NOTES

GOOD FOR THE GANDER, GOOD FOR THE GOOSE: EXTENDING THE AFFORDABLE CARE ACT UNDER EQUAL PROTECTION LAW TO COVER MALE STERILIZATION

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The Affordable Care Act requires coverage for female but not male sterilization, a disparity that this Note refers to as the Sterilization Gap. Although female sterilization is more dangerous, more expensive, and less effective than male sterilization, the Sterilization Gap incentivizes women to be sterilized rather than men. This Note argues that sterilization coverage should be extended to men. Because courts are empowered to extend underinclusive laws—like that which creates the Sterilization Gap—if they find them unconstitutional, litigation may be the best method of extending coverage. This Note presents a comprehensive argument for why the Sterilization Gap is unconstitutional and coverage should be extended. First, it argues that the Sterilization Gap is a facial sex classification because both sexes can be sterilized, even though the procedure is sex specific. Next, it argues that the classification violates constitutional equal protection law, because it is not based on a biological difference and does not remedy discrimination against women. Then, it argues that the classification was created either through impermissible oversight or gender stereotypes, and that it will perpetuate the stereotype that contraception is a woman's responsibility, to the detriment of both sexes. Finally, it concludes by asserting that had Congress known that the Sterilization Gap was unconstitutional, it would likely have chosen to extend coverage to men rather than nullify the law, because extension would further its goals while causing comparatively little disruption to the statutory scheme.

 J.D., 2015, New York University School of Law; B.A., 2009, Tulane University. My deepest love and gratitude to Jenna Schaeffer, my sweetheart: I could not have written this without you. I would also like to give a hulk-sized thank you to my parents for all their encouragement and support, and to Professor Sylvia Law for her inspiration, guidance, and helpful comments. Finally, I must thank the dedicated editors of the *N.Y.U. Law Review* who helped get this Note into fighting shape, especially my editor Sarah Hu, as well as Johann Strauss, East Berhane, Steve Tensmeyer, Bradley Markano, Shayon Ghosh, Jessica Gardner, Paul White, Nicole Kramer, and all the eagle-eyed Staff Editors whose names I will never know.

INTRODUCTION

Isaac and Lin Grimnebulin are married, parents of three, and living just above the poverty line. Barely able to support the children they have, they decide to ensure that they will not have any more. Isaac and Lin's combined income level qualifies them for subsidized health insurance under the Affordable Care and Patient Protection Act (ACA), and Lin confirms that her health plan includes female sterilization. Before scheduling the procedure, Lin visits her doctor to make sure sterilization is right for her. Unfortunately, Lin's doctor tells her that due to her physiology, it would be dangerous for her to undergo sterilization. Her doctor recommends that Isaac be sterilized instead.[1] Isaac agrees, but when he checks his own insurance benefits,

[1] Vasectomy is the procedure for male sterilization in the United States. *See* Deborah Bartz & James A. Greenberg, *Sterilization in the United States*, 1 REVS. OBSTETRICS &

he finds that male sterilization is not included. Perplexed, he visits HealthCare.gov to determine what coverage the ACA requires. There he discovers that while insurers are required to cover female sterilization procedures, they are not required to cover the male equivalent.[2] Concerned about Lin's health and their family's future, Isaac and Lin sue the Secretary of the Department of Health and Human Services (HHS), the government official responsible for implementing the relevant sections of the ACA.[3] What result?

Although Isaac and Lin are fictional,[4] the problem they face is not. The ACA does only require insurers to cover female sterilization.[5] As Isaac and Lin will argue in their case, and as this Note will explain, covering sterilization for women but not men violates constitutional equal protection law because it provides a benefit to women but not men without an "exceedingly persuasive justification."[6] First, however, some background is in order.

In late 2009, before the ACA became law, the United States Preventive Services Task Force (USPSTF)[7] revised its recommenda-

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GYNECOLOGY 23, 24–26 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2492586/pdf/RIOG01001_0023.pdf (listing the sterilization procedures practiced in the United States). The primary methods of female sterilization in the United States are tubal ligation, which can be performed in several ways, and transcervical sterilization. *Id.* Although a hysterectomy also results in sterilization, it is not considered appropriate to perform one solely for this purpose. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION, STERILIZATION OF WOMEN, INCLUDING THOSE WITH MENTAL DISABILITIES 2 (2007), *available at* http://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co371.pdf. Unless otherwise noted, when this Note refers to female sterilization, it only refers to tubal ligation and transcervical sterilization. Furthermore, because the Food and Drug Administration did not approve transcervical sterilization until 2002, any reference in this Note to the rate of female sterilization at any time before 2003 applies only to tubal ligation. Bartz & Greenberg, *supra* at 25.

[2] *See Birth Control Benefits*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/birth-control-benefits/ (last visited Oct. 24, 2015) ("Plans in the Health Insurance Marketplace must cover contraceptive methods and counseling for all women, as prescribed by a health care provider. . . . Plans *aren't* required to cover drugs to induce abortions and services for male reproductive capacity, like vasectomies." (emphasis added)).

[3] *See infra* notes 16–22 and accompanying text (explaining the creation of the Sterilization Gap).

[4] *See generally* CHINA MIÉVILLE, PERDIDO STREET STATION (2000). For those in the know, it will be impressive that they were able to procreate at all.

[5] *See infra* notes 20–22 and accompanying text.

[6] *See infra* Part II (explaining the constitutional argument against the Sterilization Gap).

[7] The USPSTF is an independent panel of experts selected by the Agency for Health Research and Quality. *About the USPSTF*, U.S. PREVENTIVE SERVICES TASK FORCE, http://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf (last visited Oct. 21, 2015).

tions on mammograms.[8] Where before it had recommended that women over forty years old receive annual mammogram screenings, it now recommended that these screenings be biannual and not begin until a woman was fifty.[9] At that time, the ACA only required insurers to fully cover mammograms to the extent they were "recommended by the [USPSTF]."[10] This meant that unless an insurer chose to exceed the requirements of the statute, women who planned to acquire insurance through the ACA and wanted a mammogram would need to pay—or wait until they were fifty.

Given the public's well-stoked fears about whether the ACA would lead to a reduction in services, the USPSTF's recommendation generated significant pushback.[11] Women have historically paid more for health care than men and received fewer needed benefits,[12] and the recommendation seemed to continue the trend. Capitalizing on the controversy, Senator Barbara Mikulski sponsored an amendment to the ACA requiring insurers to cover preventive services for women.[13] The Mikulski Amendment passed,[14] and ultimately achieved its goals of providing preventive services—including sterilization—to women without cost-sharing.[15] However, the Mikulski Amendment has not been interpreted to provide equivalent services to men. The regulatory aftermath of the Mikulski Amendment illustrates how this happened.

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[8] Gina Kolata, *New Guidelines Suggest Cutback in Mammograms*, N.Y. TIMES, Nov. 17, 2009, at A2.

[9] *Id.*

[10] Adam Sonfield, *Contraception: An Integral Component of Preventive Care for Women*, GUTTMACHER POLICY REVIEW 2 (Spring 2010) [hereinafter Sonfield, *Integral Component*], *available at* https://www.guttmacher.org/pubs/gpr/13/2/gpr130202.pdf (last visited Oct. 21, 2015).

[11] *See id.* at 3 ("[A] wide range of critics decried the new guidelines for sending a mixed message to women about the importance of mammography," while "[c]onservative opponents of the administration's health care reform legislation seized on the USPSTF recommendations as evidence that reform would lead to federal 'rationing' of care.").

[12] *See* Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, N.Y. TIMES, Mar. 30, 2010, at D2 (describing insurance companies' common practice of charging higher rates for women than for men, even where policies did not include maternity-related services).

[13] *See* 155 CONG. REC. S11,986 (daily ed. Nov. 30, 2009) (statement of Sen. Reid) ("The amendment [Senator Mikulski] is going to offer is very sound and good. She will explain it in detail. It expands women's health services. We had a consternation about mammograms a couple weeks ago, and this will put that all to rest.").

[14] *See* Press Release, Sen. Mikulski, Senate Approves Mikulski Amendment Making Women's Preventive Care Affordable and Accessible (Dec. 3, 2009), *available at* http://www.mikulski.senate.gov/newsroom/press-releases/senate-approves-mikulski-amendment-making-women-and-39s-preventive-care-affordable-and-accessible [hereinafter Press Release] (documenting the passage of the Mikulski Amendment).

[15] *See infra* notes 16–20 and accompanying text (explaining what was included in the text of the codified Mikulski Amendment and its implementing regulations).

The actual text of the Mikulski Amendment, codified at 42 U.S.C. § 300gg-13(a)(4), requires insurers to cover, "*with respect to women*, such additional preventive care and screenings [not already recommended by the USPSTF] as provided for in comprehensive guidelines supported by the Health Resources and Services Administration [HRSA]."[16] HRSA, a division of HHS, enlisted the Institute of Medicine (IOM) to determine "what preventive services are important to *women's* health and well-being."[17] IOM recommended, among other things, that the ACA should cover "the full range of Food and Drug Administration-approved contraception methods, sterilization procedures, and patient education and counseling *for women with reproductive capacity*."[18] HRSA adopted IOM's recommendations in their entirety, publishing its "Women's Preventive Services Guidelines," which included "sterilization procedures."[19]

Then, in its final rule implementing § 300gg-13(a)(4), HHS promulgated that the HRSA "women's preventive health services" guidelines included "sterilization procedures," and required health insurers "to provide coverage consistent with the HRSA Guidelines."[20] In a brief but definitive footnote, HHS clarified that "[t]he HRSA Guidelines exclude services relating to a *man's* reproductive capacity, such as vasectomies and condoms."[21] The law that requires insurers to cover sterilization for women but not men, which this Note will refer to as the Sterilization Gap, was thus most explicitly created by a footnote.[22]

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16 42 U.S.C. § 300gg-13(a)(4) (2010) (emphasis added). The statute also forbids insurers from "impos[ing] any cost sharing requirements" for the services it includes. § 300gg-13(a).

17 INSTITUTE OF MEDICINE, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 1 (2011) [hereinafter IOM REPORT] (emphasis added). The IOM is part of the National Academy of Sciences, which Congress created to provide advice to the government. *About the IOM*, NAT'L ACADS. OF SCIS., ENG'G, & MED., http://iom.nationalacademies.org/About-IOM.aspx (last visited Oct. 21, 2015).

18 IOM REPORT, *supra* note 17, at 3 (emphasis added).

19 *Women's Preventive Services Guidelines*, HRSA.GOV, http://www.hrsa.gov/womensguidelines/ (last visited Oct. 21, 2015) (emphasis added).

20 Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,870 (July 2, 2013) (to be codified at 45 C.F.R. pts. 147 & 156) [hereinafter Preventive Services Coverage].

21 *Id.* at 39,870 n.1 (emphasis added).

22 § 300gg-13(a)(4) and the HHS Final Rule also require insurers to cover HIV screenings for all sexually active women, but only for men who are "at higher risk," *Preventive Services Covered Under the Affordable Care Act*, HHS.GOV, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforWomenIncludingPregnantWomen (last visited Oct. 21, 2015), as well as diaphragms and birth control for women but not condoms for men. *See supra* notes 19–22 and accompanying text (describing disparities in the coverage of male and female preventive care under the ACA). This Note will not address whether these gender disparities also violate equal protection.

This is more than just an instance in which men are unable to receive a benefit provided to women. Certainly, the Sterilization Gap impacts men like Isaac, who wish to be sterilized but are unable to afford it.[23] At the same time, however, the Sterilization Gap puts the burden of family planning squarely on women like Lin. For couples like Isaac and Lin, who wish to no longer have children but are unable to afford a vasectomy, female sterilization is the only permanent option provided—even when it could be harmful to the woman's health. For couples who can afford an uncovered procedure, the Sterilization Gap still incentivizes women to undergo sterilization rather than men.[24]

Not only does this perpetuate harmful gender stereotypes, it is problematic because the procedures are not the same. [25] Female sterilization is twenty times more likely to result in major complications than male sterilization.[26] It is also more likely to fail than male sterilization, which can result in unintended pregnancy, as well as potentially life-threatening conditions.[27] Such complications create

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[23] This Note is specifically about *voluntary* sterilization. The United States has an unfortunate and still relatively recent history of encouraging or forcing the sterilization of individuals deemed "unfit." *See* REBECCA M. KLUCHIN, FIT TO BE TIED: STERILIZATION AND REPRODUCTIVE RIGHTS IN AMERICA, 1950–1980, at 73–113 (2009) (cataloguing the history of coercive sterilization of the "unfit"). Those issues are beyond the scope of this Note.

[24] *See Obamacare Drives Women to Get Tubes Tied*, MAIN ST (July 31, 2014, 3:25 PM), http://www.mainstreet.com/article/obamacare-drives-women-get-tubes-tied [hereinafter *Tubes Tied*] (relating the posts of a man on the FatWallet price comparison website who nearly decided to have his wife undergo free sterilization rather than pay $180 for a vasectomy; however "his fellow penny pinchers urged him to get the vasectomy"). Even if some of the cost of male sterilization is covered by insurance, the remaining expense might still be prohibitive. *See* David K. Turok et al., *Thinking (Re)Productively: Putting the Man in Contraceptive Mandate*, ARHP.ORG, https://www.arhp.org/publications-and-resources/contraception-journal/january-2014 (last visited Oct. 21, 2015) (explaining that even if insurers paid for 70% of the procedure, the cost to the patient for the average vasectomy would still be over $200; furthermore, because the average deductible is more expensive than a vasectomy, many patients will be responsible for the full price).

