INSURANCE PRACTICES AND DISPARITIES IN ACCESS TO ASSISTED REPRODUCTIVE TECHNOLOGIES

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I. INTRODUCTION

Natural conception of children through unsupplemented sexual intercourse has dominated as the leading method of procreation for thousands of years.[1] However, not every female and male have the basic biological systems replete to succeed in creating new life.[2] For a variety of reasons, people may suffer from infertility or the inability to conceive a child.[3] Historically, people in these circumstances were left to live without the ability to raise genetically related offspring.[4] With advances in science and rising awareness of this medical condition, the development of assisted reproductive technologies ("ART") brought new hope to this group of people.[5] ART now makes reproduction possible for anyone previously unable to procreate and become parents, including, but not limited to, same-sex couples, single persons, and those suffering from infertility.[6]

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[1] *See* Stephanie Hunt, *8 Surprising Facts About Fertility*, PARENTS, http://www.parents.com/getting-pregnant/fertility/boost/facts-about-fertility/ (last visit Oct. 14, 2017).

[2] *Infertility FAQS*, CENT. FOR DISEASE CONTROL, https://www.cdc.gov/reproductivehealth/infertility/index.htm (last updated Mar. 30, 2017).

[3] *Id.*

[4] Stephen Smith, *A Fertility Timeline*, AM. RADIOWORKS, http://americanradioworks.publicradio.org/features/fertility_race/part1/timeline.shtml (last visited Oct. 15, 2017),

[5] *What is Assisted Reproductive Technology?,* CENT. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/art/whatis.html (last updated Feb. 7, 2017).

[6] *See Id.*

However, while ART enables procreation, access to and cost of these services remain troubling burdens.[7] Headlines across the nation have revealed fertility clinics that deny their services to same-sex couples and have asserted allegations against state laws regarding infertility coverage that discriminate based on sexual orientation.[8] Only fifteen states have enacted legislation that requires insurers to cover some or all forms of infertility treatments, but even among these states, disparities remain.[9] While states hope to increase the availability of ART, many fall short of this goal for a variety of reasons, including how they define infertility and the types of services actually covered.[10] Ultimately, groups of people are marginalized because they are unable to bear children naturally as a result of their sexual orientation, marital status or other unexplained reasons.[11]

This Article argues for broader coverage of ART in the United States based not only on social justice, but on economic and legal reasons as well. Part II provides a background of the costs associated with common forms of ART and the various insurance mandates enacted by states.[12] In addition, this section will explore the differences and similarities between the laws and explain the higher costs in states that do not have insurance mandates.[13] Part III outlines the economic reasons

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[7] Georgina M. Chambers et al., *The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries*, 91 FERTILITY & STERILITY, June 2009, 2281, 2281.

[8] *See* Kimberly Leonard, *Who Has the Right to Build a Family?*, U.S. NEWS & WORLD REPORT, (Aug. 15, 2016), http://www.usnews.com/news/articles/2016-08-15/same-sex-infertility-case-exposes-lack-of-access-to-reproductive-treatment; Ananya Bhattacharya, *An Outdated Law is Preventing Same-Sex Couples in New Jersey from Getting Fertility Treatment*, QUARTZ (Aug. 13, 2016), http://qz.com/757305/new-jersey-infertility-mandate-discriminates-against-lesbian-couples/.

[9] Tara Siegal Bernard, *Insurance Coverage for Fertility Treatments Varies Widely*, N.Y. TIMES: YOUR MONEY (July 25, 2014), http://www.nytimes.com/2014/07/26/your-money/health-insurance/insurance-coverage-for-fertility-treatments-varies-widely.html?_r=0.

[10] *Id.*

[11] *Id.*

[12] *See infra* Part II.

[13] *See infra* Part II(a)-(b).

why broader coverage of ART would benefit the entire population.[14] This includes a breakdown of economic analyses that shows broader ART coverage would not burden total health care expenditures and the pertinent facts that should be used to advise coverage practices.[15] Part IV describes the social beliefs presented by opponents of expanding ART and the resulting inequalities.[16] This segment shares various scholarly works that argue for and against same-sex parenthood.[17] Part V provides the general legal context of the fundamental right to procreate and the equal rights afforded to same-sex couples and unmarried persons.[18] This Article recognizes that fairer access to ART is a goal that the legal system has the power to accomplish.[19] It concludes with a proposal to change existing insurance mandates and guide future proposals for equal access, without any exclusion based on sexual orientation, gender identity, or marital status.[20]

II. COSTS AND COVERAGE OF ART

A. Direct and Indirect Costs of ART

The Centers for Disease Control and Prevention define ART as infertility treatments that "involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body . . . ."[21] The most commonly used form of ART is in vitro fertilization ("IVF"), making up over 99% of all ART procedures in 2014.[22] IVF is a medical procedure that combines a

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[14] *See infra* Part III.

