Impairment

An individual bringing a claim under the ADA must have a “physical or mental impairment,” a prior record of such an impairment, or be regarded as having such an impairment.⁹⁶ The EEOC has

91. 42 U.S.C. § 12112(b)(6) (1994).

92. *Id.* § 12182(a).

93. *Id.* § 12182(b)(1)(A).

94. *Id.* § 12112(b)(2); *see also* Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 29 C.F.R. § 1630.6(a) (2000) (providing that, “It is unlawful for a covered entity to participate in a contractual . . . relationship that has the effect of subjecting the covered entity’s own qualified applicant or employee with a disability to . . . discrimination . . .”).

95. 42 U.S.C. § 12102(2)(A) (1994). A person also qualifies under this section if he or she has a record of such impairment, or is regarded as having an impairment, even if they are not presently impaired. *Id.* § 12102(2)(B)–(C).

96. *Id.* § 12102(2).

provided a list of physical and mental impairments that qualify under the statute. This list includes “reproductive” body systems as one of the several qualifying functions of the body that can be “impaired,” creating a disability.⁹⁷ The American Society for Reproductive Medicine defines infertility as “a disease of the reproductive system that impairs one of the body’s most basic functions: the conception of children.”⁹⁸

However, infertility has many causes, some specific to a physiological disorder and others more general or undiscovered. A precise underlying medical cause can be found in only eighty to ninety percent of couples experiencing infertility.⁹⁹ It is unclear whether infertile couples will be able to benefit from the protection of the ADA unless such a precise underlying medical cause can be found, or whether older women whose infertility accompanies the normal aging process will be able to benefit. Therefore, not all persons who desire infertility treatment may be considered “impaired” under the ADA, although the vast majority are likely to be.

B. “Major Life Activity”

A physical or mental impairment must also affect a major life activity—the second element of a qualifying disability.¹⁰⁰ Defining the scope of “major life activities” has been a major point in the controversy regarding the scope of the ADA.¹⁰¹ The implementing regulations define “major life activities” to include “functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”¹⁰² The regulations explicitly stipulate that the list of “major life activities” is intended to be illustrative rather than exhaustive, and thus go on to include activities such as “sitting, standing, lifting, [and] reaching” under the definition.¹⁰³ The activities listed are those which “the average person in the general population can perform with little or no difficulty.”¹⁰⁴ Because of this arguably unclear language, courts have had to deal with

97. See 29 C.F.R. § 1630.2(h)(1).

98. ASRM, FAQ, *supra* note 20.

99. Tischler, *supra* note 63, at 250. It is unclear whether infertile couples will be able to benefit from the protection of the ADA without a diagnosis of a related medical condition such as blocked fallopian tubes, endometriosis, or of a similar medical condition in the male.

100. 42 U.S.C. § 12102(2)(A).

101. For a fuller discussion of this controversy, see *infra* Part II.B.1.

102. 29 C.F.R. § 1630.2(i).

103. 29 C.F.R. app. § 1630.2(i).

104. *Id.*

the question of when disorders such as infertility interfere with “major life activities.”

I. Different Interpretations of “Major Life Activity”

The main interpretive dispute about the meaning of the “major life activity” language in the ADA centered around whether “major” meant that the life activity occurred frequently or whether it meant that the life activity was important.¹⁰⁵ The standard argument against claims that infertility was a disability, on the grounds that it did not adversely impact a “major life activity,” was articulated in *Krauel v. Iowa Methodist Medical Center*.¹⁰⁶

Mary Jo Krauel was a forty-one-year-old employee of the Iowa Methodist Medical Center who sought coverage under the hospital’s self-insured benefits plan for infertility drugs, doctor visits, and a successful gamete intrafallopian transfer (GIFT) procedure.¹⁰⁷ The plan denied coverage on the basis of a written exclusion to its coverage for the treatment of “‘fertility or infertility problems.’”¹⁰⁸ The *Krauel* court found three grounds for dismissing her claim under the ADA. First, the court held that there was no discrimination under the statute, since reproduction was a “lifestyle choice” and not a “major life activity” that occurred on a daily basis.¹⁰⁹ Unlike the other listed terms, the court noted that, “Some people choose not to have children, but all people care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work, unless a handicap or illness prevents them from doing so.”¹¹⁰ Thus, the frequency and universality of the listed “major life activities” were used as evidence that reproduction should not be included.¹¹¹

Other courts rejected *Krauel’s* reasoning, and characterized reproduction as a “major life activity.” In *Pacourek v. Inland Steel Co.*,¹¹² the District Court for the Northern District of Illinois denied an employer’s motion to dismiss an employee’s claim that she was terminated as a result of her infertility, reasoning that because the reg-

105. See *Pacourek v. Inland Steel Co.*, 916 F. Supp. 797, 804 (N.D. Ill. 1996) (finding importance of life activity to be more of a factor than its frequency).

106. 915 F. Supp. 102 (S.D. Iowa 1995), *aff’d*, 95 F.3d 674 (8th Cir. 1996).

107. *Id.* at 105.

108. *Id.*

109. *Id.* at 106.

110. *Id.* at 106 n.1.

111. In addition, the *Krauel* court invoked the reason that infertility was a condition that affected both disabled and nondisabled individuals as grounds for denying relief. *Id.* at 108.

112. 858 F. Supp. 1393 (N.D. Ill. 1994).

ulations list disorders to the reproductive system as qualifying physical impairments, procreation and reproduction must have been contemplated as major life activities.¹¹³ In other words, the court felt that excluding reproduction from the definition of “major life activities” would render the mention of “reproductive” body systems in the EEOC regulations moot, since no other major life activity would likely be substantially limited by reproductive disorders.