[25] *See* Bartz & Greenberg, *supra* note 1, at 24–26 (explaining that female sterilization involves the occlusion or implantation of a device in the fallopian tubes, while male sterilization involves the occlusion of the bilateral vas deferens).

[26] Turok, et al., *supra* note 24. Post-sterilization complications, such as bleeding and infection, are also more likely for female rather than male sterilization. *Id*. *See also Tubes Tied*, *supra* note 24 (quoting Marc Goldstein, Professor of Reproductive Medicine and Urology at Weill Cornell Medical College, who considers it "absolutely, incredibly outrageous and irresponsible to be putting women at risk by promoting a surgery with higher mortality rate, or any mortality rate in the American context. . . . In the U.S. there has never been a documented death from vasectomy but every year there are 10 to 20 women in this country alone who have died from tubal ligation surgery.").

[27] Turok et al., *supra* note 24.

additional costs on top of female sterilization's baseline cost,[28] which is already far greater than that of male sterilization.[29] Therefore, it is likely that insurers will save money by covering male sterilization. Not only does covering sterilization save money by reducing the number of unplanned pregnancies,[30] if men choose to be sterilized instead of

[28] *See id.* ("Costs of these complications each year are also estimated to be $62.52 vs. $0.06 for tubal ligation and vasectomy per procedure, respectively.").

[29] *See id.* ("A 2012 cost index cites the average cost of vasectomy as approximately $708, compared to the average cost of tubal ligation methods at $2912."). Furthermore, "[t]ubal ligations performed in the operating room incur anesthesia fees, leading to procedures costing up to $3449. Even office-based transcervical methods, $1374, are still more expensive than vasectomy." *Id.*

[30] *See* Preventive Services Coverage, *supra* note 20, at 39,872–73 (explaining how covering contraceptives could potentially save billions of dollars); *see also* Sonya Borrero et al., *Potential Unintended Pregnancies Averted and Cost Savings Associated with a Revised Medicaid Sterilization Policy*, 88 CONTRACEPTION 691, 691 (2013) (finding that increasing the number of female sterilizations under Medicaid would lead to significant savings).

Among the reasons that covering sterilization could save so much money is that pregnancy and childbirth are extraordinarily expensive. *See* Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES, June 30, 2013, at A1, *available at* http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html (finding that between 2004 and 2010, in the United States "[t]he average total price charged for pregnancy and newborn care was about $30,000 for a vaginal delivery and $50,000 for a C-section, with commercial insurers paying out an average of $18,329 and $27,866"). Pregnancy-related complications—which are more likely for unplanned pregnancies—increase these costs. *See* AGENCY FOR HEATHCARE RESEARCH & QUALITY, COMPLICATING CONDITIONS OF PREGNANCY AND CHILDBIRTH (2011), at 2, *available at* http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf (finding that maternal hospital stays in 2008 were 50% more expensive when pregnancy-related complicating conditions were present); *Unintended Pregnancy Prevention*, CDC, http://www.cdc.gov/reproductive health/unintendedpregnancy/ (last updated Jan. 22, 2015) ("Unintended pregnancy is associated with an increased risk of problems for the mom and baby."). More than half of pregnancies in the United States are unintended. GUTTMACHER INSTITUTE, FACT SHEET: UNINTENDED PREGNANCY IN THE UNITED STATES 2 (2015), *available at* http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html.

There is also the cost to employers, who, if they provide health coverage, may need to pay some portion of the direct cost of pregnancy. *See* NATIONAL WOMEN'S LAW CENTER, COVERING PRESCRIPTION CONTRACEPTIVES IN EMPLOYEE HEALTH PLANS: HOW THIS COVERAGE SAVES MONEY 1 (2012), *available at* http://www.nwlc.org/sites/default/files/pdfs/contraceptive_coverage_saves_money_fact_sheet.pdf ("Direct costs [of unintended pregnancy] include costs related to childbirth—which can be among the highest cost drivers of an employer's health care expenditures."). But even employers who do not provide health coverage must still reckon with pregnancy-related burdens in the form of "employee absences, maternity leave, employee replacement, and reduced employee productivity." *Id*.

Finally, there is the high cost to the parents themselves—and potentially the public—of child rearing. Raising a child through age eighteen has been estimated to cost almost $227,000. Jessica Dickler, *The Rising Cost of Raising a Child*, CNN MONEY (Sept. 21, 2011, 2:20 PM), http://money.cnn.com/2011/09/21/pf/cost_raising_child/index.htm. Adding a four-year college education can raise that amount to over one million dollars. Jonathan V. Last, *Duggar Economics: The Costs of 19 Kids*, WALL ST. J. (Sept. 18, 2009, 12:01 AM), http://online.wsj.com/article/SB10001424052970203917304574413792994350108.html.

their partners, the costs attendant to the procedure itself will also be lower.

Nonetheless, at least a quarter of insurers do not cover vasectomies, creating a problem that must be fixed.[31] Congress could, of course, amend the ACA to specifically cover male sterilization, but given Republican opposition to the ACA as a whole, this is unlikely.[32] HHS could also promulgate a new rule requiring insurers to cover female and male sterilization, perhaps under the theory that, because vasectomies avoid the health hazards accompanying pregnancy and female sterilization, they constitute preventive care for women. However, this change in the rule would create its own legal issues,[33] and at least one scholar believes that HHS's current interpretation of § 300gg-13(a)(4) is correct.[34]

Instead, this Note suggests constitutional litigation against the federal government, using the arguments advanced below, as the solution to the Sterilization Gap. Part I explains the relevant constitutional law. Part II then argues that the Sterilization Gap violates equal protection law, perpetuates harmful gender stereotypes, and should be extended to cover men.

I
Equal Protection Law and Sex Classifications

As an initial matter, it must be understood that the United States Constitution does not obligate the government, whether federal or state, to provide men and women with sterilization. It is indeed uncon-

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[31] Turok et al., *supra* note 24.

[32] Any legislative correction to the ACA would need to go through the Senate Health, Education, Labor, and Pensions (HELP) Committee, whose Chairman, Republican Lamar Alexander, did not respond favorably when asked about extending the law to cover vasectomies and male condoms: "It's time for Democrats and the president[sic] to realize this law is an historic mistake and work with Republicans to start over as rapidly and responsibly as possible with step-by-step reforms that reduce the cost of health insurance and expand freedom and choice." *Tubes Tied*, *supra* note 24. Nor were Democrats optimistic about the chances of such a change: According to the aide of one large-state Senate Democrat, "There are certainly other benefits that you could consider adding, but Republicans in the Senate and House would never go along with it. All they want to do is repeal the law." *Id.*

[33] Because any rule extending sterilization coverage to men might appear contrary to the text of § 300gg-13(a)(4), it could be challenged as a misinterpretation of the statute. *See generally* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842–46 (1984) (explaining the judicial approach to reviewing an agency's construction of a statute).

[34] *See Tubes Tied*, *supra* note 24 (quoting Professor Timothy Jost, an expert in health care law at Washington & Lee University School of Law, as stating that "[a]s a matter of statutory interpretation, it's a very heavy lift to include vasectomies and male condoms as women's preventive care. . . . Sure, it's a very good idea to cover vasectomies and male condoms. We can certainly do things with men to improve the health of women, but most people would not consider those to be women's health preventive services.").

stitutional for the government to prohibit individuals from *acquiring* contraception,[35] a category that may include sterilization.[36] But if an individual is unable to *afford* sterilization, the government need not provide it.[37] In other words, there is no right to be sterilized, so the Sterilization Gap will not be found unconstitutional on a rights-based theory.

But when the government chooses to provide a benefit, as § 300gg-13(a)(4) and the HHS Final Rule have done with sterilization coverage, it cannot discriminate between men and women except in limited circumstances.[38] If the government does so, its actions may violate equal protection law. Therefore, this Note will focus on equal protection law as a basis for finding the Sterilization Gap unconstitu-

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[35] *See* Eisenstadt v. Baird, 405 U.S. 438, 453–54 (1972) (holding that banning the distribution of contraceptives to unmarried as well as married people is unconstitutional).

[36] *See, e.g.*, Peck v. Califano, 454 F. Supp. 484, 486 (D. Utah 1977) (noting that voluntary sterilization implicates the constitutional "right of the individual to be free from unwarranted governmental intrusion into the decision whether to bear or beget a child" (internal citation omitted)). *But see* McCabe v. Nassau Cnty. Med. Ctr., 453 F.2d 698, 704 (2d Cir. 1971) (declining to decide whether a hospital's refusal to perform voluntary sterilization violated the plaintiff's constitutional rights, but finding that the claim was valid and remanding for full adjudication). Despite challenges, courts have consistently held that private hospitals may refuse to sterilize voluntary pateints if doing so conflicts with their code of ethics. KLUCHIN, *supra* note 23, at 146–47. The Supreme Court has never ruled on the constitutionality of prohibiting sterilization, and fifteen states still have laws allowing hospitals and doctors to refuse to sterilize. *See* Ariel S. Tazkargy, *From Coercion to Coercion: Voluntary Sterilization Policies in the United States*, 32 LAW & INEQ. 135, 159 (2014) (noting that in most of these states, physicians are "often protected from legal liability, termination of employment, and any other penalties," and may refuse to sterilize even in medical emergencies); *see also supra* note 161 (listing these laws).

[37] *See Peck*, 454 F. Supp. at 486–88 (holding that the government need not provide sterilization to a patient unable to pay for it because it "has imposed no restriction on access to . . . sterilizations that was not already there."); *see also* Harris v. McRae, 448 U.S. 297, 318 (1980) ("It cannot be that because government may not prohibit the use of contraceptives . . . government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives."); Maher v. Roe, 432 U.S. 464, 469 (1977) ("The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents.").

[38] *See infra* Part I.C (assessing the requirements of intermediate scrutiny as applied to the Sterilization Gap). A benefit could be defined as any *advantage* or *opportunity* that the government provides or makes available. *See* United States v. Virginia, 518 U.S. 515, 520 (1996) (explaining that in maintaining a single-sex public military school, "Virginia has elected to preserve exclusively for men the advantages and opportunities a VMI education affords"); Califano v. Webster, 430 U.S. 313, 318 n.5 (1977) (describing a Social Security statute that compensated women under a more favorable calculation than men as an "advantage"). Laws that *burden* individuals based on sex may also violate equal protection law. *See, e.g.*, Orr v. Orr, 440 U.S. 268, 282–83 (1979) (holding that a state law requiring men but not women to pay alimony violated equal protection). But because the Sterilization Gap creates a sex-based benefit rather than a burden, benefits will be the focus of this Note.

tional. Part I.A briefly summarizes the scope of equal protection law, and establishes that laws that create sex classifications are assessed under the non-deferential intermediate scrutiny standard. Part I.B then explains how to determine whether a law creates a sex classification. Finally, Part I.C describes how laws are assessed under intermediate scrutiny.

A. The Importance of Intermediate Scrutiny

The Equal Protection Clause of the Fourteenth Amendment provides that "No state shall . . . deny to any person within its jurisdiction the equal protection of the laws."[39] This has been interpreted to generally prohibit state laws that classify individuals—i.e. distinguish between them for the distribution of benefits or imposition of burdens—on certain protected bases, such as race.[40] The prohibition was later extended, via the Due Process Clause of the Fifth Amendment, to discriminatory federal laws and regulations.[41] In 1971, the Supreme Court held that laws classifying individuals on the basis of sex may also violate equal protection law.[42]

Under modern equal protection doctrine, the State has the burden of providing an "exceedingly persuasive justification" for laws that create "sex classifications."[43] Such a justification requires, at the

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[39] U.S. CONST. amend. XIV, § 1.

[40] *See, e.g.*, Brown v. Bd. of Educ., 347 U.S. 483, 493–94 (1954) (holding that state laws segregating public schools on the basis of race violate equal protection).

[41] *See* Bolling v. Sharpe, 347 U.S. 497, 499 (1954) (stating that "the concepts of equal protection and due process . . . are not mutually exclusive" and, under the Fifth Amendment, "discrimination may be so unjustifiable as to be violative of due process"). The Supreme Court has held that the scope of equal protection law is the same under the Fourteenth and Fifth Amendments. *See* Weinberger v. Wiesenfeld, 420 U.S. 636, 638 n.2 (1975) ("Th[e] Court's approach to Fifth Amendment equal protection claims has always been precisely the same as to equal protection claims under the Fourteenth Amendment.").

[42] *See* Reed v. Reed, 404 U.S. 71, 76–77 (1971) (holding that providing dissimilar treatment based on the sex of otherwise similarly situated applicants for letters of administration violates equal protection). Equal protection law only addresses sex classifications created by "state action," whether through laws, regulations, or the policies of public institutions. *See* Shelley v. Kraemer, 334 U.S. 1, 13 (1948) ("[T]he action inhibited by the first section of the Fourteenth Amendment is only such action as may fairly be said to be that of the States. That Amendment erects no shield against merely private conduct, however discriminatory or wrongful."). This Note will not address private sex discrimination laws.