[15] *See infra* Part III.

[16] *See infra* Part IV.

[17] *See infra* Part IV(a)-(b).

[18] *See infra* Part V.

[19] *See infra* Part V.

[20] *See infra* Part VI.

[21] *See generally What is Assisted Reproductive Technology?,* CENT. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/art/whatis.html (last updated Feb. 7, 2017) (excluding from the definition of ART procedures only involving sperm like artificial insemination (AI) and intrauterine insemination (IUI). Note, for the purposes of this Article, ART refers to the CDC definition that excludes AI and IUI).

[22] CENT. FOR DISEASE CONTROL AND PREVENTION, ASSISTED REPRODUCTIVE

woman's egg with sperm in the laboratory, grows the resulting embryo for three to five days, and transfers the embryo into the woman's uterus.[23] The remaining procedures include gamete intrafallopian transfer ("GIFT"), zygote intrafallopian transfer ("ZIFT"), or a combination of one of these with IVF.[24] GIFT is the transfer of the sperm and egg into the fallopian tube to allow for natural fertilization, and ZIFT involves combining the sperm and egg in the laboratory, like IVF, but transferring the embryo into the fallopian tube after only a day.[25] These procedures take months to accomplish[26] and often require multiple attempts before resulting in pregnancy.[27]

Affordability of care has been a determinative factor in pursuing ART treatments.[28] The cost of ART varies between clinics, but average data has been collected to guide prospective patients.[29] One organization in particular, RESOLVE, advocates for patients with infertility and collects information regarding the options available for them.[30]

TECHNOLOGY: NATIONAL SUMMARY REPORT (2014) (allocating data from 458 of the 497 total number of fertility clinics across the United States at that time).

[23] JUDITH DAAR, REPRODUCTIVE TECHNOLOGIES AND THE LAW 39 (2d ed. 2012) (reporting IVF has four phases: ovarian stimulation and monitoring, egg collection, fertilization and embryo culture, and embryo transfer).

[24] *Id.*

[25] *Id.*

[26] *Fertility Treatment FAQ's*, USC FERTILITY, http://uscfertility.org/fertility-treatments/fertility-treatment-faqs (last visited Oct. 20, 2017).

[27] *Davis v. Davis*, 842 S.W.2d 588, 591 (Tenn. 1992) (involving a couple who attempted IVF seven times).

[28] Donna Rosato, *Three Ways to Cut the High Costs of Infertility*, TIME (July 08, 2014), http://time.com/money/2951923/three-ways-to-cut-the-high-costs-of-infertility/; *see also Making Infertility Affordable*, RESOLVE, http://www.resolve.org/family-building-options/making-treatment-affordable/the-costs-of-infertility-treatment.html (last visited Oct. 20, 2017).

[29] Patricia Katz, PhD et al., *Costs of Infertility Treatment: Results from an 18-Month Prospective* (Dec. 4, 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043157/.

[30] *About Us,* RESOLVE, http://www.mydestinationfamily.org/build-your-family (last visited Oct. 20 2017) (defining RESOLVE as "a non-profit, charitable organization, who works to improve the lives of women and men living with infertility." The organization was established in 1974 and continues to provide resources for people searching for information regarding all aspects of family building, including ART, insurance coverage, and treatment costs).

According to their website, the average cost of one cycle of IVF using nonfrozen, fresh embryos is $8,158, not including medications.[31] The average cost of medications per cycle amounts to anywhere between $3,000 and $5,000.[32] Combining these costs results in an average of $11,158 to $13,158 per IVF cycle. Before any government subsidies, this cost can represent up to 50% of an average individual's annual disposable income.[33] Furthermore, the average cost of GIFT and ZIFT are more than IVF because the surgery requires injection into a more particularized structure—the fallopian tube—rather than generally in the uterus.[34]

The high direct cost of ART can be offset by health insurance, but the majority of states do not mandate such coverage.[35] Therefore, the expenses are out of pocket for many individuals seeking these procedures.[36] To assist with the cost, clinics, banks, and other lenders

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[31] *Making Treatment Affordable,* RESOLVE, THE NAT'L INFERTILITY ASS'N, http://www.resolve.org/family-building-options/making-treatment-affordable/the-costs-of-infertility-treatment.html (last visited Oct. 20, 2017) (collecting data from 30 fertility clinics across the United States in 2006. The median cost of one cycle of IVF using fresh embryos was $7,500).

[32] Jennifer Gerson Uffalussy, *The Cost of IVF: 4 Things I Learned While Battling Infertility*, Forbes (Feb. 6, 2014), https://www.forbes.com/sites/learnvest/2014/02/06/the-cost-of-ivf-4-things-i-learned-while-battling-infertility/#1a3a01c924dd.