This reasoning was rejected as circular “bootstrapping” in *Zatarain v. WDSU-Television*.¹¹⁴ The *Zatarain* court argued that the *Pacourek* court collapsed two separate inquiries—whether there was an impairment, and whether that impairment affected a major life activity—into one.¹¹⁵ However, the *Pacourek* court, in a second opinion dismissing the motion for summary judgment put forth by the employer, replied with an even more ringing endorsement of reproduction as a major life activity on its own terms, criticizing the *Zatarain* and *Krauel* courts of “trivializing” reproduction.¹¹⁶ Because reproduction is integral to the life process itself, the court reasoned, it should be considered major on its own terms.¹¹⁷ The unspoken corollary to this logic, however, is that if reproduction is considered a major life activity, then almost all disorders that substantially impair reproduction constitute *per se* disabilities under the ADA.¹¹⁸

2. *The Supreme Court Speaks: Bragdon v. Abbott*

The Supreme Court seemingly ended this debate over whether reproduction constitutes a “major life activity” with its 5-4 decision in *Bragdon*, where the Court agreed with the reasoning in *Pacourek* by explicitly holding that “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself,” and thus were well within the “major life activities” contemplated by the ADA.¹¹⁹ However, this analysis has been fiercely criticized by many.¹²⁰ In his separate opinion, joined by Justices Scalia, O’Connor, and Thomas, Chief Justice Rehnquist began by noting the importance of maintaining an

113. *Id.* at 1404–05.

114. 881 F. Supp. 240 (E.D. La. 1995).

115. *Id.* at 243.

116. 916 F. Supp. 797, 804 (N.D. Ill. 1996).

117. *Id.*

118. The exception would most likely be those reproductive disorders that could be mitigated or otherwise fully corrected through treatment. See *Sutton v. United Air Lines*, 527 U.S. 471, 475 (1999) (holding that courts must acknowledge positive and negative effects of mitigating measures in ‘substantial limitation’ analysis of ADA disability claim).

119. *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998).

120. See, e.g., Johnston, *supra* note 87, at 233.

individualized inquiry in the construction of the ADA, as opposed to creating *per se* rules about whether a particular condition constitutes a disability.¹²¹ In particular, Rehnquist noted that the statute defines a disability as impacting a major life activity of *such individual*.¹²² After bemoaning the “inartful” usage of the term “activity” to describe the “process” of reproducing, Rehnquist’s opinion attacked the majority’s construction of the term “major” for ignoring what he saw as the common thread linking all the activities listed in the regulations together—“repetitively performed and essential to the day-to-day existence of a normally functioning individual.”¹²³

In addition to Rehnquist’s vigorous dissent, some commentators and scholars have noted that the logic behind *Bragdon* is something of an oddity, and even suggest that it could be abandoned in the near future.¹²⁴ The decision’s focus on the plaintiff’s reproductive capacity and intentions has been criticized by one commentator as “arbitrarily distinguish[ing] between individuals based on circumstances . . . that have nothing to do with the discrimination at issue,” namely, irrational discrimination based on HIV infection and fear of individuals with HIV.¹²⁵ However, as long as *Bragdon* remains good law, all people with medically diagnosed reproductive disorders are among the “disabled” protected by the ADA.

3. Saks v. Franklin Covey: *The First Test of Bragdon*

After the Supreme Court’s seeming endorsement of the concept of reproduction as a “major life activity” under the ADA, a case soon arose that tested how lower courts would respond to the *Bragdon* decision. Rochelle Saks was a thirty-seven-year-old woman who worked as a store manager for Franklin Covey Co., a seller of motivational family-oriented publications including the best-selling self-help book, *The Seven Habits of Highly Effective Families*.¹²⁶ Franklin Covey of-

121. 524 U.S. at 657 (Rehnquist, C.J., concurring in part and dissenting in part).

122. *Id.* at 658–59. This dispute was heightened by the fact that the case dealt with an asymptomatic HIV positive woman who may or may not have been trying to get pregnant at the time.

123. *Id.* at 659–60.

124. *See, e.g.*, Finley, *supra* note 7, at 866 (“In addition, given *Bragdon*’s slim majority, it is reasonable to believe the broad language of that holding could be abandoned at some future point. If *Bragdon* results in increasing claims from the infertile and impotent, the minority may sway a Justice to its reasoning because of concerns about rising healthcare costs.”).

125. Elizabeth C. Chambers, Note, *Asymptomatic HIV as a Disability Under the Americans with Disabilities Act*, 73 WASH. L. REV. 403, 422–23 (1998).

126. Jane Gross, *The Fight to Cover Infertility: Suit Says Employer’s Refusal to Pay Is Form of Bias*, N. Y. TIMES, Dec. 7, 1998, at B1.

ferred all of its employees a self-insured health benefits plan, administered through a third-party processing agent.¹²⁷ However, the plan contained an exclusion for “surgical impregnation procedures,” including IVF.¹²⁸ Beginning in 1994, Saks and her husband attempted to conceive a child, with no success.¹²⁹ Three years later, Saks was diagnosed with a hormonal disorder and prescribed drugs to regulate her ovulation cycle.¹³⁰ Her health plan refused to cover almost all of her costs on the basis of its exclusion of infertility treatment, and, after the New York District Director for the EEOC found in her favor, Saks filed suit in the Southern District of New York in September of 1999.¹³¹ Judge Colleen McMahon quickly disposed of Franklin Covey’s claim that Rochelle Saks lacked standing under the ADA as a disabled person, calling such arguments “simply silly” and “unsupportable” in light of *Bragdon*.¹³²

Prior to Judge McMahon’s decision granting summary judgment for Franklin Covey, the conventional wisdom in the New York legal community was that the case was expected to turn solely on the question of whether infertility was to be considered a disability under the ADA.¹³³ Instead, Judge McMahon ruled that although Rochelle Saks had standing as a disabled person under the ADA, her claims failed to demonstrate discrimination on the basis of her disability.¹³⁴ This decision surprised many, and leads to more substantial questions about the scope of protection the ADA provides to infertile women.