[43] *See Virginia*, 518 U.S. at 531, 533 (1996) (internal quotation marks omitted) (stating that the burden for proving that the "proffered justification is exceedingly persuasive . . . is demanding and it rests entirely on the State"). *But see id.* at 570–75 (Scalia, J., dissenting) (arguing that the "exceedingly persuasive" standard does not apply to intermediate scrutiny). The exact requirements of the exceedingly persuasive standard are much debated, but the Court may require that the government provide "persuasive evidence" that the classification is substantially related to an important governmental objective. *See*

very least, that the sex classification "serve important governmental objectives" and be "substantially related to [the] achievement of those objectives."[44] This is known as the "intermediate scrutiny" standard.[45] It applies whether the plaintiff is a man arguing that he should be admitted to an all-women's nursing school,[46] or a woman arguing that she should be admitted to an all-men's military school.[47]

However, if a court finds that a challenged law does not create a sex classification, the law is assessed under the deferential "rational basis" standard of review.[48] Under this standard, so long as a law is "rationally related to a legitimate government purpose," it will be upheld.[49] Not only do laws assessed under rational basis carry "a pre-

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Jason M. Skaggs, *Justifying Gender-Based Affirmative Action Under* United States v. Virginia*'s "Exceedingly Persuasive Justification" Standard*, 86 CALIF. L. REV. 1169, 1204 (1998) (arguing that because "[t]he *Virginia* Court found 'no persuasive evidence in th[e] record that VMI's male-only admission policy is in furtherance of a state policy of diversity.' . . . *Virginia* therefore seems to require persuasive evidence to support the stated government interest" (quoting *Virginia*, 518 U.S. at 539) (emphasis omitted)).

44 Craig v. Boren, 429 U.S. 190, 197 (1976).

45 *Virginia*, 518 U.S. at 523, 532–33.

46 *See* Miss. Univ. for Women v. Hogan, 458 U.S. 718, 720–21, 723–24 (1982) (holding that legislation that discriminates against men is subject to the same heightened standard of review as that which discriminates against women).

47 *See Virginia*, 518 U.S. at 520, 533–34 (applying the intermediate scrutiny standard).

48 *See, e.g.*, Geduldig v. Aiello, 417 U.S. 484, 494–97 (1974) (holding that excluding pregnancy-related disability coverage from a state insurance system was not a sex classification, and that the exclusion should be upheld because "with respect to social welfare programs, so long as the line drawn by the State is *rationally* supportable, the courts will not interpose their judgment as to the appropriate stopping point" (emphasis added)).

49 Hodel v. Indiana, 452 U.S. 314, 331–32 (1981). Under rational basis, laws purposed on administrative convenience will be constitutional even if they are discriminatory. *See, e.g.*, N.Y.C. Transit Auth. v. Beazer, 440 U.S. 568, 592 (1979) (upholding a discriminatory classification under rational basis where that classification "serves the general objectives of safety and efficiency"). Under intermediate scrutiny, however, such laws will generally be unconstitutional. *See* Wengler v. Druggists Mut. Ins. Co., 446 U.S. 142, 152 (1980) (finding that the state did not meet the requisite showing of "administrative convenience" to justify its failure to "individualize determinations about widows as well as widowers"); *see also* Frontiero v. Richardson, 411 U.S. 677, 690 (1973) ("[A]ny statutory scheme which draws a sharp line between the sexes, solely for the purpose of achieving administrative convenience . . . involves the 'very kind of arbitrary legislative choice forbidden by the [Constitution].'" (quoting Reed v. Reed, 404 U.S. 71, 76 (1971))). *But see* Nguyen v. INS, 533 U.S. 53, 89 (2001) (O'Connor, J., dissenting) (arguing that the majority upheld a sex classification under intermediate scrutiny based in part upon administrative convenience). Relatedly, when the objective to be served is saving money, under intermediate scrutiny the government must prove that the classification actually would save money—this cannot merely be assumed. *See, e.g.*, *Frontiero*, 411 U.S. at 689 (holding that in order to satisfy heightened scrutiny, the government must offer "concrete evidence . . . tending to support its view that such differential treatment in fact saves the Government any money").

sumption of rationality," [50] the Supreme Court has held that a law will pass rational basis review "if any state of facts reasonably may be conceived to justify" its discrimination.[51] The decision to apply rational basis review is often viewed as outcome determinative.[52] Therefore, in order to find the Sterilization Gap unconstitutional, proving that it creates a sex classification is critical.

B. Geduldig *and Its Discontents*

A law that explicitly provides a benefit to one sex but not the other "on its face" usually creates a facial sex classification.[53] In *Frontiero v. Richardson*, for example, the Supreme Court held that a law requiring female servicewomen to prove that their husbands were actually dependent on them was a facial sex classification, because the law explicitly stated that men could claim their wives as dependents without offering such proof.[54] But under current doctrine, not all laws

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[50] *Hodel*, 452 U.S. at 331–32; *see also* McGowan v. Maryland, 366 U.S. 420, 425–26 (1961) ("State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality.").

[51] *McGowan*, 366 U.S. at 426.

[52] *See* Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VAND. L. REV. 793, 799 (2006) ("[The rational basis] standard is famously lenient, and, according to widespread belief, nearly every law judged by it is upheld.").

[53] *See* Weinberger v. Wiesenfeld, 420 U.S. 636, 641 n.8 (1975) (agreeing that a law found to be a sex classification "*on its face* precludes granting benefits to men" (emphasis added)); *see also* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW 777 (4th ed. 2011) (explaining facial sex classifications as existing where "the law in its very terms draws a distinction among people based on gender"). Even if a law is facially sex neutral, it may still constitute a sex classification if the plaintiff proves that it was created with a discriminatory purpose and causes a discriminatory impact. *See* Pers. Adm'r of Mass. v. Feeney, 442 U.S. 256, 259, 270, 274–75, 279–80 (1979) (holding that a law that preferenced hiring veterans did not create a sex classification even though 98% of Massachusetts veterans were male and 1.8% were female, because the law was facially sex neutral and there was no proof of discriminatory purpose). The Court in *Feeney* explained that discriminatory purpose "implies more than intent as volition or intent as awareness of consequences. It implies that the decisionmaker . . . selected or reaffirmed a particular course of action at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." *Id.* at 279 (citation omitted). Because discriminatory purpose and discriminatory impact are so difficult to prove, this Note will only address whether the Sterilization Gap creates a facial gender classification.

[54] *See* Frontiero v. Richardson, 411 U.S. 677, 679 n.2 (1973) (invalidating a provision that distinguished service members' dependents as between "the wife" and "the husband, if he is in fact dependent on the member . . . for over one-half of his support" (quoting and invalidating in part 10 U.S.C. § 1072(2) (1976)) (internal quotation marks omitted)). Similarly, in *Wiesenfeld*, the Court held that a law allowing widowed mothers but not fathers to receive benefits based on the earnings of their deceased spouse created a facial sex classification. *See* 420 U.S. at 637–38 & n.1, 653 (invalidating a statute that limited a deceased spouse's insurance benefits to "[t]he widow and every surviving divorced mother of an individual" (quoting 42 U.S.C. § 402(g) (1982))).

that might logically appear to create facial sex classifications actually do so. *Geduldig v. Aiello* is the most relevant case of this type, because it holds that an insurer does not create a facial sex classification if it does not insure a "risk" that only applies to one sex.[55] In defending the Sterilization Gap, the government will likely argue that vasectomies are a sex-specific risk since the procedure is only performed on men, so refusing to cover them does not create a facial sex classification.

In *Geduldig*, the plaintiff challenged a California disability insurance program that excluded from coverage all disabilities resulting from pregnancy.[56] The text of the law did not mention either sex.[57] The Supreme Court ultimately upheld the law under rational basis review after finding that it did not create a facial sex classification.[58] The Court based this conclusion on two core rationales.

First, the Court held that pregnancy classifications are not automatically sex classifications, even though only women become pregnant.[59] As the Court explained, "[t]he California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities."[60] In other words, because the statutory text excluded pregnant *people* from coverage rather than pregnant *women*, it could only be a facial sex classification if pregnancy was actually a proxy for sex. The Court found that it was not, explaining that, for the purpose of benefits, "[t]he program divides potential recipients into two groups—pregnant women and nonpregnant persons," and that the second group included men *and* women.[61] This meant that there was a "lack of identity" between pregnancy and women.[62] Broadly stated, the Court therefore held that where a phys-

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[55] *See infra* notes 56–72 and accompanying text (discussing *Geduldig*'s holding).

[56] Geduldig v. Aiello, 417 U.S. 484, 492 (1974). While *Geduldig* was pending, an earlier case interpreted the law to exclude from coverage only those disabilities resulting from "normal" pregnancy, meaning "hospitalization and disability benefits for normal delivery and recuperation." *Id.* at 489–91.

[57] *Id.* at 489 ("In no case shall the term 'disability' or 'disabled' include any injury or illness caused by or arising in connection with pregnancy up to the termination of such pregnancy and for a period of 28 days thereafter." (emphasis omitted)).

[58] *See supra* note 48 (discussing the holding of *Geduldig*). The Court also found that the law was not a facially neutral sex classification. As the Court noted, the state had an "objective and wholly noninvidious basis" for its policy, and furthermore "women contribute about 28 percent of the total disability insurance fund and receive back about 38 percent of the fund in benefits." *Id.* at 496, 497 n.21. Therefore, to the Court, there was no evidence that the plan discriminated against women in its purpose and effect.

[59] *Geduldig*, 417 U.S. at 496 n.20.

[60] *Id.*

[61] *Id.* at 497 n.20.

[62] *Id.*

ical condition is not a proxy for sex, excluding it from coverage does not create a facial sex classification.[63]

Second, the Court held that because pregnancy-related disabilities only affect women—but, as noted above, not all women—refusing to insure them does not create a facial sex classification because it does not affect the parity of benefits given to men and women. As the Court explained, "[t]here is no risk from which men are protected and women are not. Likewise, there is no risk from which women are protected and men are not."[64] To the Court, in other words, sex discrimination only occurs when a benefit that could be provided to both sexes is only provided to one.[65] Therefore, only if men received coverage for pregnancy-related disabilities would women need to receive such coverage as well.[66]

Both of *Geduldig*'s rationales were reaffirmed in *General Electric Co. v. Gilbert*, in which the Supreme Court held that the exclusion of pregnancy-related disabilities from an employer's health care plan did not violate Title VII.[67] Elaborating upon *Geduldig*'s second rationale, the *Gilbert* Court explained that "pregnancy-related disabilities con-

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[63] Another commentator has suggested that in its first rationale, the *Geduldig* Court held that where only some members of one sex seek a benefit, denying them that benefit while giving it to the other sex is constitutional. *See* Diane L. Zimmerman, Comment, Geduldig v. Aiello*: Pregnancy Classifications and the Definition of Sex Discrimination*, 75 COLUM. L. REV. 441, 447–48 (1975) ("The thread of reasoning seems to be that since the law does not discriminate against all women, but only against that part of the class which happens to be pregnant, it is not drawn along sex lines."). However, in most if not all cases where the Court has found a sex classification unconstitutional, only some members of the excluded sex sought the benefit they were denied. *See infra* note 116 and accompanying text.

[64] *Geduldig*, 417 U.S. at 496–97.

[65] *See* Zimmerman, *supra* note 63, at 442 ("At the very least, the Court will not find states to be engaging in invidious discrimination in violation of the equal protection clause[sic] where they draw distinctions between men and women on the basis of traits exclusive and peculiar to one or the other sex.").

[66] *See id.* at 459 n.99 ("Once the Court decided that California did not cover men for any risks for which women were not also covered, it found that the demands of equality had been satisfied."). Zimmerman may believe that the risk-parity analysis is used to determine whether a facially-neutral law creates a sex classification. *See id.* (implying that in looking at risk parity, the *Geduldig* Court was assessing the effects of the law). This Note disagrees. If a law protects women but not men from the same risk, then the law on its face distributes a benefit on the basis of sex.

[67] *See* 429 U.S. 125, 135, 138–40 (1976), *superseded by statute*, Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (2012) ("Just as there is no facial gender-based discrimination in [*Geduldig*], so, too, there is none here."). Although the specific text of the plan is unavailable, the district court did include the plaintiff's supervisor's response to the plaintiff's request for pregnancy-related disability benefits. The response makes no mention of sex: "In accordance with the IUE-GE Pension and Insurance Agreement and page 18 of the Insurance Pension Booklet (ERB-32D) Weekly Disability Benefits are not payable for absence due to pregnancy or childbirth." Gilbert v. Gen. Elec. Co., 375 F. Supp. 367, 373 (E.D. Va. 1974), *rev'd*, 429 U.S. 125 (1976). Therefore, *Gilbert*

stitute an *additional* risk, unique to women, and the failure to compensate them for this risk does not destroy the presumed parity of the benefits, accruing to men and women alike, which results from the facially evenhanded *inclusion* of risks."[68] In other words, because pregnancy was *not* a risk that was covered for men but not women, benefits remained even.

In dissent, Justice Brennan explained that this reasoning would allow an insurer to remove coverage for every sex-specific disability: All it needed to do was explicitly revoke coverage for the disability itself without mentioning gender.[69] Justice Brennan's analysis of the majority's holding is particularly relevant to the Sterilization Gap, because the HHS Final Rule specifically excludes "vasectomies" from coverage—though both it and § 300gg-13(a)(4) do expressly invoke gender as well.[70] Indeed, Justice Brennan noted that the plan in *Gilbert* "also insures *risks* such as prostatectomies, *vasectomies*, and circumcisions that are specific to the reproductive system of men and for which there exist no female counterparts covered by the plan."[71] In other words, Justice Brennan seemed to believe that under the majority's analysis, a plan could cover vasectomies but not female sterilization, *or vice versa*, because each procedure constitutes a sex-specific risk.[72]

Congress responded to *Gilbert* by passing the Pregnancy Discrimination Act,[73] which "made clear that, for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face,

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also appears to be a case in which pregnancy needed to be a proxy for sex to create a facial sex classification.