[33] Chambers, *supra* note 7 (determining that the average cost of a standard IVF cycle was $12,513 in the United States. The study recognized that funding of ART came directly from the patient or other finance companies. After taking into account health insurance, the average of cost of a standard IVF cycle decreased from 50% to 44% of disposable income).

[34] *GIFT: Gamete Intra-Fallopian Transfer for Infertility Treatment, for Infertility*, ADVANCED FERTILITY CENTER OF CHI., http://www.advancedfertility.com/gift.htm. (last visited Oct. 27, 2017) (reporting that "GIFT costs much more than IVF because of the surgical procedure involved and the resulting operating room and hospital fees involved." At this clinic, a single cycle of IVF without monitoring costs $8,500 and $10,000 with monitoring, both of which do not include medication prices. They state that medications alone can cost up to $7,000); *see also Single Cycle IVF Cost Details – Advanced Fertility Center of Chicago*, ADVANCED FERTILITY CENTER OF CHI., http://www.advancedfertility.com/ivf-cost.htm. (last visited Oct. 27, 2017) (reporting the comparatively higher cost of GIFT compared to IVF).

[35] *Id.*

[36] *Id.*

offer financing programs.[37] For patient convenience, RESOLVE has compiled a list of all these programs.[38] The majority of them offer discounts on treatments by bundling services and medications.[39] Six of the plans offer some form of refund to the patient if a live birth is not achieved.[40] However, only one of those programs guarantees a 100% refund for failure to achieve a live birth at the end of its cycle allotment,[41] while the rest offer anywhere between a 70% to 100% refund based on a variety of clinical factors unique to the individual patient.[42]

It is important to note that, in addition to the direct cost of each cycle, the physical toll from the countless injections and eventual surgery; the loss of wages from time off work; the travel, and the other accommodations necessary for each cycle add more dimensions to the "cost" of the procedure.[43] These other factors are considered "indirect costs."[44] However, the most significant indirect cost of ART has

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[37] *Infertility Financing Programs*, RESOLVE: THE NAT'L INFERTILITY ASS'N, http://resolve.org/what-are-my-options/making-infertility-affordable/infertility-financing-programs. (last visited Oct. 27, 2017) (providing the financing list last updated in July 2016 and offering 19 different options that vary in types of treatments, amount of financial assistance, and availability based on income of the patient).

[38] *Id.*

[39] *Id.*

[40] *Shared Risk 100% Refund Program*, SHADY GROVE FERTILITY, https://www.shadygrovefertility.com/affording-care/guarantee-programs. (last visited Oct. 27, 2017) (reporting the Shared Risk 100% Refund Program is only available at certain fertility clinics in four areas: Maryland, Pennsylvania, Virginia, and Washington, D.C.).

[41] *Infertility Financing Programs*, *supra* note 37. (reporting the Advanced Reproductive Care, Inc. offers "a portion of the money" to be refunded. Assisted Reproduction Insurance Program offers refunds but does not specify how much on their website. Assure IVF Refund Program offers an 80% refund. "Attain IVF" by Attain Fertility Centers offers a 70% refund if you use your own eggs and up to 100% if you use donor eggs. The IVF Financing Share Program offers a 70% refund).

[42] Mark P. Connolly et al., *The Costs and Consequences of Assisted Reproductive Technology: An Economic Perspective*, 16 HUM. REPROD. UPDATE 603, 605-06 (2010).

[43] *Id.* at 605. (reporting this epidemiological and economic report of ART used worldwide analyzed key studies regarding the direct and indirect costs and consequences of utilizing ART. They define "direct" costs as those "attributed to providing ART treatment itself" and "indirect" costs as "those occurring as a consequence of ART treatment..").

[44] *Id.*

consistently been the possibility of pregnancies resulting in multiple births.[45] According to a summary report by the Centers for Disease Control and Prevention in 2014, about 24.2% of resulting live births from ART cycles using fresh, nondonor embryos involved multiple-infant births, which included twins, triplets, or more.[46] This increases the risk of prematurity, low birth weight, infant disability, and death.[47] Among the ART produced twins born, 56.8% were born preterm and 55.4% had a low birthweight.[48] Among the births resulting in triplets or more, 98.7% were preterm and 93.7% were low birthweight.[49] These results increase the risk of poor health outcomes that require long-term health care and additional financial resources.[50] In conclusion, the cost of undergoing ART treatment greatly outweighs those of natural conception.

B. State Coverage of Infertility Treatments and ART

Insurance coverage of infertility treatments in some form or another is mandated in only fifteen states.[51] ART is not included in all of them. Additionally, some only cover the treatment and diagnosis of the underlying cause of infertility,[52] thus leaving no coverage for those suffering for "[u]nknown reasons," which accounted for 13% of patients seeking ART treatment in 2014.[53] Common provisions that further cut at a couple's access to insurance coverage include, but are not limited to,

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[45] *Id.* at 606.