III

DIFFERENCES IN THE SCOPE OF PROTECTION UNDER TITLES I AND III

One of the first questions that arose after *Saks* was whether Rochelle Saks made a critical error by bringing her claim under Title I of the ADA rather than under Title III. Although it is fairly certain that employers and those in contractual relations with employers are prohibited by Title I from discriminating in the terms and conditions

127. *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 321 (S.D.N.Y. 2000).

128. *Id.*

129. *Id.*

130. *Id.* at 322.

131. *Id.* at 323.

132. *Id.* at 324.

133. *See, e.g.*, Lisa Fried, *Infertility Treatments: A Case Will Determine Employers’ Liability*, N.Y.L.J., Nov. 18, 1999, at 5 (“The case is expected to turn on whether or not infertility is a disability under the ADA.”).

134. *Saks*, 117 F. Supp. 2d at 327-28 (finding no discrimination because exclusions applied uniformly to disabled and nondisabled members and were enacted prior to passage of ADA, therefore falling into “safe harbor” exception to ADA).

of employment,¹³⁵ a circuit split exists as to whether Title III is applicable to insurance companies and third-party claims administrators of employer-funded health benefit plans.¹³⁶ A comprehensive treatment of this question is beyond the scope of this Note.¹³⁷ Nonetheless, a brief survey of the scope of the ADA's protections under both Title I and Title III is helpful in understanding how the *Saks* decision will impact further claims by advocates for the infertile.

A. *Fundamentals of Titles I and III*

There is no doubt that Title I prohibits "a covered entity" from discriminating on the basis of disability "in regard to . . . [f]ringe benefits available by virtue of employment, whether or not administered by the covered entity."¹³⁸ Rochelle Saks brought a claim against her employer, Franklin Covey, under Title I.¹³⁹ Some courts have held that where third-party administrators exercise control over the level of benefits or over some discretionary element of a benefits plan, that entity falls under Title I as acting in the role of an "employer."¹⁴⁰ Depending on the development of facts, it is possible, therefore, that Saks could have brought an additional claim against the third-party claims administrator in her case under Title I. Title III, which prohibits discrimination in the "full and equal enjoyment of the goods [and] services . . . of any place of public accommodation," provides an alternative means of getting to the insurance company or third-party administrator of the employer's health benefits plan under the theory that disabled individuals are entitled to equal access to the underwriting and actuarial services of insurance companies.¹⁴¹ In *Carparts Distribution Center v. Automotive Wholesalers' Ass'n of New England*, the

135. See sources cited *supra* note 90.

136. Compare *Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New England, Inc.*, 37 F.3d 12 (1st Cir. 1994) (holding that employer health benefit plan is good or service offered by place of public accommodation within Title III), with *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997) (holding that employer benefit plans are not goods offered by places of public accommodation).

137. For a comprehensive discussion of this topic, see Bonnie Poitras Tucker, *Insurance and the ADA*, 46 DEPAUL L. REV. 915 (1997); Jeffrey S. Manning, Comment, *Are Insurance Companies Liable Under the Americans with Disabilities Act?*, 88 CAL. L. REV. 607 (2000).

138. Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 29 C.F.R. § 1630.4(f) (2001).

139. *Saks*, 117 F. Supp. 2d at 323.

140. See *Carparts Distribution Ctr., Inc.*, 37 F.3d at 17 ("employer" includes any group that "exercise[s] control over an important aspect of . . . employment"); *Boots v. Northwestern Mut. Life Ins. Co.*, 77 F. Supp. 2d 211, 214 (D.N.H. 1999) (accepting *Carparts'* definition of "employer").

141. 42 U.S.C. § 12182(a) (1994).

First Circuit explicitly held that Title III governs the provision of services irrespective of whether access to a physical place is at issue.¹⁴² Other circuits, such as the Third and the Sixth, have explicitly disagreed with the First Circuit, and have held that Title III is primarily concerned with access to and equal treatment at physical places of public accommodation.¹⁴³

Title III does seem to provide for more comprehensive, integrative protection for disabled individuals than Title I. Although both Title I and Title III specifically prohibit “criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities,”¹⁴⁴ Title III creates additional affirmative obligations upon places of public accommodation to not only “make reasonable modifications in policies, practices, or procedures, when such modifications are necessary,”¹⁴⁵ but also to “take such steps as may be necessary to *ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals.*”¹⁴⁶ Whereas Title I seems to require only that employers provide equal access to the same policy to both disabled and nondisabled individuals,¹⁴⁷ the text of Title III seems to require that insurance companies take affirmative steps to provide actual substantive equality of value between the disabled and the nondisabled. Therefore, at least at first glance, it appears as though Title III provides a somewhat better method for reaching insurance companies than would Title I.

142. 37 F.3d at 20.

143. See *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 614 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999) (“[W]e part company with the First Circuit in this regard.”); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1013 (6th Cir. 1997) (“We . . . disagree with the First Circuit’s decision in *Carparts* . . .”). *But cf.* Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 28 C.F.R. § 36 app. B (2001) (“It is the public accommodation, and *not the place of public accommodation*, that is subject to the regulation’s nondiscrimination requirements.”) (emphasis added).

144. 42 U.S.C. §§ 12112(b)(6), 12182(b)(2)(A)(i) (1994).

145. *Id.* § 12182(b)(2)(A)(ii).

146. *Id.* § 12182(b)(2)(A)(iii) (emphasis added).

147. See Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. § 1630.5 (2001).

[T]his part is intended to require that employees with disabilities be accorded equal access to whatever health insurance coverage the employer offers to other employees. . . . [B]enefit plans that are uniformly applied do not violate this part simply because they do not address the special needs of every individual with a disability.