[68] *Gilbert*, 429 U.S. at 139. The Court added that holding otherwise "would endanger the commonsense notion that an employer who has no disability benefits program at all does not violate Title VII even though the 'underinclusion' of risks impacts, as a result of pregnancy-related disabilities, more heavily upon one gender than upon the other." *Id.* at 139–40.

[69] *See id.* at 152 n.5 (Brennan, J., dissenting) ("Had General Electric assembled a catalogue of all ailments that befall humanity, and then systematically proceeded to exclude from coverage *every* disability that is female-specific or predominantly afflicts women, the Court could still reason as here that the plan operates equally . . . ," such that "[w]omen, like men, would be entitled to draw disability payments for their circumcisions and prostatectomies, and neither sex could claim payment for pregnancies, breast cancer, and the other excluded female-dominated disabilities.").

[70] *See supra* text accompanying notes 21–22.

[71] *Gilbert*, 429 U.S. at 152 (emphasis added).

[72] This Note confronts Justice Brennan's assertion *infra* Part II.A.2.

[73] 42 U.S.C. § 2000e(k) (2012) ("The terms 'because of sex' or 'on the basis of sex' include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions."). Title VII only applies to employment-based discrimination. 42 U.S.C. § 2000e-2(a) to (d) (listing the specific unlawful employment practices to which the law applies).

discrimination because of her sex."[74] This did not, however, affect *Geduldig*'s core *constitutional* holding that refusing to provide benefits for a sex-specific risk is not a facial sex classification.[75] And although there has been a "cottage industry" of articles criticizing *Geduldig*,[76] it has never been explicitly overruled.[77]

C. The Requirements of Intermediate Scrutiny

Once a law is proven to create a sex classification, the next step is to show that the law fails intermediate scrutiny. Recall that intermediate scrutiny requires the state to offer an *exceedingly persuasive justification* for a sex classification, which entails proving that the classification serves *important governmental objectives* and is *substantially related* to the achievement of those objectives.[78] If a law meets this standard, then it is constitutional even if it creates a sex classification.[79]

As noted, the exact requirements of the "exceedingly persuasive" standard are ambiguous, though at the very least it requires that the government justify its sex classification with some evidence—perhaps even persuasive evidence.[80] This Note will accept that the government's objectives for the Sterilization Gap are important: reducing unintended pregnancies, "safeguarding public health," and "ensuring

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[74] Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 684 (1983).

[75] Congressional action cannot overrule constitutional decisions. *See* City of Boerne v. Flores, 521 U.S. 507, 519 (1997) ("Congress does not enforce a constitutional right by changing what the right is. It has been given the power 'to enforce,' not the power to determine what constitutes a constitutional violation.").

[76] *See* Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983 (1984) (noting the extensive scholarly criticism of *Geduldig*).

[77] *Geduldig* may have been partially limited to the insurance context by *Turner v. Dep't of Emp't Sec. of Utah*, 423 U.S. 44, 45 n.* (1975) (per curiam) (noting that "coverage limitations" and "insurance principles" are "central to *Aiello*"). However, the Court in *Bray v. Alexandria Women's Health Clinic*, a sex discrimination case involving abortion protests, reaffirmed that even though "only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification," and also noted the significance that women were on both sides of the protests, which diminished the sex discrimination argument. 506 U.S. 263, 270–71 (1993) (quoting Geduldig v. Aiello, 417 U.S. 484, 496 n.20 (1974) (internal quotation marks omitted)).

[78] *See supra* Part I.A.

[79] *See, e.g.*, Heckler v. Mathews, 465 U.S. 728, 746, 748–49 (1984) (holding that the "protection of reasonable reliance interests . . . provides 'an exceedingly persuasive justification'" for a challenged sex classification because that classification was substantially related to the achievement of an important governmental objective).

[80] *See supra* note 43 and accompanying text (explaining the requirements of an "exceedingly persuasive justification").

that women have equal access to health care."[81] The crux of this Note's argument is that the Sterilization Gap is a sex classification that is not substantially related to these governmental objectives.

In order for a sex classification to be substantially related to the achievement of a governmental objective, the objective must actually be "substantially advanced" by the exclusion of one sex or the other.[82] But proof that there is *some* connection between the classification and the objective is often not enough.[83] For example, in *Craig v. Boren*, the Supreme Court held that excluding men aged 18–20 from drinking low-alcohol beer but not women of the same age was not substantially related to the important objective of traffic safety, even though the government demonstrated that men of this age group were over ten times more likely to be arrested for driving while intoxicated. [84] Additionally, if the objective would be just "as well served" without the exclusion, then the sex classification is not substantially related.[85]

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[81] Preventive Services Coverage, *supra* note 2, at 39,872. Specifically, the HHS Final Rule states its relevant policy goal as "provid[ing] women with access to contraceptive coverage without cost-sharing, thereby advancing the compelling government interests in safeguarding public health and ensuring that women have equal access to health care." *Id.* In other words, "reducing unintended pregnancies" was not explicitly included. But it is undeniable that covering sterilization "safeguards public health" *because* it reduces unintended pregnancies. Unintended pregnancy increases health risks for women contraindicated for pregnancy and for the future child, and may lead to abortion. *See id.* (listing negative health outcomes that can result from unintended pregnancy). Reducing the rate of unintended pregnancy will therefore reduce the rate of these and other harms. Furthermore, in its discussion of the health benefits of contraceptive coverage, the HHS Final Rule refers almost exclusively to the reduction of unintended pregnancies. *Id.* Therefore, this Note will assume that reducing unintended pregnancies was one of the primary objectives of the Sterilization Gap.

[82] *See* United States v. Virginia, 518 U.S. 515, 545–46 (1996) (holding that VMI has not provided "exceedingly persuasive justification" for excluding women because excluding women does not substantially advance VMI's institutional goals). In order to determine if a sex classification substantially advances an objective, the court does not weigh the importance of the objective against the invidiousness of the sex classification; rather, the question is simply whether the sex classification "substantially furthers" the objective. J.E.B. v. Alabama *ex rel.* T.B., 511 U.S. 127, 136–37 (1994).

[83] *See J.E.B.*, 511 U.S. at 139 n.11 ("We have made abundantly clear in past cases that gender classifications that rest on impermissible stereotypes violate the Equal Protection Clause, even when some statistical support can be conjured up for the generalization.").

[84] 429 U.S. 190, 199–201, 204 (1976). Note, however, that the total numbers were small, even if the relative difference was significant: Only 2% of men had been arrested, compared to .18% of women. *Id.* at 201.

[85] *See* Orr v. Orr, 440 U.S. 268, 283 (1979) ("Where, as here, the State's compensatory and ameliorative purposes are as well served by a gender-neutral classification as one that gender classifies and therefore carries with it the baggage of sexual stereotypes, the State cannot be permitted to classify on the basis of sex.").

1. Basic Biological Differences and Remedying Discrimination

There are two particularly relevant ways that a sex classification may be substantially related to achieving a governmental objective.

First, the Supreme Court may uphold a sex classification if it finds that it is based on "basic biological differences" that are substantially related to achieving an important governmental objective.[86] In *Nguyen v. INS*, the Court upheld a sex classification favoring unmarried U.S. citizen mothers over unmarried U.S. citizen fathers of children born overseas.[87] The law in question automatically conferred citizenship on a child if the child's mother was a U.S. citizen.[88] However, citizenship would not be granted to a child of a U.S. citizen father (and alien mother) unless the father took certain required steps to prove paternity.[89]

The Court held that the sex classification was substantially related to achieving two important governmental objectives: first, ensuring that the child had a U.S. citizen parent, and second, ensuring that the child had an opportunity to develop a personal relationship with that parent.[90] According to the Court, the first interest justified the sex classification because a child's maternity is certain at the moment of birth, whereas paternity is not.[91] The second interest justified the sex classification because a mother will automatically have an "opportunity" to develop a relationship with her child because she is necessarily present at the moment of birth, whereas a father is not.[92] Basic biological differences are relevant to the Sterilization Gap because the sterilization procedures for men and women are specific to each sex.[93]

Second, if the important governmental objective involves remedying discrimination, whether current or historical, then a sex classification substantially related to this remedy may be constitutional.[94] For example, in *Schlesinger v. Ballard*, the Court held that a provision

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[86] *See* Nguyen v. INS, 533 U.S. 53, 60–61, 73 (2001) ("The difference between men and women in relation to the birth process is a real one, and the principle of equal protection does not forbid Congress to address the problem at hand in a manner specific to each gender.").

[87] *Id.* at 61–62, 73.

[88] *Id.* at 59–60.

[89] *Id.*

[90] *Id.* at 62–63, 64–65.

[91] *Id.* at 62–63.

[92] *Id.* at 64–65.

[93] *See supra* note 25 and accompanying text.

[94] *See* Miss. Univ. for Women v. Hogan, 458 U.S. 718, 728 (1982) ("In limited circumstances, a gender-based classification favoring one sex can be justified if it intentionally and directly assists members of the sex that is disproportionately burdened."); *see also* Califano v. Webster, 430 U.S. 313, 318–20 (1977) (holding that a Social Security provision that calculated women's benefits more advantageously than men's was

allowing women to remain in the navy thirteen years without a promotion, and thus longer than the usual time allowed for men, was constitutional because men were able to fully serve in combat and on sea duty and therefore had more opportunities for promotion.[95] In *Schlesinger*, the Court made clear that the remedy of allowing women to serve longer was based on a factual disparity in the treatment of male and female naval officers, rather than on stereotypical notions.[96] In order to give women more opportunities for promotion, the law needed to explicitly classify on the basis of gender. Therefore, this classification was not only substantially related to the remedy, it was necessary to implementing it. Remedying discrimination is relevant to the Sterilization Gap, because it was purportedly conceived, in part, to remedy health care discrimination against women.[97]

2. The Problem of Perpetuating Stereotypes

When a sex classification is not substantially related to achieving an important governmental objective, it may instead arise from gender stereotypes. Sex classifications that are based on or will perpetuate gender stereotypes fail intermediate scrutiny and are therefore unconstitutional.[98] As this Note will explain in Part II, the Sterilization Gap is not substantially related to achieving an important governmental objective, but rather was both based on and will perpetuate gender stereotypes.

The Supreme Court has characterized gender stereotypes as "fixed notions concerning the roles and abilities of males and females."[99] A statute is unconstitutionally based on a gender stereotype when it "relie[s] upon the simplistic, outdated assumption that gender could be used as a 'proxy for other, more germane bases of

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constitutional because it "operated directly to compensate women for past economic discrimination").

[95] 419 U.S. 498, 508 (1975).

[96] Schlesinger v. Ballard, 419 U.S. 498, 508 (1975).

[97] *See infra* Part II.B.2.

[98] *See* United States v. Virginia, 518 U.S. 515, 541–42 (1996) (quoting J.E.B. v. Alabama *ex rel.* T.B., 511 U.S. 127, 139 n.11) ("[E]qual protection principles, as applied to gender classifications, mean state actors may not rely on 'overbroad' generalizations to make 'judgments about people that are likely to . . . perpetuate historical patterns of discrimination.'").

[99] *Hogan*, 458 U.S. at 725. In *Nguyen*, the dissent accused the majority of relying on a gender stereotype in its assumption that women would automatically be more likely to develop a relationship with their child due to their presence at the time of birth. Nguyen v. INS, 533 U.S. 53, 86 (2001) (O'Connor, J., dissenting) ("[T]he idea that a mother's presence at birth supplies adequate assurance of an opportunity to develop a relationship while a father's presence at birth does not would appear to rest only on an overbroad sex-based generalization.").

classification.'"[100] In other words, statutes based on stereotypes improperly classify people based on gender rather than on their individual abilities and traits. For example, as the Court explained in *Orr v. Orr*:

> [T]he "old notio[n]" that "generally it is the man's primary responsibility to provide a home and its essentials" can no longer justify a statute that discriminates on the basis of gender. "No longer is the female destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas."[101]

To be permissible, sex classifications must therefore be created "through *reasoned analysis* rather than through the mechanical application of traditional, often inaccurate, assumptions about the proper roles of men and women."[102] Sex classifications must also be well-supported; they are impermissible if they result merely from oversight or caprice.[103] But even if a sex classification possesses some empirical support, if it is overbroad it will be unconstitutional.[104]

Thus, a court must closely assess sex classifications to ensure that they are not merely perpetuating an underlying stereotype.[105] In *Hogan*, for example, the Supreme Court found that the proffered reason for excluding men from a nursing school—namely, remedying discrimination in education against women—was not demonstrated by sufficient evidence, including the policy's legislative history.[106] As the Court explained, the school's policy "lends credibility to the old view that women, not men, should become nurses, and makes the assumption that nursing is a field for women a self-fulfilling prophecy."[107] In

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[100] *Hogan*, 458 U.S. at 726 (quoting Craig v. Boren, 429 U.S. 190, 198 (1976)).

[101] Orr v. Orr, 440 U.S. 268, 279–80 (1979) (quoting Stanton v. Stanton, 421 U.S. 7, 10, 14–15 (1975)).