[46] *NAT'L SUMMARY REP.*, *supra* n. 22, at 17. (reporting that of the multiple-infant live births, 0.9% were triplets or more and 23.3% were twins).

[47] Connolly, *supra* n. 42, at 606.

[48] *NAT'L SUMMARY REP.*, *supra* note 22, at 18. (explaining that preterm infants are born before 37 full weeks of pregnancy and low birth weight infants are less than 2,500 grams, or about 5 pounds, 8 ounces).

[49] *NAT'L SUMMARY REP.*, *supra* note 22, at 18.

[50] Connolly, *supra* note 42 at 606.

[51] *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT'L CONF. OF ST. LEGISLATURES, http://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx. (last visited Oct. 27, 2017).

[52] *Id.*

[53] *NAT'L SUMMARY REP.*, *supra* note 22, at 18 (reporting the leading patient diagnosis was a male factor accounting for 33%. Remaining reasons for infertility included diminished ovarian reserve (32%), ovulatory dysfunction (15%), tubal factor (13%), endometriosis (9%), and uterine factors (6%)).

requirements that treatment is medically necessary, gametes come from a spouse, and maximum coverage limits.[54] The various mandates from each state are discussed below.

Among the fifteen states, only Texas and California require that insurance companies offer coverage, but do not mandate them to cover some form of infertility treatment.[55] Texas offers coverage for IVF procedures but has several limitations.[56] For example, Texas requires the sperm and egg come from the patient's spouse and that one of the individuals has a history of infertility for at least five years.[57] As a result, this law excludes unmarried persons and same-sex couples because both gametes must be obtained from each spouse.[58] Also, religious organizations are not required to offer coverage if it is contrary to their "moral principles."[59]

California also requires the insurer to only offer infertility coverage but does not mandate its benefit.[60] California excludes coverage of IVF for treatment of infertility but offers coverage of GIFT.[61] The code defines infertility as either "(1) the presence of a demonstrated condition recognized by a licensed physician . . . as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a

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[54] Valarie Blake, *It's an ART not a Science: State-Mandated Insurance Coverage of Assisted Reproductive Technologies and Legal Implications for Gay and Unmarried Persons*, 12 MINN. J.L. SCI. & TECH. 651, 665 (2011).

[55] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 51.

[56] TEX. INS. CODE ANN. art. 1366.003(a) (West 2017) ("[A]n issuer of a group health benefit plan . . . shall offer . . . coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.").

[57] § 1366.005(1)-(3). (outlinging how the individual may have a history of infertility or be diagnosed with one of the following: endometriosis, exposure to diethylstilbestrol, blockage of one or both fallopian tubes, or oligospermia).

[58] Blake, *supra* note 54, at 670.

[59] TEX. INS. CODE ANN. art. 1366.006 (West 2017).

[60] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 51.

[61] CAL. INS. CODE § 10119.6(a)-(b) (Deering 2014) ("[E]very insurer issuing. . .a policy of disability insurance that covers hospital, or surgical expenses on a group basis shall offer coverage of infertility treatment, except in vitro fertilizationFalse").

live birth" after at least a year of unprotected sex.[62] The legislation also includes a religious exemption like Texas;[63] however, the law explicitly requires coverage be offered without any discrimination on the basis of "domestic partner status . . . gender expression, gender identity . . . marital status . . . sex, or sexual orientation."[64] This anti-discrimination clause expressly protects same-sex and unmarried persons—a provision unfortunately not common in other states' mandates.[65]

The remaining thirteen states require coverage of infertility treatments and diagnoses but differ based on the extent of ART coverage specifically.[66] One of the first states to adopt an insurance mandate, Arkansas, requires all health insurance companies doing business in the state to include IVF as a benefit.[67] However, several restrictions apply pursuant to the rules set forth by the insurance commissioner, who has authority to do so from the mandate.[68] The regulation requires unexplained infertility for at least two years and, like Texas, the patient's spouse must fertilize the oocytes.[69] Furthermore, the policy may include a lifetime maximum benefit of $15,000.[70] The result of the spousal restriction excludes any unmarried person and same-sex couples that cannot contribute both of the necessary gametes.[71] Furthermore, same-sex couples that have an explained physical reason for infertility may not qualify.[72] Also, the lifetime cap presumably allows for insurance companies to stop coverage after only one cycle of IVF, based on the

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[62] § 10119.6(b).
[63] § 10119.6(d).
[64] § 10119.6(g).
[65] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* n. 51.
[66] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 51.
[67] ARK. STAT. ANN. § 23-86-118 (2017)*; see also Coverage by State,* RESOLVE: THE NAT'L INFERTILITY ASS'N, http://resolve.org/what-are-my-options/insurance-coverage/coverage-state (last visited Oct. 27, 2017) (reporting the mandate was originally enacted in 1987).
[68] *Rule and Regulation 1: In Vitro Fertilization*, ARK. INS. DEP'T (July 12, 1991), https://insurance. arkansas.gov/uploads/finalrules/rnr01.pdf.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*

average costs described above.[73]

Similarly, Hawaii only actually requires coverage of one cycle of IVF.[74] The sperm must come from the patient's spouse,[75] and the couple must prove a history of infertility for at least five years.[76] Therefore, similar to Arkansas and Texas, this mandate excludes unmarried persons and same-sex couples from obtaining coverage.