B. Doe v. Mutual of Omaha—*Limiting the Scope of Title III*

Despite this initial optimism, in 1999, the Seventh Circuit cast a dark shadow on claims of insurance discrimination based on disparities in the substantive value of a policy between disabled and nondisabled individuals, whether such claims were brought under either Title I or Title III.¹⁴⁸ In *Doe v. Mutual of Omaha*, Chief Judge Richard Posner argued that nothing in the ADA required that insurance policies provide equal value to the disabled and the nondisabled.¹⁴⁹ Mutual of Omaha had issued health insurance policies with specific monetary caps on treatments for AIDS and AIDS-related complexes that were set well below the caps for other conditions.¹⁵⁰ The district court had ruled against Mutual of Omaha on a motion to dismiss, holding that Title III extended not only to mere access to, but to the very substance of insurance policies.¹⁵¹ Mutual of Omaha subsequently appealed the denial of their motion to the Seventh Circuit.

In an eloquent but logically convoluted decision reversing the district court, Judge Posner first observed that benefit caps are present in almost all insurance policies, and that regulating the content of insurance policies “would discriminate among diseases,” as those ailments that also happened to be disabilities could not have caps imposed on them.¹⁵² Mutual of Omaha had put a cap of \$25,000 in one policy and \$100,000 in another for lifetime AIDS-related benefits, whereas all other conditions had a lifetime benefit cap of \$1 million.¹⁵³ Had the court ruled that the ADA applied in this situation, the most reasonable accommodation would have been to make the AIDS benefit cap the same as the benefit cap for all other conditions, thereby eliminating any discrimination against AIDS treatment.

Judge Posner then raised the right of the insurance company to simply not offer certain forms of coverage. He analogized the insurance policy to a bookstore and paraphrased an oft-quoted metaphor from the Justice Department’s implementing regulations on Title III, noting that just as the ADA did not require bookstores to stock braille books to accommodate the blind, insurers should not be required to

148. *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 528 U.S. 1106 (2000).

149. *Id.* at 563 (“[The ADA] does not require a seller to alter his product to make it equally valuable to the disabled and to the nondisabled, even if the product is insurance.”).

150. *Id.* at 558.

151. *Doe v. Mut. of Omaha Ins. Co.*, 999 F. Supp. 1188, 1194, (N.D. Ill. 1998), *rev’d*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 529 U.S. 1106 (2000).

152. 179 F.3d at 559.

153. *Id.* at 558.

alter the nature and content of their policies and procedures in order to guarantee insurance to people with disabilities.¹⁵⁴ This analogy to braille books has been repeated in a number of cases to draw a bright line distinction between access and content regulation.¹⁵⁵

However, this analogy fails for three reasons. First, it misconstrues the Justice Department's original point in making the analogy to retail goods. Second, it presumes that insurance benefits are goods and not services. Third, it ignores the specific and exclusionary nature of the discrimination found in insurance policies.

The braille books analogy is used in the Justice Departments implementing regulations, but only with regard to "accessible or special goods" in facilities like retail outlets.¹⁵⁶ Further, in order to determine the intent of the Justice Department and Congress with respect to the scope of the ADA's protections, a separate section in the comment accompanying the final rule discussing insurance practices is enlightening. The Justice Department concluded that "Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified."¹⁵⁷ Thus, the Justice Department believed, at the very least, that the "refusal to stock" scenario illustrated by the braille books analogy simply did not apply to the goods and services offered by insurance in particular.

Second, the access/content dichotomy only makes sense when insurance policies are viewed as goods instead of service contracts.¹⁵⁸ Unlike books, insurance contracts are not intrinsically valuable goods. Insurance is literally worth much more than the paper it is printed on. Insurance is a service that provides protection against the significant

154. *Id.*; see also *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 28 C.F.R. pt. 36, app. B § 36.307 (2000).

The purpose of the ADA's public accommodations requirements is to ensure accessibility to the goods offered by a public accommodation, not to alter the nature or mix of goods that the public accommodation has typically provided. In other words, a bookstore, for example, must make its facilities and sales operations accessible to individuals with disabilities, but is not required to stock Brailled or large print books.

Id.

155. See, e.g., *Lenox v. Healthwise of Ky., Ltd.*, 149 F.3d 453, 457 (6th Cir. 1998); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1010–11 (6th Cir. 1997).

156. *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 28 C.F.R. § 36.307.

157. *Final Rule—Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 56 Fed. Reg. 35,544, 35,562 (July 26, 1991).

158. See 179 F.3d at 560 ("An insurance policy is a product, and a policy with a \$25,000 limit is a different product from one with a \$1 million limit, just as a wheelchair is a different product from an armchair.").

and unpredictable risk of adverse events and financial loss in return for advance payments based on principles of actuarial fairness.¹⁵⁹ Actuarial fairness principles suggest that insurers link the cost of and access to insurance coverage to an individual's risk class, estimating an individual's expected claim costs based on the risk characteristics of an individual that have a "direct causal or statistical link to the risk that the insurance company is measuring, such as disability income or medical expenses."¹⁶⁰ Especially in the context of self-insured employer-based health benefit plans covered by ERISA, where insurance companies are often hired merely to process claims and administer the plan rather than provide the plan itself, the distinction between the provision of goods and services becomes stark, with the insurance company appearing to fall firmly on the "services" side of the line. Employers do not provide for individualized risk classifications but rely instead on blanket limitations that affect all employees, leaving insurance administrators with the task of applying the blanket rules to individual cases.¹⁶¹

Once insurance is seen as a service and not a product, the analogy to stocks of braille books completely crumbles.¹⁶² There are many books that the average bookstore does not have in stock, including those in braille. However, most bookstores, upon request, will place special orders for books from certain publishers as a service. Although no one would fault the bookstore as biased against the blind for its failure to keep braille books in stock, most would accuse that same bookstore of discrimination if it refused to special order a book from a publisher that it would otherwise deal with, solely on the basis that the order was made by a blind customer.¹⁶³ Insurance acts as a

159. Jill L. Schultz, Note, *The Impact of Title III of the Americans with Disabilities Act on Employer-Provided Insurance Plans: Is the Insurance Company Subject to Liability?*, 56 WASH. & LEE L. REV. 343, 352 (1999).

160. *Id.* at 353.