[102] *Hogan,* 458 U.S. at 726 (emphasis added).

[103] *See* Reed v. Reed, 404 U.S. 71, 76 (1971) ("A classification 'must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.'") (citation omitted); *see also Nguyen*, 533 U.S. at 90–91 (O'Connor, J., dissenting) ("[A]n arbitrary distinction between the sexes may rely on no identifiable generalization at all but . . . would nonetheless be a classic equal protection violation.").

[104] *See* Weinberger v. Wiesenfeld, 420 U.S. 636, 645 (1975) (holding that a gender-based generalization, even with some empirical support, cannot justify the denigration of those who do not fit within the generalization).

[105] *See id.* at 648 ("[T]he mere recitation of a benign, compensatory purpose is not an automatic shield which protects against any inquiry into the actual purposes underlying a statutory scheme.").

[106] *Hogan*, 458 U.S. at 729–30. Indeed, the Court found that the legislative history "relie[d] upon the very sort of archaic and overbroad generalizations about women that we have found insufficient to justify a gender-based classification." *Id.* at 730 n.16. The legislative history of the Sterilization Gap suggests that its proponents may have been relying on similarly archaic notions. *See infra* Part II.B.3.ii.

[107] *Hogan*, 458 U.S. at 730.

Part II, this Note argues that rather than remedy discrimination against women, the Sterilization Gap will make female responsibility for contraception "a self-fulfilling prophecy."

II
The Sterilization Gap Violates Equal Protection

Part II of this Note argues that the Sterilization Gap violates equal protection law because it creates a facial sex classification that is not substantially related to an important governmental objective. Part II.A distinguishes *Geduldig* and argues that the Sterilization Gap creates a facial sex classification. Part II.B argues that the Sterilization Gap fails intermediate scrutiny because it is not substantially related to remedying discrimination or to a basic biological difference, but rather perpetuates gender stereotypes. Part II.C concludes by asserting that if a court finds the Sterilization Gap unconstitutional, it should extend coverage to men.

A. The Sterilization Gap Creates a Facial Sex Classification

Recall that a facial sex classification is one that explicitly distinguishes between men and women in its very terms.[108] By this logic, the Sterilization Gap would appear to fit the bill. It provides, "on its face," a benefit to women—required coverage for sterilization—while also specifically withholding that benefit from men.[109] But because of the Supreme Court's holding in *Geduldig*, the government will surely argue that the Sterilization Gap does not create a facial sex classification, because vasectomies are an additional "risk" that only applies to men.

Remember that in *Geduldig*, the Supreme Court held that an insurance program's failure to cover pregnancy-related disabilities did not create a facial sex classification.[110] The Court explained that this was the case for two core reasons. First, the program distinguished between "pregnant women and nonpregnant persons."[111] Because the latter group also contained women, the Court held that pregnancy was not a direct proxy for sex—which it needed to be, because sex was never explicitly mentioned in the challenged law.[112] Second, because only women become pregnant, "[t]here is no risk from which men are

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[108] *See supra* note 53 and accompanying text.

[109] *See supra* note 21 and accompanying text (quoting the HHS Final Rule footnote that expressly excludes services related to a man's reproductive capacity).

[110] *See supra* notes 55–64 and accompanying text.

[111] Geduldig v. Aiello, 417 U.S. 484, 497 n.20 (1974).

[112] *See id.* at 489 (providing the relevant portion of the statute at issue, which explicitly mentions pregnancy but not gender).

protected and women are not."[113] This Note argues that both of these rationales are distinguishable.

1. Geduldig*'s First Rationale Is Distinguishable*

The first rationale is easily distinguishable. In *Geduldig*, the law at issue did not mention sex. It simply stated that pregnancy or any injury or illness resulting therefrom was not a disability.[114] Therefore, the plaintiff needed to make pregnancy a proxy for sex. No such proxy is needed with the Sterilization Gap because the law on its face makes the classification clear: All women are eligible for sterilization benefits, and all men are not.[115]

It also does not matter that not all men would want to be sterilized. In cases where one sex is excluded on the face of the law, the Supreme Court looks to whether any member of the excluded sex would want to be included, not whether all members of that sex would.[116] For example, in *Virginia*, the Court explicitly acknowledged that not all women would want to attend Virginia Military Institute (VMI).[117] However, as long as one woman wanted to but could not because of her sex, the law created a facial sex classification.[118]

2. Geduldig*'s Second Rationale Is Distinguishable*

Still, the second core holding of *Geduldig* must be addressed, which is that under the Constitution, pregnancy-related disabilities are an additional risk that apply only to one sex (women), so a health plan need not cover them to be equally distributive and therefore facially neutral. This holding is particularly relevant to this Note, because it could be argued that even though the Sterilization Gap specifically excludes "services relating to a man's reproductive capacity,"[119] this should not be dispositive as to whether the law creates a facial sex

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113 *Id.* at 496–97.

114 *Id.* at 489.

115 *See supra* note 21–22 and accompanying text.

116 *See* Mary Anne Case, *"The Very Stereotype the Law Condemns": Constitutional Sex Discrimination Law as a Quest for Perfect Proxies*, 85 CORNELL L. REV. 1447, 1450 (2000) ("Even a generalization demonstrably true of an overwhelming majority of one sex or the other does not suffice to overcome the presumption of unconstitutionality the Court has attached to sex-respecting rules: virtually every sex-respecting rule struck down by the Court in the last quarter century embodied a proxy that was overwhelmingly, though not perfectly, accurate.").

117 United States v. Virginia, 518 U.S. 515, 542 (1996).

118 *See id.* ("[T]he question is whether the Commonwealth can constitutionally deny to *women who have the will and capacity*, the training and attendant opportunities that VMI uniquely affords." (emphasis added)).

119 *See supra* note 21 and accompanying text.

classification.[120] Since only one sex (men) receive vasectomies, then, under the second prong of *Geduldig*, it could be argued that the law remains equal even if men are explicitly not covered.[121]

Part II.A.2.i argues that in *Geduldig* and *Gilbert*, the Court intended "risk" to mean the unwanted eventuality that procedures like vasectomies are intended to prevent, rather than vasectomies themselves. Part II.A.2.ii then argues that the Sterilization Gap creates a facial sex classification because it does not protect both sexes from the same risk, regardless of the fact that this risk is prevented in sex-specific ways.

a. The Meaning of Risk

In *Gilbert*, Justice Brennan dissented that under the majority's analysis, a vasectomy constitutes a "risk" in and of itself, and a sex-specific one at that.[122] Disproving this point is essential to this Note's argument, because if vasectomies are the "risk" to be prevented, then this risk inarguably applies only to men, and thus the Sterilization Gap does not create a sex classification under the second prong of *Geduldig*. However, there is evidence that the majority in *Geduldig* and *Gilbert* understood risk not to mean the medical procedure itself, but rather the undesired condition that the procedure was designed to prevent or remedy.

In *Geduldig*, the Court noted that "California has created a program to insure most risks of employment disability,"[123] suggesting that the Court viewed "risk" as an involuntary event that could disrupt one's employment, rather than something an individual would choose to undergo. This is supported by the Court's later assertion that the plaintiff "encountered a risk that was outside the program's protection."[124] To "encounter" means to come upon something unexpectedly.[125] In other words, the plaintiff came upon something unexpected (a pregnancy-related disability) rather than something she sought—but was unable to remedy it.

In *Gilbert*, the Court noted that the result might have been different if the plan excluded "a disease or disability comparable in all

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120 *See* Geduldig v. Aiello, 417 U.S. 484, 496–97 (1974) (holding that removing pregnancy from a list of compensable disabilities does not equate to gender-based exclusion).

121 *See supra* Part I.B (discussing *Geduldig*'s second prong, which suggests that a law singling out a procedure that only applies to one sex is not necessarily unequal).

122 *See supra* notes 69–72 and accompanying text.

123 *Geduldig*, 417 U.S. at 494–95.

124 *Id.* at 497.

125 *See Encounter Definition*, MERRIAM-WEBSTER ONLINE, http://www.merriam-webster.com/dictionary/encounter (last visited Oct. 21, 2015).

other respects to covered diseases or disabilities."[126] However, pregnancy was "significantly different from the typical covered disease or disability" because it was "not a 'disease' at all, and is often a *voluntarily undertaken* and *desired* condition."[127] Although the Court does not use the word "risk" here, its analysis nonetheless indicates that the crux of what plans are protecting against—the risks that must be equally covered—are not desired conditions like pregnancy or voluntary procedures like sterilization, but rather unwanted eventualities.

It could be argued that although a pregnancy is often desired, a pregnancy-related *disability* is undesired. But even if the Court admitted that pregnancy-related disabilities are undesired and therefore are similar to other risks, this would not diminish its separate argument that these disabilities are still an *additional* risk because they only apply to women. Sterilization, on the other hand, prevents a risk—causing an undesired pregnancy—that applies to both sexes. The key is that involuntariness relates to the understanding of risk, whereas whether a risk applies to both sexes relates to the existence of a sex classification.[128]

Both common usage and the purpose of the Sterilization Gap support this understanding of "risk." First, when people speak of a health risk, they refer to a condition that they wish to avoid, not the manner in which they avoid it. Second, one of HHS's purposes in covering sterilization for women was reducing unintended pregnancies,[129] suggesting that the eventuality that sterilization avoids, rather than sterilization itself, should be seen as the risk prevented.

b. Different Sex, Same Goal

Still, even if the risk to be prevented is not the sex-specific sterilization procedure itself, it could be argued that male and female sterilization prevent different risks: the risk of *causing* an unintended pregnancy for men, and the risk of *becoming* unintentionally pregnant for women.[130] However, even if sterilization prevents a different risk

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126 Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 136 (1976).

127 *Id.* (emphasis added).

128 This distinction is arguably bolstered by the dissent's point, in both *Geduldig* and *Gilbert*, that the plans cover cosmetic surgery. *Gilbert*, 429 U.S. at 415–16 (Brennan, J., dissenting); *Geduldig*, 417 U.S. at 499–500 (Brennan, J., dissenting). While cosmetic surgery itself may be voluntarily undertaken, it prevents an unwanted condition—the dissatisfaction one feels with how one looks. And unlike pregnancy-related disabilities, cosmetic surgery applies to both sexes.

129 *See supra* note 81 and accompanying text.

130 *Cf.* Michael M. v. Super. Ct. of Sonoma Cnty., 450 U.S. 464, 471–73 (1981) (holding that because women become pregnant, it is constitutional to only punish men for statutory rape, since women are already sufficiently deterred).

for men and women because only women become pregnant, it simultaneously prevents the same risk in that both men and women can cause a pregnancy.[131] *Geduldig* and *Gilbert* specifically held that pregnancy is an additional risk that does not befall men, but they also held that those risks which do befall both sexes must be covered for both if they are covered for one.[132] Therefore, if male sterilization is not covered, there *is* a "risk from which women are protected and men are not,"[133] even if women are also simultaneously protected from a risk that does not happen to men.

As noted, the procedures that men and women undergo to prevent the risk of unintended pregnancy are sex-specific. But this should not matter, because *Geduldig* and *Gilbert* held only that a facial sex classification is created when men and women are not protected from the same risk; they did not hold that this risk must be prevented identically for both sexes. As the Court in *Gilbert* explained, "[t]he 'package' going to . . . male and female employees . . . covers exactly the same categories of risk, and is facially nondiscriminatory."[134] In other words, the Court was concerned with categories of risk, rather than sex-specific applications. The Sterilization Gap creates a category of risk—unintended pregnancies—that are prevented for women but not for men.[135] The Supreme Court's opinion in *United States v. Virginia* accords with this understanding of facial sex classifications: they are created when a benefit that could be given to both sexes is only given to one, even if the application of that benefit is sex specific.

In *Virginia*, the Court held that excluding women from an all-men's military school violated equal protection law even though women's experience would be fundamentally different than that of their male counterparts.[136] The school, VMI, prided itself on the "absolute equality of treatment" given to its students, which included punishing physical exercise and a complete lack of privacy.[137] The Court acknowledged that "[a]dmitting women to VMI would undoubtedly require alterations necessary to afford members of each

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[131] In other words, if a sterilized man has sex with an unsterilized woman, she will not become pregnant because he has been prevented from causing a pregnancy, and vice versa.

[132] *See supra* note 67 and accompanying text.

[133] *Geduldig*, 417 U.S. at 497 (emphasis added).

[134] Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 138 (1976).

[135] Women are able to prevent this risk using diaphragms, birth control pills, and sterilization—all covered under § 300gg-13(a)(4) and the HHS Final Rule. *See supra* note 22. There are only two contraceptive methods available to men, vasectomies and condoms, *see infra* note 208 and accompanying text, and neither is covered. *See supra* note 22 and accompanying text.

[136] United States v. Virginia, 518 U.S. 515, 540, 557–58 (1996).