Rhode Island mandates coverage of only "medically necessary expenses of . . . infertility"[77] and a lifetime maximum benefit of $100,000.[78] Only women between twenty-five and forty-two years of age are covered, and up until 2017, they must have been married.[79]

Maryland also has a spousal requirement; however, it uniquely states that no health service plan may require a same-sex married couple to use the sperm of the patient's spouse or "demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse."[80] If the couple is of the same-sex, infertility may be proven by "six attempts of artificial insemination" over two years or a diagnosis of one of the listed medical conditions that proves infertility.[81] For married, opposite-sex couples, they must use their own gametes unless the husband is "unable to produce and deliver functional sperm."[82]

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[73] Jillian Casey et al., *Assisted Reproductive Technologies*, 17 GEO. J. GENDER & L. 83, 109 (2016).

[74] HAW. REV. STAT. ANN. § 431:10A-116.5(a) (West 2016) (All health insurance policies must offer a "a one-time only benefit for all outpatient expenses arising from in vitro fertilization. . .").

[75] § 431:10A-116.5(a)(3).

[76] § 431:10A-116.5(a)(4)(A).

[77] 27 R.I. GEN. LAWS ANN. § 27-18-30(a)-(b) (2017) (amending 27 R.I. GEN. LAWS ANN. § 27-18-30(a)-(b) (2007)).

[78] § 27-18-30(g).

[79] *Id.* ("[I]nfertility means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year.").

[80] MD. CODE ANN., INS. § 15-810(b)(1)-(2) (LexisNexis 2016).

[81] § 15-810(d)(3)(i)(2), (ii)(1)-(4) (defining that the associated medical conditions capable of proving infertility are endometriosis, exposure in utero to diethylstilbestrol, surgical removal of one or both of the fallopian tubes, or abnormal male factors).

[82] § 15-810(d)(2)(i)-(ii) (explaining that if the husband has been voluntarily sterilized,

Maryland requires all health plans that cover "pregnancy-related benefits" to include "all outpatient expenses arising from in vitro fertilization"[83] for up to three IVF cycles and like Rhode Island, a maximum lifetime benefit of $100,000.[84] Additionally, Maryland provides a religious exemption similar to the other states discussed above.[85]

Connecticut defines infertility as the inability to "conceive or produce conception or sustain a successful pregnancy" for at least one year.[86] The provision requires coverage of IVF, GIFT, and ZIFT; however, limitations apply. [87] The policy may stop coverage after two cycles of IVF[88] or after a patient turns forty.[89] The mandate also includes a religious exemption.[90]

Illinois offers coverage for IVF, GIFT, and ZIFT,[91] but like Connecticut and Maryland, a limited number of cycles could be covered.[92] Only up to four "completed oocyte retrievals" may be covered, and if a live birth follows a retrieval, then only coverage of two more are allowed.[93] Illinois defines infertility as "the inability to conceive after one year of unprotected sexual intercourse . . . ."[94] The mandate includes a religious exemption but defines infertility broadly

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the mandate to cover IVF may not apply).

[83] § 15-810(c)(2).

[84] § 15-810(e).

[85] § 15-810(i).

[86] CONN. GEN. STAT. § 38a-509(a) (2016).

[87] *Id.* (explaining that coverage only extends to "medically necessary expenses of the diagnosis and treatment of infertility").

[88] § 38a-509(b)(4).

[89] § 38a-509(b)(1).

[90] § 38a-509(c)(1).

[91] 215 ILL. COMP. STAT. ANN. § 5/356m(b)(1) (2016).

[92] § 5/356m(b)(1)(B).

[93] *Id.*

[94] § 5/356m(c) ("'[I]nfertility' means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy").

enough that it may be interpreted to include same-sex couples.[95]

Massachusetts defines infertility as the inability to conceive after one year, but extends coverage only to "medically necessary expenses" of infertility treatment and diagnosis.[96] The required benefits include IVF, GIFT, ZIFT, and banking of any sperm or inseminated eggs.[97] No exclusions may apply to prescription drugs for any of those benefits,[98] and there is no maximum lifetime dollar cap or limited number of cycles covered.[99] This mandate does not prevent unmarried or same-sex couples from obtaining coverage because it does not define infertility too narrowly or have a spousal restriction.