161. *Id.*

162. Circuit Judge Evans, in his dissent in *Doe*, alludes to the distinction between the treatment of goods and services. A store owner who treats customers differently based on their disabilities does not discriminate in the provision of goods, but through the provision of inferior service:

Chief Judge Posner's opinion likens the insurance company here to a camera store forced to stock cameras specially designed for disabled persons. While I agree that the ADA would not require a store owner to alter its inventory, I think the analogy misses the mark. The better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras.

179 F.3d at 565.

163. In fact, the Justice Department's comments accompanying the Final Rule implementing Title III raise this exact point:

service, providing reimbursement for the consequences of risks, based on the rate paid to the insurer. To the extent that a policy specifically excludes an otherwise actuarially fair risk on the basis of disability, the insurer is providing discriminatory service to that disabled individual.

Third, Judge Posner's reasoning fails to account for the specific and exclusionary nature of insurance policy benefit caps and their targeted nature towards the disabled. A bookstore's "refusal to stock" in most cases is an act of omission, whereas an insurance company affirmatively commits to excluding a disability, either by excluding the individuals with disabilities or excluding coverage for the treatments that they require to overcome their disability. A bookstore that would otherwise special order books for the disabled but singles out braille as an example of a book it would not stock or special order should be more readily required to provide a nondiscriminatory justification for that policy of exclusion than a bookstore that simply does not have any braille books in stock. As the comments accompanying the Title III implementing regulations establish, "[A] public accommodation may offer insurance policies that limit coverage for certain procedures or treatments, but may not entirely deny coverage to a person with a disability."¹⁶⁴ Once insurance is seen as a service and not a retail good, the rhetorical force of the entire access/content debate collapses on itself, and remedial actions that were seen as intruding upon the substance of a good transform into pragmatic calls for equal access to equal services.

Given that Judge Posner's analogy of insurance to consumer goods fails on several levels, it may be possible that claims could be brought against an insurance company under Title III. Title III's broader scope may enable courts to more readily find that a company's insurance practices violate the ADA when they deny coverage for infertility treatments.

Although a public accommodation is not required by § 36.307(a) to modify its inventory, it is required by § 36.307(b), at the request of an individual with disabilities, to order accessible or special goods that it does not customarily maintain in stock if, in the normal course of its operation, it makes special orders for [such] unstocked goods. . . .

Final Rule, Title III, 56 Fed. Reg. 35,544, 35,571 (July 26, 1991).

164. *Id.* at 35,563.

IV

PROVING DISCRIMINATION: THE MISSING DISPARATE
IMPACT ANALYSIS IN *SAKS*

Regardless of whether a claim under the ADA is based on Title I or Title III, “discrimination” must be proven. Each section has distinct requirements for what must be proven in order to show discrimination. Under Title I, the definition and construction of discrimination includes effects-based methods of proof, such as “participating in a contractual or other arrangement or relationship that has the *effect* of subjecting a covered entity’s qualified applicant” to discrimination¹⁶⁵ and “utilizing standards, criteria, or methods of administration that have the *effect* of discrimination on the basis of disability.”¹⁶⁶ Title III allows for proof of discrimination through the same effects-based disparate treatment language,¹⁶⁷ but it also creates affirmative obligations upon “place[s] of public accommodation” to create “the most integrated setting appropriate” to the needs of disabled individuals.¹⁶⁸ Much like the leaders of the civil rights battles fought before them, people seeking to vindicate their rights as disabled individuals must now advance theories of “disparate impact,” where uniformly applied criteria have an adverse impact on an individual with a disability or a disproportionately negative impact on a class of individuals with disabilities. These claims must be articulated in such a way that questions of access are implicated, as opposed to questions of content.¹⁶⁹ However, provided that an actionable claim can be brought under Title III, the inquiry is broadened to include whether the specific exclusion in question fulfills the promise of “full and equal enjoyment” of goods and services.¹⁷⁰

In *Saks*, one of the reasons Judge McMahon dismissed the plaintiff’s claim was that she had equal access to the same insurance policy as the nondisabled.¹⁷¹ All employees faced the same limitation on coverage for “surgical impregnation procedures.” Judge McMahon

165. 42 U.S.C. § 12112(b)(2) (1994) (emphasis added).

166. *Id.* § 12112(b)(3) (emphasis added).

167. *Id.* § 12182(b)(1)(D) (1994) (“An individual or entity shall not, directly or through contractual or other arrangements, utilize standards or criteria or methods of administration that have the *effect* of discriminating on the basis of disability.”) (emphasis added).

168. *Id.* §§ 12182(a), 12182(b)(1)(B).

169. *See* Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. pt. 1630, app. § 1630.5 (2001) (discussing “disparate impact” defenses to claims under the ADA); *cf.* *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 559 (7th Cir. 1999) (rejecting claim under ADA based on “disparate impact” evidence).

170. 42 U.S.C. § 12182(a).

171. *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 326 (S.D.N.Y. 2000).

pointed to cases in the Second, Third, Seventh, and Eighth Circuits that held “that insurance distinctions that apply equally to all insured employees do not discriminate on the basis of disability.”¹⁷² Judge McMahon noted that other types of procedures, such as penile prosthetic implants, were also expressly excluded from the terms of the benefits plan.¹⁷³ Although Judge McMahon acknowledged that the exclusions for infertility treatments hit infertile employees like Ms. Saks harder than most, she pointed out that the Second Circuit had ruled in a similar case, involving huge disparities between mental health and physical health benefits, that insurers were under no obligation to provide equal benefits across disabilities.¹⁷⁴

Two problems with this analysis seem fairly evident. First, neither of the analogies, to mental health benefits and to penile prosthetic implants, fit with the previous holding that, under *Bragdon*, disorders to the reproductive system constituted *per se* disabilities. As another district court noted in *Boots v. Northwestern Mutual Life Insurance Co.*, “Just as most employees who use their health insurance to cover medical costs are not physically disabled, most employees seeking insurance coverage for mental health treatment are not mentally disabled.”¹⁷⁵ Under this reasoning, if nondisabled people have a medical need for a particular procedure, a policy that limits or excludes that procedure is not making a disability-based distinction. Although it is true that, in theory, nondisabled couples could use surgical impregnation methods, post-*Bragdon* they would have no medically necessary reason for doing so, since all infertile couples are, by definition, disabled. The only people upon whom this exclusion falls are the reproductively disabled. To argue that there is no disability-based distinction because non-infertile people are affected is like arguing that because nondisabled people could use wheelchair ramps, failure to install a ramp does not discriminate against the wheelchair bound.