[137] *Id.* at 522.

sex privacy from the other sex in living arrangements, and to adjust aspects of the physical training programs."[138] This meant that women at VMI would have a different experience than men. But because "the VMI methodology could be used to educate women,"[139] the Court held that VMI needed to admit women.[140]

Although *Virginia* never refers to pregnancy or health insurance, it is relevant to the proper interpretation of *Geduldig* and *Gilbert*, because in each case the plaintiff was requesting a benefit. Protection against risk is no less a benefit than being able to attend a public school.[141] Holding that both sexes must be given the same benefit is thus no different than holding that both sexes must be protected from the same risk—and that when they are not, a facial sex classification is created. In ruling that VMI had to admit women even though their experience would be fundamentally different than that of men, the Supreme Court implicitly held that a sex classification is created when both sexes are not given the same benefit—here, attending a military school—even if the application of that benefit might differ in sex-specific ways.[142] This clarifies the application of *Geduldig* to the Sterilization Gap. Because both sexes can be protected from the risk of causing an unintended pregnancy, failing to cover male sterilization creates a facial sex classification, even though the procedure is sex-specific.

B. The Sterilization Gap Fails Intermediate Scrutiny

Once it has been shown that the Sterilization Gap creates a facial sex classification, the next task is to demonstrate that it fails intermediate scrutiny. This Part argues, in three sections, that it does. First, Part II.B.1 argues that biological differences between men and women do not justify the sex classification, because they are not substantially related to achieving the government's objectives. Next, Part II.B.2 argues that the sex classification is not substantially related to reme-

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138 *Id.* at 550 n.19.

139 *Id.* at 540 (quoting United States v. Virginia, 852 F. Supp. 471, 481 (W.D. Va. 1994)).

140 *Id.* at 557 (adding that "[w]omen seeking and fit for a VMI-quality education cannot be offered anything less, under the Commonwealth's obligation to afford them genuinely equal protection").

141 *Compare Virginia*, 518 U.S. at 539–40 (holding that VMI's plan to "affor[d] a unique *educational benefit* only to males" is not equal protection (emphasis added)), *with* Geduldig v. Aiello, 417 U.S. 484, 497 n.20 (1974) (holding that California's disability insurance program was constitutional because "[t]he fiscal and *actuarial benefits* of the program thus accrue to members of both sexes"). An actuary is a person who calculates insurance risks. *See Actuary Definition*, MERRIAM-WEBSTER ONLINE, http://www.merriam-webster.com/dictionary/actuary (last visited Oct. 21, 2015).

142 *See Virginia*, 518 U.S. at 550–51, 551 n.19.

dying discrimination. Finally, Part II.B.3 argues that the Sterilization Gap will perpetuate gender stereotypes.

1. The Sterilization Gap Is Not Substantially Related to Basic Biological Differences

It is true that different sterilization procedures apply to men and women due to their "basic biological differences."[143] But these differences argue against creating a sex classification, not in favor of it. In *Nguyen*, the Supreme Court held that a sex classification that required U.S. citizen fathers to prove paternity of children born to alien mothers furthered the governmental objectives of ensuring that these children had a citizen parent and were able to develop a relationship with that parent.[144] Because a U.S. citizen mother had to be present at the time of her child's birth, the child's maternity would not be in doubt, and there would automatically be a greater likelihood that the mother would develop a relationship with the child. [145]

The Sterilization Gap's objectives are reducing unintended pregnancies, safeguarding public health, and ensuring that women have equal access to health care.[146] It could be argued that the third objective suggests that special solicitude should be given to protecting women's health, making it more important that female sterilization be covered than male, since only women become pregnant.[147] But women already enjoy equal access to sterilization,[148] and covering male sterilization will not negatively impact a woman's ability to be sterilized.[149] Furthermore, covering sterilization for both sexes will do more to reduce unintended pregnancies and safeguard public health than only covering female sterilization—and it will also do more to promote women's health specifically—because male sterilization is safer and more effective than female sterilization.[150]

In other words, the situation here is unlike that in *Nguyen*, where the sex classification arguably furthered the government's objectives.

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143 *See supra* Part I.C.1.

144 *See supra* notes 86–92 and accompanying notes.

145 *See supra* notes 90–92 and accompanying notes.

146 *See supra* note 81 and accompanying text.

147 Of course this treads dangerously close to becoming the sort of paternalism that has historically limited women's opportunities. *See infra* Part II.B.3.i.

148 *See infra* notes 156–60 and accompanying text.

149 Requiring coverage for men will not reduce coverage for women because, first, § 300gg-13(a)(4) already *requires* that women be covered, *see supra* notes 16–20 and accompanying text, and second, insurers will likely save money by covering sterilization for both sexes. *See supra* notes 28–30 and accompanying text explaining how male sterilization is cheaper than female sterilization, but that sterilization itself saves money due to the high costs of pregnancy.

150 *See supra* notes 26–28 and accompanying text.

Instead, the Sterilization Gap actually *hinders* the government's objectives, because they would be better achieved with a sex-neutral law. Therefore, because the sex classification does less to further the government's objectives than a sex-neutral law would, these objectives are not substantially related to a basic biological difference.[151] Male and female sterilization procedures are necessarily different, but this difference does not support the Sterilization Gap.

2. *The Sterilization Gap Is Not Substantially Related to Remedying Discrimination*

In the legislative history surrounding the Mikulski Amendment, several senators, including Senator Mikulski herself, made clear that one goal of the Amendment was to remedy the discriminatory treatment that women have faced in the acquisition of health care.[152] This goal is seemingly reflected in the HHS Final Rule's objective of "ensuring that women have equal access to health care."[153]

But although it is true that women have faced disproportionate health care discrimination,[154] the Sterilization Gap does not remedy this discrimination. This is because women have not been discriminated against when it comes to access to sterilization. As of 2012, roughly three times as many women relied on female rather than male sterilization to prevent pregnancy, [155] and an average of 200,000 more women are sterilized each year than men.[156] These rates have remained constant over the past forty years.[157] In 1993, coverage rates for male and female sterilization were essentially identical across national health plans.[158] In 2002, eighty-nine percent of employment-

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151 *See supra* note 85 and accompanying text.

152 *See* 155 CONG. REC. S11,987 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski) ("Women are often faced with the punitive practices of insurance companies. No. 1 is gender discrimination. Women often pay more and get less. For many insurance companies, simply being a woman is a preexisting condition. . . . What does my amendment do? It guarantees access to those critical preventive services for women to combat their No. 1 killers.").

153 Preventive Services Coverage, *supra* note 20, at 39,872.

154 *See supra* note 12 and accompanying text (discussing health care discrimination against women in the form of higher prices and fewer benefits).

155 GUTTMACHER INSTITUTE, FACT SHEET: CONTRACEPTIVE USE IN THE UNITED STATES 1 (2015), http://www.guttmacher.org/pubs/fb_contr_use.html. Specifically, over nine-and-a-half million women relied on female sterilization for contraception, whereas roughly three million relied on male sterilization. *Id*.

156 Bartz & Greenberg, *supra* note 1, at 24.

157 *Id.*

158 Ann Kurth et al., *Reproductive and Sexual Health Benefits in Private Health Insurance Plans in Washington State*, 33 FAM. PLAN. PERSP. 153, 157 (2001), http://www.guttmacher.org/pubs/journals/3315301.pdf (showing that tubal ligation and vasectomy

based insurance plans covered both male and female sterilization.[159] Additionally, thirty-six states and the District of Columbia cover vasectomy and tubal ligation under the Medicaid family planning benefit.[160] And although a number of states allow hospitals or individual health care practitioners (or both) to refuse to sterilize voluntary patients, these laws apply to men and women.[161]

Therefore, the Sterilization Gap is unlike the problem addressed in *Schlesinger*, where the Court found that allowing women more time for promotion than men was based on remedying a situation in which women were demonstrably given fewer opportunities for promotion.[162] Instead, it is similar to *Hogan*, where a nursing school claimed that its policy of only admitting women was intended to remedy discrimination against women in education.[163] Although women had

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coverage rates in 1993 were within a few percentage points of each other across four categories of national health plan).

159 Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSP. ON SEXUAL & REPROD. HEALTH 72, 75 (2004), http://www.guttmacher.org/pubs/journals/3607204.pdf. At the time of the survey, "approximately 77% of insured Americans younger than 65 receive benefits through their or a relative's employer, 6% through individual coverage and 17% through government programs, such as Medicaid." *Id.* at 72.

160 THE KAISER FAMILY FOUND. & THE GEORGE WASHINGTON UNIV. MED. CTR. SCH. OF PUB. HEALTH AND HEALTH POLICY, STATE MEDICAID COVERAGE OF FAMILY PLANNING SERVICES: SUMMARY OF STATE SURVEY FINDINGS 3 (2009), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8015.pdf. Additionally, thirteen states cover postpartum tubal ligation as part of Medicaid expansion programs, which serve individuals whose income does not qualify them for Medicaid, and twenty states cover it when performed as part of another procedure. *Id.* at 5. Only twenty states cover vasectomies under these expansion programs. *Id.* Although Medicaid recipients must sign consent forms and wait thirty days before undergoing sterilization, this requirement applies to men and women. U.S. DEP'T OF HEALTH AND HUMAN SERVS., HHS-687 (10/12), Consent for Sterilization (2015), *available at* http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf.

161 Georgia, Idaho, Maryland, New Jersey, Pennsylvania, New Mexico, and West Virginia allow hospitals and individual health care practitioners to refuse to perform voluntary sterilizations. *See* GA. CODE ANN. § 31-20-6(a)–(b) (2012); IDAHO CODE ANN. § 39-3915 (West 2015); MD. CODE ANN., HEALTH–GEN. § 20-214(a)–(b) (West 2015); N.J. STAT. ANN. §§ 2A:65A-1 to -2 (West 2015); 43 PA. CONS. STAT. ANN. § 955.2(a)–(b) (West 2015); N.M. STAT. ANN. § 24-8-6(A)(2) (West 2013); W. VA. CODE ANN. § 16-11-1 (West 2011).

Illinois, Kansas, Kentucky, and Rhode Island only allow individual health care practitioners to refuse to perform voluntary sterilizations. *See* 745 ILL. COMP. STAT. ANN. 70/4 (West 2010); KAN. STAT. ANN. § 65-446 (West 2012); KY. REV. STAT. ANN. § 311.800(5)(c) (West 2015); R.I. GEN. LAWS ANN. § 23-17-11 (West 2014).

Massachusetts, Montana, and New Mexico only allow hospitals to refuse to perform voluntary sterilizations. *See* MASS. GEN. LAWS ANN. ch. 272, § 21B (West 2015); MONT. CODE ANN. §§ 50-5-502, -505 (West 2015); N.M. STAT. ANN. § 24-8-6(A)(2) (West 2015).

162 *See supra* Part I.C.1.

163 *See supra* Part I.C.2.

been discriminated against regarding access to education generally,[164] the Court found that women already predominated in nursing schools so there was no discrimination to remedy in this specific area.[165] Similarly, even though women have been discriminated against regarding access to health care generally, women and men have historically had equal access to sterilization specifically. Therefore, the Sterilization Gap cannot be justified on the grounds that it equalizes the treatment of men and women. If anything, as the Court found to be the case with nursing in *Hogan*, it will make the ratio of men and women who are sterilized even more unequal than it already is.[166]

3. *The Sterilization Gap Was Based on and Will Perpetuate Gender Stereotypes*

In the preceding sections, this Note has argued that the Sterilization Gap is not substantially related to an important governmental interest. This Part argues that the Sterilization Gap was not created through the requisite "reasoned analysis," but rather was both based on and will perpetuate gender stereotypes.[167] To this end, Part II.B.3.i examines gender stereotypes as reflected in disaffirmed Supreme Court opinions. Next, Part II.B.3.ii argues that the Sterilization Gap was not created through reasoned analysis, but rather by way of the same stereotypes seen in the disaffirmed opinions. Finally, Part II.B.3.iii asserts that contraception is seen as a stereotypically female responsibility, and argues that the Sterilization Gap will perpetuate this stereotype to the detriment of men and women.

a. Women Have Historically Been Stereotyped as Mothers and Caretakers

As Justice Brennan noted in *Frontiero*, "[t]here can be no doubt that our Nation has had a long and unfortunate history of sex discrimination. Traditionally such discrimination was rationalized by an attitude of 'romantic paternalism' which, in practical effect, put women, not on a pedestal, but in a cage."[168] This "romantic paternalism" was reflected in Supreme Court opinions, which frequently relied on

164 Miss. Univ. for Women v. Hogan, 458 U.S. 718, 727 n.13 (1982) ("[I]n Mississippi, as elsewhere in the country, women's colleges were founded to provide some form of higher education for the academically disenfranchised.").

165 *Id.* at 729–30.

166 *See supra* note 24 and accompanying text (describing how requiring coverage for female but not male sterilization will incentivize women to be sterilized rather than men).

167 *See supra* Part I.C.2 (outlining Supreme Court jurisprudence holding unconstitutional sex classifications that are based on or will perpetuate gender stereotypes).

168 Frontiero v. Richardson, 411 U.S. 677, 684 (1973).

gender stereotypes to uphold sex classifications. The following three cases exemplify these stereotypes; the Supreme Court has subsequently repudiated all three.