Montana,[100] Ohio,[101] and West Virginia[102] only list "infertility services" as a "basic health care service[]" that all Health Maintenance Organizations ("HMO") must provide. These states do not define infertility or list the type of services offered. Of these three states, only Ohio requires that any of the basic health care services covered be "medically necessary," but unlike Massachusetts, it does not expressly include IVF, GIFT, or ZIFT as coverable services.[103]

New Jersey lists several definitions of infertility that encompass all groups of people, including same-sex couples and unmarried persons.[104] The mandate extends to IVF, GIFT, ZIFT, and

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[95] Blake, *supra* note 54, at 705-06.

[96] MASS. GEN. LAWS ANN. ch. 175, § 47H (West 2016) (explaining that for woman under 35 years, infertility is the inability to conceive within one year. For woman over 35 years, it is the inability to conceive within 6 months).

[97] 211 MASS. CODE REGS. 37.05 (2016) (explaining that other benefits include artificial insemination, intrauterine insemination, intracytoplasmic sperm injection, assisted hatching, and cryopreservation of eggs).

[98] 211 MASS. CODE REGS. 37.06 (2016).

[99] 211 MASS. CODE REGS. 37.08 (2016).

[100] MONT. CODE ANN. § 33-31-102(3)(v) (2015).

[101] OHIO REV. CODE ANN. § 1751.01(A)(1), (h) (LexisNexis 2016) (explaining that infertility services are included as "[p]reventative health care services").

[102] W. VA. CODE § 33-25A-2(1) (2010).

[103] § 1751.01(A)(1) ("Basic health care services' means the following services when medically necessary . . . .").

[104] N.J. STAT. ANN. § 17:48-6x(a) (West 2016) ("'[I]nfertility means. . .a male is unable

medications.[105] However, New Jersey limits coverage to four completed egg retrievals and a maximum age of forty-five years.[106] The mandate also lists a religious exemption.[107]

Unlike the mandates already discussed, Louisiana does not mandate coverage of ART or even require insurers to offer it.[108] Louisiana only prevents health insurance policies from excluding coverage for "a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility."[109] However, this provision does not apply to requiring coverage of fertility drugs or any form of ART.[110]

Similar to Louisiana, New York also does not require coverage for IVF, GIFT, and ZIFT.[111] However, New York requires coverage of all diagnostic and treatment procedures as well as prescription drugs used for infertility.[112] The patient must be between twenty-one and forty-four years in age.[113] Interestingly, in an effort to improve access to infertility services, New York created a grant program funded by the tobacco control and insurance initiatives pool.[114]

Several statutory constructs appear throughout the language of the

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to impregnate a female; a female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse; a female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse. . .partners are unable to conceive as a result of involuntary medial sterility; [or] a person is unable to carry a pregnancy to live birth. . . .").

[105] N.J. STAT. ANN. § 17:48A-7w(a) (West 2016).

[106] *Id.*

[107] § 17:48A-7w(b).

[108] LA. STAT. ANN. § 22:1036(A)(2) (2016).

[109] § 22:1036(A)(1).

[110] § 22:1036(A)(2)(a)-(c).

[111] N.Y. INS. LAW § 3221(6)(C)(v) (Consol. 2016).

[112] § 3221(6)(C).

[113] § 3221(6)(C)(i).

[114] N.Y. PUB. HEALTH LAW § 2807-v(1)(jj) (Consol. 2016) (explaining that the program was created in 2002).

mandates.[115] California, Illinois, and New Jersey require that the individuals have unprotected sex without a successful pregnancy.[116] Illinois,[117] Maryland,[118] Massachusetts,[119] New Jersey,[120] Arkansas,[121] California,[122] Connecticut,[123] Texas,[124] and Hawaii[125] require some formal time period before infertility is determined. States that expressly exclude unmarried persons by requiring one or both gametes to come from a spouse are Hawaii,[126] Arkansas,[127] Maryland,[128] and Texas.[129] This undoubtedly excludes unmarried persons and may have implications on same-sex couples, even if they are married, because they cannot offer both an egg and sperm. Maryland offers the best provision related to this restriction because they specifically exclude same-sex couples from that requirement, but nevertheless, unmarried persons are omitted.[130]

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[115] Blake, *supra* note 54, at 651, 665.

[116] Blake, *supra* note 54, at 667. (acknowledging that New Jersey has the most restrictive mandate in this group because the state requires there be an abnormality in the reproductive system, which could exclude same-sex couples).

[117] ILL. ADM. CODE tit. 50, § 2015.30 (2017) (requiring one year).

[118] MD. CODE ANN., INS. § 15-810(d)(3) (LexisNexis 2016) (requiring two years for same-sex couples).