A most glaring and somewhat disturbing omission from the decision in *Saks* was the failure of the court to perform the disparate impact analysis required by the ADA in order to determine whether the plaintiff proved discrimination. Under both Titles I and III, if the effect of a facially neutral policy, practice, or procedure is to have a disproportionately negative impact on a class of similarly-situated disabled individuals, then the burden shifts to the covered entity or public

172. *Id.* at 326–27 (citing *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 150 (2d Cir. 2000)).

173. *Id.* at 327.

174. *Id.* (citing *Staten Island Savings Bank*, 207 F.3d at 150).

175. 77 F. Supp. 2d 211, 220 (D.N.H. 1999).

accommodation to show that the policy, practice, or procedure is job-related and justified by business necessity.¹⁷⁶

Typically, disparate impact analysis is relied upon chiefly in Title I cases, as Title III addresses the various forms of “disparate treatment” that can occur at a place of public accommodation. Disparate treatment, where a person is being treated differently because of membership in a protected class, may be proved either through direct evidence or by inference.¹⁷⁷ Direct evidence of intentional discrimination is difficult to produce, as discrimination against the disabled typically takes on complex and subtle forms.¹⁷⁸ Disparate impact theory enables facially neutral practices that have a discriminatory, disparate impact on members of the protected class to be deemed “discriminatory,” and therefore forbidden by the ADA and other civil rights laws.¹⁷⁹

Much of disparate impact theory was formed as a response to the enactment of the Civil Rights Act of 1964.¹⁸⁰ In a unanimous opinion by Chief Justice Warren Burger in 1971, the Supreme Court held in *Griggs v. Duke Power Co.* that Title VII of the Civil Rights Act prohibited not only practices adopted with an explicitly discriminatory motive, but also practices that, though adopted without discriminatory intent, have a discriminatory *effect* on minorities.¹⁸¹ *Griggs* left a tremendous legacy and served as the anchor for a workable and widely accepted set of legal principles on how to prove a disparate impact case.¹⁸²

Under the *Griggs* standard, the plaintiff in an ADA action first must meet a very high level of proof. Specifically, the complaining party must prove that the procedures in question adversely select applicants on the basis of disability. Once this showing is made, the burden of persuasion shifts back to the employer, whose only real defense is that the procedures that have a discriminatory effect are the result of a “business necessity.”¹⁸³ As applied to the *Saks* case, the

176. 42 U.S.C. §§ 12112(b)(6), 12182(b)(2)(A) (1994).

177. Ellen M. Saideman, *The ADA as a Tool for Advocacy: A Strategy for Fighting Employment Discrimination Against People with Disabilities*, 8 J.L. & HEALTH 47, 51 (1993).

178. *Id.*

179. *Id.* at 52.

180. Civil Rights Act of 1964, Pub. L. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 42 U.S.C.).

181. 401 U.S. 424, 429–33 (1971).

182. See Alfred W. Blumrosen, *The Legacy of Griggs: Social Process and Subjective Judgments*, 63 CHI-KENT L. REV 1, 10–11 n.53 (1987) (charting citations of *Griggs* by various adjudicatory bodies).

183. 401 U.S. at 431.

initial proffer of discrimination would have been quite easy: The exclusion targeted and caused most, if not all, of the discriminatory coverage denials to be suffered by reproductively disabled employees. The EEOC has made it clear that there is a difference between simply denying coverage for a particular treatment, which is acceptable, and denying access to coverage for an entire disability, which is not.¹⁸⁴ By excluding coverage for artificial insemination and related procedures, employers like Franklin Covey Co. and their insurers assured that their reproductively-disabled employees would be excluded from full and equal access to the company's health plan. If nothing else, the significance of standing under the ADA means that no longer should simple facial neutrality justify differential treatment across the reproductively disabled as a protected class.

The disparate impact case in *Saks* is perhaps best illustrated by the statement in *Bray v. Alexandria Women's Health Center* that "[a] tax on wearing yarmulkes is a tax on Jews."¹⁸⁵ However, in *Bray*, the Court distinguished the antiabortion protesters blocking abortion clinics as not harassing women in violation of sex discrimination laws, even though the only people seeking abortions at the time were women.¹⁸⁶ While the link in identity is so strong between yarmulkes and Jews that the tax singles out an "irrational object of disfavor,"¹⁸⁷ the Court argued that the link between women as a class and women seeking abortions is less so because the protesters were blocking and harassing, not because of, but rather in spite of, the fact that those seeking abortion were only women. Anti-abortion demonstrators were protesting the abortions themselves, and arguably not the women who sought them. The question in the context of infertility is whether any nondisability-based justifications need be provided by employers and insurers who enact specific treatment exclusions that only affect the infertile.

V

LEGITIMATE DISABILITY-BASED DISTINCTIONS: THE SAFE HARBOR

The second justification made by the *Saks* court for dismissing Ms. Saks's claim was grounded in the "safe harbor" insurance excep-

184. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,544, 35,563 (July 26, 1991) (codified at 28 C.F.R. pt. 36).

185. 506 U.S. 263, 270 (1993).