In *Bradwell v. Illinois*,[169] the Supreme Court's first sex discrimination case,[170] the Court upheld a state law prohibiting women from being licensed to practice law.[171] Although the majority did not address the sex discrimination claim and found against the plaintiff on other grounds,[172] Justice Bradley's concurrence was explicitly paternalistic:[173] "The paramount destiny and mission of woman are to fulfil[sic] the noble and benign offices of wife and mother," he observed, "[t]his is the law of the Creator. . . . [I]n view of the peculiar characteristics, destiny, and mission of woman, it is within the province of the legislature to ordain what offices, positions, and callings shall be filled and discharged by men."[174]

In *Muller v. Oregon*, the majority relied on gender stereotypes[175] in upholding a maximum work-hours law for women even though a similar law for men had been struck down.[176] As the *Muller* Court explained: "[H]er physical structure and a proper discharge of her maternal functions—having in view not merely her own health, but the well-being of the race—justify legislation to protect her from the greed as well as the passion of man."[177]

As recently as 1961, the Supreme Court in *Hoyt v. Florida* relied on essentially the same stereotypes [178] in holding that women could be automatically exempted from jury duty.[179] "[W]oman is still regarded as the center of home and family life," the Court opined. Therefore it was constitutional for a state "*acting in pursuit of the general welfare*, to conclude that a woman should be relieved from the civic duty of

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169 83 U.S. 130 (1872).

170 CHEMERINSKY, supra note 53, at 769.

171 *See Bradwell*, 83 U.S. at 138–39 (holding that admission to the state bar was not a privilege or immunity within the meaning of the Fourteenth Amendment, and therefore a state need not provide it).

172 *See id.* (ruling against the plaintiff's Fourteenth Amendment argument via the Priveleges and Immunities Clause rather than the Equal Protection Clause).

173 *See Frontiero*, 411 U.S. at 684–85 (noting the "paternalistic attitude" present in *Bradwell*, and explaining that "[a]s a result of notions such as these, our statute books gradually became laden with gross, sterotyped [sic] distinctions between the sexes").

174 *Bradwell*, 83 U.S. at 141–42.

175 *See* Nev. Dep't Human Res. v. Hibbs, 538 U.S. 721, 729–30 (2003) (referencing *Muller* as having relied on discriminatory gender stereotypes).

176 208 U.S. 412, 418–23 (1908).

177 *Id.* at 422.

178 *See Hibbs*, 538 U.S. at 729–30 (referencing *Hoyt* as having relied on discriminatory gender stereotypes).

179 368 U.S. 57, 59–69 (1961).

jury service unless she herself determines that such service is consistent with *her own special responsibilities*."[180]

In each of these cases, the common themes are that women are different than men, that their role is to take care of the family, and that this role must be protected for the benefit of all. These stereotypes are reflected in the Mikulski Amendment's legislative history.

b. The Mikulski Amendment's Legislative History Reflects Gender Stereotypes

The Mikulski Amendment's legislative history and the IOM Report demonstrate that the required "reasoned analysis" was not applied in creating the Sterilization Gap.[181] The legislators who supported the Amendment and the experts who wrote the Report explained at length why preventive care for women was important.[182] They articulated how contraception coverage was an integral component of such care.[183] But little, if any, thought was apparently given as to why sterilization coverage should not be given to men.[184] Indeed, it

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[180] *Id.* at 62 (emphasis added).

[181] Except for Republican Senators Tom Coburn and Mike Enzi, every senator quoted in this section in regards to the Mikulski Amendment was a co-sponsor. *See* Press Release *supra* note 14 (listing the Mikulski Amendment's co-sponsors). Their statements are therefore "'an authoritative guide to the statute's construction,' because the sponsors are the Members of Congress most likely to know what the proposed legislation is all about." William N. Eskridge, Jr., *The New Textualism*, 37 UCLA L. REV. 621, 638 (1990) (quoting N. Haven Bd. of Educ. v. Bell, 456 U.S. 512, 526–27 (1982)). Eskridge ranks sponsor statements second only to committee reports in a "hierarchy of legislative history sources," and notes that the Supreme Court routinely relies on them. *Id*. at 636–38.

[182] Early on in the debate, Senator Mikulski set out the purpose of the amendment: "The essential aspect of my amendment is that it guarantees women access to lifesaving preventive services and screenings . . . by getting rid of, or minimizing, high copays and high deductibles." 155 CONG. REC. S11,987 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski). In a refrain picked up by several other senators, Senator Mikulski asserted that women pay more out-of-pocket health care costs than men and are more likely than men to neglect health care because of the cost. *Id.* That may be generally true, but it does not justify the Sterilization Gap. The IOM continued this uncritical assessment. Despite noting that "[f]amily planning services . . . enable women and couples to avoid an unwanted pregnancy," and that male sterilization results in a lower rate of accidental pregnancies during the first year than female sterilization, the IOM only recommended that the ACA cover female sterilization. IOM REPORT, *supra* note 17, at 104, 106, 109–10.

[183] Senator Al Franken argued that "affordable family planning services must be accessible to all women in our reformed health care system" because "[t]hese services enable women and families to make informed decisions about when and how they become parents." 155 CONG. REC. S12,052 (daily ed. Dec. 2, 2009) (statement of Sen. Franken). The IOM Report included an entire section on family planning, and reached a similar conclusion. IOM REPORT, *supra* note 17, at 102–10.

[184] The only senator to explicitly raise the sex-based coverage gap was Senator Coburn, who opposed the amendment:

"I am for the prevention aspects of the Mikulski amendment. I think it is a great idea. As a matter of fact, it should not be just about women. It should be about screening for prostate cancer for men as well. It should be about treadmills for people

has been persuasively argued that excluding men was probably an oversight.[185]

In arguing that the Sterilization Gap is unconstitutional and coverage should be extended to men, it may suffice to say that Congress simply did not consider whether men might also need coverage.[186] However, this argument gains greater force if it can be shown that the decision to omit men was due to traditional notions about gender roles rather than careful analysis.[187] These notions are implicit in three factors, discussed in greater detail below, that the Mikulski Amendment's proponents repeatedly emphasized in arguing that it should be passed: women are "unique," women must often choose between their children's wellbeing and their own health care due to current costs, and women are frequently the ones making health care decisions for the family. Even though these factors recall the very arguments that courts have historically made to uphold laws discriminating against women, they may also contain some degree of truth. Nonetheless, Supreme Court precedent holds that stereotypes may be unconstitutionally overbroad even if they have empirical support.[188]

Uniqueness is a prime example of the complex relationship between an accurate statement and a stereotype. Several senators referred to women's "uniqueness," whether this was their "unique

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with high cholesterol. It should be about true preventive measures. Why were they not included? Because what we have done under the Mikulski amendment is $892 million over 10 years. We want to do this for one group but we will not do it for the other."
155 CONG. REC. S12,123 (daily ed. Dec. 2, 2009) (statement of Sen. Coburn).

Senator Enzi, who also opposed the amendment, brought up the issue of men's coverage as well. However, it is unclear whether he was concerned that the Mikulski Amendment would not provide coverage for men, or that it would but this coverage could be revoked in the future, as the USPSTF did with mammograms for women under fifty. As the Senator stated, "[t]his amendment doesn't do anything to protect patients who might be denied access to preventive tests in the future, such as prostate exams, colonoscopies, Pap smears, and so on, if bureaucrats decide to deny access." 155 CONG. REC. S11,991 (daily ed. Nov. 30, 2009) (statement of Sen. Enzi). The amendment's supporters never addressed Senator Coburn's or Senator Enzi's concerns in this regard.

185 Adam Sonfield, an expert at the Guttmacher Institute who has written extensively about family planning issues, believes the omission was accidental. *Tubes Tied*, *supra* note 24 ("There's no one who is specifically trying to exclude preventive services for men. It was probably an oversight because with the bias in medical community [sic] for male adult patients, it wasn't as obvious to people that there might be some gaps there as well."). Indeed, several of the Mikulski Amendment's supporters were unaware that it created a sex classification. *Id.*

186 *See supra* notes 102–03 and accompanying text (explaining how sex classifications must be based on "reasoned analysis" rather than on an "arbitrary distinction between the sexes" such as those resulting from legislative oversight).

187 *See supra* Part I.C.2 (explaining how sex classifications created via stereotype are unconstitutional).

188 *See supra* note 104 and accompanying text.

needs,"[189] their "unique preventive health needs,"[190] the "unique situations" they face,[191] or the "things unique to women" which are often missing from health care reform.[192] And it is undeniable that women *do* have "unique" health needs as compared to men, and that these needs have often gone unaddressed due to discriminatory health care practices.[193] Even sterilization is arguably such a need given the physiological differences between men and women. But on the other hand, men can be sterilized too. Overemphasizing women's uniqueness may therefore be akin to those Supreme Court rulings that divided the sexes based in part on women's "peculiar characteristics."[194]

A number of senators referred to the choice women were often forced to make between caring for their families and caring for themselves. Senator Patty Murray was particularly sweeping in her description of the issue: "When the economy is hurting, women on the whole tend to think of caring for their families first and not caring for themselves. They take care of their children and their spouses first, and they end up delaying or skipping their own health care . . . ."[195] Senator Murray's view of the amendment's purpose placed women's maternal role front and center: "One of the most important things we can do is make sure the caregivers in our families—the women—get access to preventive care so they can take care of their families."[196] Many others voiced similar views,[197] including Senator Mikulski:

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189 155 CONG. REC. S12,273 (daily ed. Dec. 3, 2009) (statement of Sen. Stabenow).

190 155 CONG. REC. S12,025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer).

191 155 CONG. REC. S12,267 (daily ed. Dec. 3, 2009) (statement of Sen. Harkin).

192 155 CONG. REC. S11,988 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski).

193 *See supra* note 12 and accompanying text.

194 Bradwell v. Illinois, 83 U.S. 130, 138–39 (1872); *see also* Muller v. Oregon, 208 U.S. 412, 420 (1908) (noting that women's "physical structure" justifies special legislation); Sandra Day O'Connor, *Portia's Progress*, 66 N.Y.U. L. REV. 1546, 1554 (1991) ("The dilemma is this: if society does not recognize the fact that only women can bear children, then 'equal treatment' ends up being unequal. . . . [But] if society recognizes pregnancy as requiring special solicitude, it is a slippery slope back to the 'protectionist' legislation that historically barred women from the workplace.").

195 155 CONG. REC. S12,274 (daily ed. Dec. 3, 2009) (statement of Sen. Murray).

196 155 CONG. REC. S12,028 (daily ed. Dec. 1, 2009) (statement of Sen. Murray). Senator Murray added that "[a]s moms, you take care of your kids first. When you do that, you often leave your families at risk because you haven't gotten the necessary preventive care." *Id.*

197 155 CONG. REC. S12,042 (daily ed. Dec. 1, 2009) (statement of Sen. Harkin) ("[S]o many women whom I have met and talked to have given up on buying health insurance for themselves so they will have enough money to feed and clothe their kids and send them to school. Women should not be forced to make that kind of a choice."); 155 CONG. REC. S12,028 (daily ed. Dec. 1, 2009) (statement of Sen. Hagan) ("When these women had to choose between feeding their children, paying the rent, and meeting other financial obligations, they skipped important preventive screenings and took a chance with their personal health.").

"Many women say: Well, my insurance company provides for [early detection screenings], but this copayment and deductible, I have to choose between my children's shoes or my deductible."[198] There is surely some truth to what the senators are saying. And they are no doubt well intentioned. Nonetheless, their identification of women as the "caregivers" in the home, with no mention of the primary role men can and often do play in this area, is entirely consistent with the Court's determination in *Hoyt* that the "woman is still regarded as the center of home and family life . . . with her own special responsibilities." [199]

Similarly, many senators asserted variations on the point that "[w]e all know that often women are the ones making health care decisions for their families."[200] This may indeed be accurate.[201] But it also lines up with the traditional notion that a woman has "maternal functions" involving "not merely her own health, but the well-being of the race."[202]

c. The Sterilization Gap Will Perpetuate the Stereotype that Contraception Is a Female Responsibility

Research and development on women's health has historically been neglected in comparison to men's health.[203] However, the reverse is true for reproductive health, an area in which men lag far

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198 155 CONG. REC. S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski).

199 *Hoyt*, 368 U.S. at 62.

200 155 CONG. REC. S12,272 (daily ed. Dec. 3, 2009) (statement of Sen. Stabenow); *see also* 155 CONG. REC. S12,025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer) ("Women are often the decisionmakers for their families when it comes to health care. But women too often put the health needs of their family members and their children ahead of their own."); 155 CONG. REC. S12,042 (daily ed. Dec. 1, 2009) (statement of Sen. Harkin) ("Women are often the health care decisionmakers for their families.").

201 155 CONG. REC. S11,988 (daily ed. Nov. 30, 2009) (statement of Sen. Baucus) ("[A]bout 80 percent of health care decisions made for families are made by women. It is all the more important women are not discriminated against, partly because they make so many decisions that affect health care for Americans.").

202 Muller v. Oregon, 208 U.S. 412, 422 (1908).

203 Michelle Andrews, *Health Law Has Gaps in Men's Care*, KAISER HEALTH NEWS (Aug. 27, 2012), http://kaiserhealthnews.org/news/health-law-men-michelle-andrews-082812 ("[M]uch of the broad medical research conducted to date has focused on men. Clinical trials for many drugs, for example, for many years excluded women."). *See also* Anita Holdcroft, Editorial, *Gender Bias in Research: How Does It Affect Evidence Based Medicine?*, 100 J. ROYAL SOC'Y MED. 2, 2 (Jan. 2007), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1761670/pdf/0002.pdf (explaining that in 2005, "eight out of ten prescription drugs were withdrawn from the US market because of women's health issues").

behind women.[204] Men have often been absent from or late additions to reproductive health policies.[205] Since the 1920s, researchers have focused "almost exclusively" on developing female contraception.[206] Male contraception has essentially been an afterthought.[207] As a result, there are now eleven long-acting, reversible contraception methods available to women, while men have only two effective options: condoms and vasectomies.[208] It is little wonder that men are often uninvolved in family planning.[209]

This was not always the case. Men and women once shared responsibility for contraception, because the methods that enabled it required male participation.[210] But over the course of the twentieth century, responsibility for contraception, including sterilization, came to be seen as a woman's duty.[211] This perception is based on a stereotype, because men have been responsible for contraception in the past, and many would like to be more responsible in the future.[212] Nonetheless, this stereotype has had a powerful effect. It is among the reasons why a male birth control pill has yet to be developed.[213] It may also be among the reasons why the Sterilization Gap went virtually unquestioned in the Mikulski Amendment's legislative history.