[119] MASS. GEN. LAWS ch. 175, § 47H (2016) (requiring one year if the female is age thirty-five and younger or during a period of six months if the female is over the age of thirty-five).

[120] N.J. STAT. ANN., *supra* note 105 (requiring one year).

[121] *In Vitro Fertilization*, RULE AND REG. 1, https://insurance.arkansas.gov/ uploads/ finalrules/rnr01.pdf. (last visited Oct. 28, 2017) (requiring two years).

[122] CAL INS. CODE § 10119.6(b) (West 2016) (requiring one year).

[123] CONN. GEN. STAT. § 38a-509(a) (2016) (requiring one year).

[124] TEX. INS. CODE ANN. art. § 1366.005(3) (West 2015) (requiring five years).

[125] HAW. REV. STAT. § 431:10A-116.5(a)(4)(A) (2016) (requiring five years).

[126] § 431:10A-116.5(a)(3).

[127] *In Vitro Fertilization*, *supra* note 121.

[128] MD. CODE ANN., INS. § 15-810(d)(3) (West 2016) (requiring that if the individual is in a heterosexual relationship, the gametes must come from the individual's spouse).

[129] TEX. INS. CODE art. § 1366.005(2) (West 2015).

[130] § 15-810(a)-(d).

Connecticut,[131] Massachusetts,[132] Ohio,[133] and Rhode Island[134] all require the expenses be "medically necessary." Massachusetts defines medical necessity statutorily;[135] Ohio does not define the term in the relevant section but does define medical necessity under its Medicaid services code;[136] Connecticut includes the definition in its health insurance code;[137] and Rhode Island does not define the term in its laws referring to health insurance.[138] These definitions require some disease or abnormality with the patient, potentially excluding same-sex couples with normal functioning reproductive systems.[139] In summary, just two words in a mandated benefit can impact the coverage of ART for an entire group of people.

For all the states that mandate some form of infertility coverage, none require self-insured employers to abide by the mandates, pursuant to the Employee Retirement Income Security Act of 1974.[140] This excludes a large portion of the work force, amounting to approximately

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[131] CONN. GEN. STAT. § 38a-509(a) (2016).

[132] MASS. ANN. LAWS ch. 175 § 47H (LexisNexis 2016).

[133] OHIO REV. CODE ANN. § 1751.01(A) (LexisNexis 2016).

[134] 27 R.I. GEN. LAWS § 27-18-30(a) (2016).

[135] 130 MASS. CODE REGS. 450.204 (LexisNexis 2016) ("A service is 'medically necessary' if: (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service . . . .").

[136] OHIO ADMIN. CODE 5160-1-01 (2016) ("Medical necessity. . .is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease, or its symptoms. . .and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or party; or significant pain and discomfort.").

[137] CONN. GEN. STAT. § 38a-482a(a) (2016) ("'Medically necessary' . . . means health care services that a physician. . .would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms . . . .").

[138] 27 R.I. GEN. LAWS § 27-18-31.1 (2016).

[139] § 5160-1-01.

[140] *2015 Employer Health Benefits Survey*, KAISER FAMILY FOUND. (Sept. 22, 2015), http://kff.org/report-section/ehbs-2015-section-ten-plan-funding/ (reporting all self-funded plans are exempt from state insurance laws that mandate benefits).

63% of all employees.[141] In addition, experts believe that the Affordable Care Act has done little to expand infertility coverage.[142] Ultimately, definitions of infertility and mandated benefits are left up to the individual states, and unfortunately, thirty-five states do not even mention infertility in their insurance codes.[143] All of these inconsistencies lead to gaps in coverage, and large populations of people forced to choose between out-of-pocket financing or having no genetically related offspring at all.[144]

III. ECONOMIC ARGUMENTS FOR BROADER ACCESS

Health care spending in the United States has notoriously accounted for one of the highest shares of the gross domestic product.[145] Therefore, increase in access to health care, in general, has led to concerns over whether that is the most sustainable and viable option. Because of its high cost, ART depends on financial assistance in order to increase access, but the reality of the United States' current health care expenditures without universal coverage of ART has prevented that goal.[146] Over the past few decades, as more states have adopted insurance mandates requiring insurers to provide coverage for ART,[147] research on the cost-effectiveness of these laws has indicated a minimal effect on health care spending.[148]

Several studies have shown that broader coverage of ART

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[141] *Id.* ("[L]arge firms (200 or more workers) are significantly more likely to be in a self-funded plan than covered workers in small firms (3-199 workers) (83% vs. 17%).").

[142] Tara Siegel Bernard, *Insurance Coverage for Fertility Treatments Varies Widely*, N.Y. TIMES (July 25, 2014), http://www.nytimes.com/2014/07/26/your-money/health-insurance/insurance-coverage-for-fertility-treatments-varies-widely.html?_r=1.