186. *Id.*

187. *Id.*

tion to the ADA.¹⁸⁸ Title V of the ADA specifically carves out an exception for insurers and other entities that administer health benefit plans from “underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law” or otherwise administering a “bona fide benefit plan.”¹⁸⁹ This “safe harbor” exception for health insurers, however, cannot be used as a “subterfuge to evade the purposes” of Titles I and III.¹⁹⁰ The *Saks* court found that Franklin Covey Co.’s benefit plan fell within the “safe harbor” exception. In addition, Judge McMahon adhered to Second Circuit precedent, which held that benefit exclusions adopted by self-insured plans prior to the passage of the ADA “by definition” were not adopted as subterfuge of the purposes of the statute.¹⁹¹ However, both of these arguments misinterpret the intent and goals of the ADA.

Title V creates a safe harbor only for insurance plans which “classify risks” in a bona fide manner.¹⁹² Under Title V, differential treatment of disabilities is not “discrimination” for purposes of the ADA when such differences in extent of coverage or rates charged are practices “based on sound actuarial principles or [are] related to actual or reasonably anticipated experience.”¹⁹³ However, an employer may not entirely shut out a disabled employee from equal access to health benefits,¹⁹⁴ nor may it make disability-based distinctions in treatment as a subterfuge to circumvent the ADA.¹⁹⁵ The subterfuge language thus provides an exception to the general rule that insurers may underwrite and classify risks to account for disability-based distinctions in their policies. If an insurance provision is based on sound actuarial

188. *Saks v. Franklin Covey*, 117 F. Supp. 2d 318, 327–28 (S.D.N.Y. 2000).

189. 42 U.S.C. § 12201(c) (1994).

190. *Id.*

191. 117 F. Supp. 2d at 328 (citing *Leonard F. v. Israel Discount Bank of New York* 199 F.3d 99, 104 (2d Cir. 1999)).

192. 42 U.S.C. § 12201(c).

193. *Id.*; see also H.R. REP. NO. 101-485, pt. 2, at 136–37 (1990); Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 28 C.F.R. § 36.212 (2000) (stating that employers do not have to provide that same level or quality of coverage across disabilities and disorders, but must provide equal access to insurance coverage to people with disabilities.).

194. *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 778–79 (E.D. Tex. 1996) (holding that employer’s complete exclusion of disabled employee from health benefits could not be based on actuarial risks, as no person is uninsurable).

195. See 42 U.S.C. § 12201(c); 28 C.F.R. § 36.212 (forbidding “subterfuge to evade the purposes” of the ADA).

principles or other “legitimate risk classification and underwriting procedures,” there is no subterfuge of the ADA.¹⁹⁶

The EEOC’s Interim Guidance on Implementation of the ADA (Interim Guidance) makes several recommendations as to how courts should view the subterfuge issue.¹⁹⁷ For example, once it is determined that a health plan makes a disability-based distinction, the employer has the burden of proof to show that the plan is bona fide and that the distinction is legitimate and supported by “legitimate actuarial data, or by actual or reasonably anticipated experience.”¹⁹⁸ This need not be an overwhelming burden for employers to bear, since the Interim Guidance indicates that not all health-related plan distinctions discriminate on the basis of disability, especially if they are limitations on particular treatments or procedures and are applied across the board to all insured employees regardless of their disability status.¹⁹⁹ The Interim Guidance cites the example of health insurance plans that provide fewer benefits for “blood transfusions or X-rays” than for other physical conditions as an example of such a nondiscriminatory limitation, even though the differential treatment may have a greater impact on certain individuals with disabilities.²⁰⁰ The Interim Guidance views as suspect health-related insurance distinctions that target or single out a particular disability, such as AIDS, or a discrete group of disabilities, such as preexisting blood disorders.²⁰¹

An issue of central importance in determining the duties of insurers toward individuals with disabilities is whether the ADA creates an absolute “safe harbor” for employer benefit plans that were established before 1991, the year the ADA became law, or whether the ADA has retroactive effect. The argument for the safe harbor position turns on the controlling weight given to the case of *Public Employees Retirement System v. Betts*.²⁰² Although that case involved the Age

196. EQUAL EMPLOYMENT OPPORTUNITY COMM’N, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE 13 (1993) [hereinafter EEOC, INTERIM GUIDANCE], at <http://www.eeoc.gov/docs/guidance.pdf>.

197. *Id.* at 12–15.

198. *Id.* at 13 (footnote omitted).

199. *See id.* at 11 (“In the health insurance context, it is the respondent employer . . . who has control of the risk assessment, actuarial, and/or claims data relied upon in adopting the challenged disability-based distinction. . . . Consequently, it is the employer who should bear the burden of [proof] . . .”).

200. *Id.* at 8.

201. *Id.* at 8–9.

202. 492 U.S. 158 (1989) (holding that pre-ADEA benefit plan could not be subterfuge, and that subterfuge required showing of employer’s specific intent to discriminate in some non-fringe aspect of employment).

Discrimination in Employment Act (ADEA), the courts have noted that the ADA adopted the subterfuge language straight from the ADEA, and it is argued that the precedents interpreting that language transfer over to the ADA as well.²⁰³ If *Betts* is controlling on the question of subterfuge, plaintiffs would have the burden of proving specific intent to discriminate against the disabled in a non-fringe-benefit aspect of employment.²⁰⁴

The EEOC Interim Guidance, however, explicitly disclaims the application of *Betts* to the ADA, stating that “the ADA does not provide a ‘safe harbor’ for health insurance plans that were adopted prior to its July 26, 1990 enactment. As the Senate Report states, subterfuge is to be determined ‘regardless of the date an insurance or employer benefit plan was adopted.’”²⁰⁵ Moreover, the EEOC defines “subterfuge” as “disability-based disparate treatment that is not justified by the risks or costs associated with the disability.”²⁰⁶ The EEOC has provided a nonexclusive list of potential justifications for alleged disparate treatments, including proof denying that the defendant has engaged in the disability-based disparate treatment alleged; the disparate treatment is cost-justified by legitimate actuarial data or by actual or reasonably-anticipated experience; disparate treatment is necessary to ensure compliance with standards for fiscal soundness of the plan; the challenged activity is necessary to prevent unacceptable change in either the coverage of the plan or in the premiums charged; or that the treatment would not provide any benefit to the disabled person.²⁰⁷ According to the EEOC, whether a particular challenged disability-based distinction is being used as a subterfuge is to be determined on a case-by-case basis, considering the totality of the circumstances.²⁰⁸

Agency interpretations of statutes, such as the EEOC’s Interim Guidance, are generally granted great deference, even on strictly legal issues, provided the interpretation is reasonable and not in conflict with the expressed intent of Congress.²⁰⁹ In this case, the legislative

203. EEOC v. Aramark, 208 F.3d 266, 269–73 (D.C. Cir. 2000).

204. See 492 U.S. at 181 (“Thus, when an employee seeks to challenge a benefit plan provision as a subterfuge . . . the employee bears the burden of proving that the discriminatory plan provision actually was intended to serve the purpose of discriminating in some non-fringe benefit aspect of the employment relation.”).