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204 *See* Andrews, *supra* note 203 (explaining that "[p]art of the problem in improving coverage of sexual and reproductive health for men is that research is scarce and comprehensive clinical guidelines have never been established").

205 Turok et al., *supra* note 24.

206 Lisa Campo-Engelstein, *Contraceptive Justice: Why We Need a Male Pill*, 14 AM. MED. ASS'N J. ETHICS 146, 147–48 (2012), *available at* http://journalofethics.ama-assn.org/2012/02/pdf/msoc1-1202.pdf.

207 *Id.*

208 *Id.* at 146. Moreover, condoms are not long-acting, and vasectomies are not reliably reversible. *Id.*

209 *See* Turok et al., *supra* note 24 (describing the lack of male involvement in reproductive health care as contributing to the burdens on women); *see also* Debra Kalmuss & Carrie Tatum, *Patterns of Men's Use of Sexual and Reproductive Health Services*, 39 PERSP. SEXUAL REPROD. HEALTH 74, 74 (2007), *available at* https://www.guttmacher.org/pubs/journals/3907407.pdf (finding that "[s]exual and reproductive health care providers in the United States have traditionally served women and . . . men who have sex with men," whereas "[h]eterosexual men remain largely invisible").

210 *See* Campo-Edelstein, *supra* note 206, at 147 ("Historically, contraceptive use was tied to the actual sex act, and for this reason men had to participate in it (for example, by using a condom or withdrawing).").

211 *Id.*; *see also* KLUCHIN, *supra* note 23, at 50 (noting that "[m]en who had a vasectomy also assumed a historically female responsibility for birth control").

212 *See* Campo-Edelstein, *supra* note 206, at 147–48 (referencing a study revealing that more than seventy percent of men believe men should take more responsibility for contraception).

213 *Id.* at 148.

And it is certainly reflected in the fact that far more women than men are sterilized despite the health and cost differences.[214]

Ultimately, stereotyping women as responsible for contraception harms both sexes. Although women now have a broad ability to control their reproduction, they are disproportionally burdened by the health risks and financial costs of contraception.[215] At the same time, male reproductive autonomy is restricted. [216] Because men lack a long-acting reversible contraceptive, they must often rely on their partners to consistently and correctly use contraception.[217] This is true even when men would prefer to share in the responsibility.[218]

Because sterilization is a form of contraception, the Sterilization Gap will perpetuate the stereotype that contraception is a women's responsibility. It will do this by causing the ratio of women and men who are sterilized to become even more disproportionate.[219] As the Court explained in *Hogan*, this will make the stereotype "a self-fulfilling prophecy."[220]

As a result, the Sterilization Gap will do more than just harm those men who wish to be sterilized but cannot afford it, and those women who undergo sterilization as a result. It will also perpetuate the overdevelopment of female contraception and the underdevelopment of male contraception, as well as the harms that accompany this disparity. Extending sterilization coverage to men will help reverse this trend, to the benefit of both sexes.

C. Extending Sterilization Coverage to Men

This Note has argued that the Sterilization Gap is unconstitutional. But even if a court agrees, it can choose to equalize benefits by removing coverage from women—which this Part refers to as "nullifi-

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214 *Id.* at 149; *see also supra* note 155 and accompanying text (explaining that three times more women rely on female rather than male sterilization for their birth control).

215 *Id.* at 146.

216 *Id.*

217 *Id.* at 147.

218 *See* LAURA ELDRIDGE, IN OUR CONTROL: THE COMPLETE GUIDE TO CONTRACEPTIVE CHOICES FOR WOMEN 264 (Seven Stories Press ed., 2010) ("'I would be all about [male birth control],' one twenty-seven-year-old told me. 'It would be nice to have a feeling of control about that part of my life. And also responsibility; I feel bad always putting that on my girlfriend.'").

219 *See supra* note 24 and accompanying text (explaining how women are incentivized to undergo sterilization, whereas men are not).

220 Miss. Univ. for Women v. Hogan, 458 U.S. 718, 730 (1982); *see also supra* Part I.C.2; Campo-Engelstein, *supra* note 206, at 149 ("[W]e need both a change in technology—the development of male LARCs [long-acting, reversible contraceptives]—and a change in ideology—the belief that both women and men should be responsible for contraception—to achieve the more just contraceptive arrangement.").

cation"—rather than extending it to men.[221] This Part argues that a court faced with this decision should extend coverage.[222] Indeed, the Supreme Court has often chosen to extend benefits when it finds that a statute violates equal protection.[223]

In deciding what to do with an unconstitutional statute, the Supreme Court has held that ordinarily, "extension, rather than nullification, is the proper course."[224] Nonetheless, a court should not "use its remedial powers to circumvent the intent of the legislature."[225] Confronting an issue like the Sterilization Gap, a court must therefore determine whether the legislature would have chosen to enact the statute in its extended form.[226] Three factors are particularly relevant to this determination.

First, a court should consider whether a severability clause applies to the challenged law.[227] The Supreme Court has held that a

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221 *See* Heckler v. Mathews, 465 U.S. 728, 738 (1984) (Harlan, J., concurring in the result) (quoting Welsh v. United States, 398 U.S. 333, 361 (1970)) (holding that when faced with a law that violates equal protection, a court "may either declare [the statute] a nullity and order that its benefits not extend to the class that the legislature intended to benefit, or it may extend the coverage of the statute to include those who are aggrieved by the exclusion").

222 In extending benefits, a court is undeniably legislating; however, the same is true if it retracts benefits. *See* Ruth Bader Ginsburg, *Some Thoughts on Judicial Authority to Repair Unconstitutional Legislation*, 28 CLEV. ST. L. REV. 301, 317 (1979) ("If [a court] declares the statute unconstitutional as written, the remaining task is essentially legislative."). If courts refuse to accept responsibility for any remedy that involves "legislating," they will essentially "immunize from judicial review statutes that confer benefits unevenly." *Id.* at 303, 317.

223 *See* Bruce K. Miller, *Constitutional Remedies for Underinclusive Statutes: A Critical Appraisal of* Heckler v. Mathews, 20 HARV. C.R.-C.L. L. REV. 79, 79–80 n.1 (1985) (collecting cases in which the Court has extended benefits after finding a statute unconstitutional).

224 *Heckler*, 465 U.S. at 739 n.5 (citation omitted).

225 *Id.* (quoting Califano v. Westcott, 443 U.S. 76, 94 (1979)).

226 *See Welsh*, 398 U.S. at 355–56 (Harlan, J., concurring in the judgment) ("If an important congressional policy is to be perpetuated by recasting unconstitutional legislation . . . [i]ts justification cannot be by resort to legislative intent, as that term is usually employed." Instead, Harlan advocated for a different interpretation of legislative intent in this context, "namely[,] the presumed grant of power to the courts to decide whether it more nearly accords with Congress' wishes to eliminate its policy altogether or extend it in order to render what Congress plainly did intend, constitutional."). In *Westcott*, the Court unanimously embraced Justice Harlan's concurrence as the proper standard for expansion analysis, although the justices disagreed on its application to the statute at issue. Ginsburg, *supra* note 222, at 310.

227 *Welsh*, 398 U.S. at 364 (explaining the importance of a severability clause in determining legislative intent). A severability clause is a provision that Congress creates to indicate what should happen if part of a law is found unconstitutional. The clause may instruct a court to sever, or nullify, the unconstitutional portion while leaving the rest of the law alone. *Westcott*, 443 U.S. at 90 n.8. Or it may instruct the court to nullify more than just the unconstitutional section. *Heckler*, 465 U.S. at 742–44.

severability clause, 42 U.S.C. § 1303, applies to the ACA.[228] This clause instructs that if part of the ACA is held invalid, the rest should remain unaffected.[229] This suggests that Congress would have preferred to extend rather than nullify sterilization coverage, "for it evidences a congressional intent to minimize the burdens imposed by a declaration of unconstitutionality upon innocent recipients of government largesse."[230]

Second, a court should consider "the intensity of the legislative commitment to the policy at issue," in this case, female sterilization.[231] The legislative history of the Mikulski Amendment demonstrates that its primary goal was improving female health.[232] Reducing unplanned pregnancies via female sterilization was one aspect of this goal.[233] Retracting sterilization coverage from women would therefore hurt the very individuals that Congress "plainly meant to protect."[234] The Supreme Court has held that such a result "counsels against nullification."[235]

Third, a court should consider the "degree of potential disruption of the statutory scheme that would occur by extension as opposed to abrogation."[236] During the debate preceding the passage of the Mikulski Amendment, no senator stated anything resembling a desire to provide coverage to women *and not* men.[237] Nor does the structure of the ACA as a whole depend on providing sterilization coverage only to women: No other part of the Act will be affected if coverage is extended to men. [238] Furthermore, extending sterilization benefits

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[228] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012) (holding that the § 1303 severability clause applies to the ACA because it is within the same chapter and states that "[i]f any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby" (quoting 42 U.S.C. § 1303 (2012)).

[229] *See id.* (suggesting that even if one part of a statute is held invalid, it is often the case that a court "must leave the rest of the Act intact").

[230] *Westcott*, 443 U.S. at 90.

[231] Ginsburg, *supra* note 222, at 310; *see also Heckler*, 465 U.S. at 739 n.5 (accord).

[232] *See supra* notes 182–83 and accompanying text.

[233] *See supra* notes 182–83 and accompanying text.

[234] *Westcott*, 443 U.S. at 90.

[235] *Id.*

[236] *Heckler*, 465 U.S. at 739 n.5 (Harlan, J., concurring) (quoting Welsh v. United States, 398 U.S. 333, 365 (1970)).

[237] The Amendment's opponents criticized it in part because it did not provide coverage to men. *See supra* note 184. However, there is no evidence that this exclusion was intentional. *See supra* note 185 and accompanying text.

[238] This is partly because extension is unlikely to raise overall costs. *See supra* note 26 and accompanying text. But even in cases where extension would lead to increased public and private costs, the Supreme Court has still chosen extension over nullification. *See* Levy v. Louisiana, 391 U.S. 68, 69–72 (1968) (extending a statute to allow children born out of

would not involve difficult definitional questions, which the Court disfavors.[239] Men would simply be covered as women are now.[240]

Ultimately, extending coverage would promote women's health, reduce unplanned pregnancies, and save money.[241] To the extent that this would disrupt the statutory scheme—whether because costs might temporarily increase or because the HHS Final Rule expressly excludes male sterilization coverage—this disruption is far outweighed by the effects of nullification. Nullification would harm women, would increase unplanned pregnancies, and would increase overall costs more than if coverage were extended.[242]

Given the choice, Congress would surely have preferred to extend sterilization coverage to men, rather than remove it from women. Given the choice, a court confronted with the Sterilization Gap should do the same.

Conclusion

When Congress passed the Mikulski Amendment, it was motivated by a benevolent goal: improving women's health. In order to meet that goal, the HHS Final Rule that implemented the Amendment required insurers to cover female sterilization. It did not, however, require them to cover male sterilization, even though vasectomies are safer, cheaper, and more effective than any form of female sterilization. This is the Sterilization Gap.

This Note has argued that the Sterilization Gap is a facial sex classification because both sexes can be sterilized, even though the procedure is sex specific. This classification violates constitutional equal protection law, because it is not based on a biological difference nor does it remedy discrimination. Instead, the classification was cre-

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wedlock to privately recover against a tortfeasor for the wrongful death of their mother); Ginsburg, *supra* note 222, at 302, 305 (explaining that in *Wiesenfeld* the Court extended public benefits to the surviving children of all wage-earning women at a projected cost of $500 million).

239 In *Westcott*, the Court held that extending certain unemployment benefits to both sexes was preferable to covering only "principal wage-earners," a class newly defined during litigation. Califano v. Westcott, 443 U.S. 76, 92 (1979). Although including all men and women would create a broader class, it had the "virtue of simplicity" and "avoided disruption." *Id.* Whereas the newly defined class posed "definitional and policy questions" best left to the legislature. *Id.*

240 *Id.* (noting the simplicity of extension where it merely necessitated that "'father' be replaced by its gender-neutral equivalent, . . . for benefits simply will be paid to families with an unemployed parent on the same terms that benefits have long been paid to families with an unemployed father").

241 *See supra* notes 26–30 and accompanying text (finding that male sterilization is safer, cheaper, and more effective than female sterilization).

242 *See supra* notes 26–30 and accompanying text.

ated either through impermissible oversight or stereotypical views of gender roles. It will perpetuate the notion that contraception is a woman's responsibility, to the detriment of both sexes.

Had Congress known the Sterilization Gap was unconstitutional, it would likely have chosen to extend coverage to men rather than nullify the law, because extension would promote its goals with comparatively little disruption. If a court finds the Sterilization Gap unconstitutional, it should follow suit.