205. EEOC, INTERIM GUIDANCE, *supra* note 196, at 9 (quoting S. REP. No. 101-116, at 85 (1989)).

206. *Id.* at 12.

207. *Id.* at 12–15.

208. *Id.* at 12.

209. See, e.g., *Chevron U.S.A. v. Natural Res. Def. Council*, 467 U.S. 837, 844 (1984) (holding that agency rule-making interpretations are to be given “controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.”).

history in the conference reports of both the House of Representatives and the Senate specifically state that the “subterfuge” provision should not be interpreted according to *Betts*.²¹⁰ However, it is still unsettled exactly how much deference courts should give to informal pronouncements such as the Interim Guidance, which has not gone through notice and comment rulemaking procedures.²¹¹ Furthermore, some courts have been quick to apply a rule of statutory construction that imputes knowledge of Supreme Court interpretations to policymakers to demonstrate that Congress must have intended to import *Betts* into the ADA, noting that although Congress reacted to *Betts* by eliminating the subterfuge clause in the ADEA, it left it in the ADA.²¹² Therefore, it may be difficult for advocates to convince courts that they should use a definition of “subterfuge” other than the one adopted in *Betts*.

The Second Circuit has failed to give due deference to the EEOC Interim Guidance, as well as the ADA itself, especially in its decision in *Saks*. Section 501(c) prohibits “subterfuge to evade *the purposes*” of Titles I and III.²¹³ Section 501 was not designed to be a grandfather clause for discriminatory or outdated disability-based blanket exclusions that would otherwise be held in violation of the ADA. Read broadly, the purposes of Titles I and III—ensuring that the disabled have comprehensive and full access to all the terms, conditions, and privileges of employment—preexisted the actual passage of the ADA. Those egalitarian norms are merely an extension of the civil rights principles championed in the Equal Protection Clause of the Fourteenth Amendment.²¹⁴ Ultimately, the important question should be whether employers and insurers can cost-justify their blanket exclusions of coverage for infertility treatments according to standard actuarial principles. Is it that unreasonable to ask an organization in the business of underwriting, classifying, and administering risks to accommodate the disabled by either *offering* to cover treatments that would improve the quality of life for the disabled or providing some justification for the exclusion of such treatments? As another district

210. 136 CONG. REC. 17,378 (statement of Sen. Kennedy) (1990); *Id.* at 17,290 (statement of Rep. Owens).

211. *See* *United States v. Mead*, 121 S. Ct. 2164, 2173 (2001).

212. *See, e.g., Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102, 110 (S.D. Iowa 1995), *aff'd*, 95 F.3d 674 (8th Cir. 1996) (rejecting claim that *Betts* did not apply to ADA); *see also* *Millsap, supra* note 18, at 64 (“The fact that the ADA uses the same words as the ADEA in a similar context gives rise to the argument that Congress intended the *Betts* definition of subterfuge to apply to the ADA.”).

213. 42 U.S.C. § 12201(c) (2001).

214. U.S. CONST. amend. XIV, § 1.

court noted in *Anderson v. Gus Mayer Boston Store of Delaware*: “No actuarial risk makes someone uninsurable.”²¹⁵ The *Saks* court’s deferential interpretation of “safe harbor” seems to allow insurers and employers to exclude disabilities—and the individuals afflicted by them—wholesale from the benefit of insurance coverage, without providing actuarial justification, provided that the exclusions took the form of targeting treatments instead of conditions.

CONCLUSION

Based on a close reading of the events following the Supreme Court’s momentous decision in *Bragdon v. Abbott* and the battles in the circuit courts over the scope and purpose of the Americans with Disabilities Act, it appears as if the tide is moving away from infertile couples and their dreams of insurance coverage that could help ease the financial burden of achieving a successful pregnancy. The general acceptance of infertility as a disability has not resolved the debate as to whether employers can specifically exclude medically necessary infertility treatments without actuarial justification under the ADA. The *Saks* decision illustrates that this debate continues.

It is evident that the court in *Saks* was only giving lip service to the notion that infertility constituted a truly protected disability under the ADA. If not, the holding has profound implications for the scope of protection provided to any and all disabled people under the ADA. It would be inconceivable to argue that an insurer could exclude coverage of wheelchairs specially designed for people with multiple sclerosis, for example, without triggering a violation of the ADA. Such a distinction would indeed constitute a “tax on wearing Yarmulkes” against the disabled, and might well be approved if the logic in *Saks* is extended.

Despite having held that all clinically diagnosed infertility was a disability because it intrinsically limited the major life activity of reproduction, in the context of surgical impregnation procedures the court in *Saks* seemed perfectly comfortable arguing that treatment-based exclusions did not single out the disabled. It is often said that a woman cannot be “a little bit pregnant.” However, infertile women seem to be viewed by the *Saks* court as only a “little bit disabled,” and therefore only a little bit entitled to the same protections as other members of their protected class. The holding in *Saks* presents dramatic implications not just for the infertile and their advocates, but for all persons committed to the rights of the disabled under the ADA.

215. 924 F. Supp. 763, 779 (E.D. Tex. 1996).