[143] *See Id.*

[144] *See Id.*

[145] *See Historical*, CTR. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/research-statistics-data-and-systems/statistics-trendsandreports/nationalhealthexpenddata/nationalhealthaccountshistorical.html. (last visited Oct. 29, 2017) (providing that health spending accounted for 17.5% of the GDP in 2014.)

[146] *See Id.*

[147] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 51.

[148] *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 51.

services would be a small, fractional increase of a typical insurance premium.[149] One study used the American Medical Association benefits package for currently employed persons and calculated only a $2.79 increase in costs per year and a premium increase of $3.14, resulting in only a "minute fraction of the annual cost of a typical family benefits program . . . ."[150]

In a similar study, investigators concluded that the cost of ART for an HMO in Massachusetts would only be "$2.49 [per member] per annum."[151] Additionally, a global study that compared regulatory and economic factors of ART in developed countries found that "the total direct costs of ART did not exceed 0.25% of public and private expenditure on healthcare, indicating that the economic burden of ART treatment to society . . . is not substantial."[152]

Another study found a cost-effective result on a group insurance plan costs over a seven-year period after implementing the Massachusetts insurance mandate.[153] This study found that expenditures for infertility services, which included "fertilization and transfer of donor gametes," decreased the total expenditures from 0.8% to 0.4% for a group health

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[149] John A. Collins et al., *An Estimate of the Cost of In Vitro Fertilization Services in the United States in 1995*, 64 FERTILITY & STERILITY 538 (1995); Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 FERTILITY & STERILITY 22 (1998).

[150] Collins, *supra* note 149 (suggesting that according to a survey performed around the same time, respondents were "willing to pay $32 per year for a public program that would provide 200 IVF cycles per million population per year." This suggests that regardless of the low economic burden it would have on the public, members of a health plan may want to pay extra to offer that service to the entire population).

[151] Dennis A. Hidlebaugh et al., *Cost of Assisted Reproductive Technologies for a Health Maintenance Organization*, 42 J. REPROD. MED. 570, 573 (1997) (concluding that this cost is "is much less than we spend for organ transplantation and mental health").

[152] Chambers, *supra* note 7, at 2291 (stating that this conclusion is supported by "a number of cost analyses of ART as part of medical insurance plans").

[153] Griffin, *supra* note 149, at 28 ("The available data indicate that the consumer savings in terms of reduced insurance premiums that would result from benefit limits on infertility-related services would be small relative to total premiums.").

insurance plan before the mandate and after the mandate, respectively.[154] The study proposed several reasons for this surprising result.[155] First, they found an increase in success rates of IVF procedures, thus decreasing the number of total cycles required to achieve a live birth.[156] Second, ART has replaced other expensive, more invasive and risky therapies for infertility like tuboplasty.[157] By offering more successful and less risky procedures, additional medical expenses usually spent on complications were saved.[158] Third, the authors stated that the most cost-effective method for providing ART services has been within HMOs that use capitation models to fund these procedures.[159]

These studies show that adding coverage for ART services would have a low burden on insurance companies and their members.[160] It is important to note that all premiums of the plans would pay into this pool of money for ART services, regardless of whether its members utilize the services or not. Therefore, spreading the cost over a large population decreases each individual financial contribution and also, as shown above, makes up a small proportion of the total expenditures for the insurance company.

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[154] Griffin, *supra* note 149, at 25.

[155] Griffin, *supra* note 149, at 27.

[156] Griffin, *supra* note 149, at 27 ("From 1985–1993, the success rates of IVF procedures, expressed in terms of live deliveries per initiated cycles, have nearly tripled, from an estimated 5.4% in 1985 to 16% in 1993.").

[157] Griffin, *supra* note 149, at 27 (stating "comparative cost analyses have suggested that IVF is cost-effective compared with alternative therapies such as tuboplasty"); *see Tuboplasty*, MONTGOMERY FERTILITY CENT., http://www.montgomeryfertilitycenter.com/tuboplasty.php (last visited Oct. 30, 2017); *see also* Collins et al., *supra* note 149, at 542 ("Providing reasonable access to IVF treatment is likely yield savings in the cost of other treatments, such as tubal surgery, which is more invasive and entails additional risk." Tuboplasty refers to surgical procedures that attempt to restore the function of the fallopian tubes).

[158] Griffin, *supra* note 149, at 26.

[159] Griffin, *supra* note 149, at 27 ("Perhaps the most important cost-saving measure, however, was provider arrangements and capitation plans within the HMO groups that led to substantial discounts for infertility-related services in general and ART services in particular within Massachusetts.").

[160] Griffin, *supra* note 149, at 28.

In addition to having a low financial burden on the population, insurance coverage mandates for ART are more economically beneficial than no mandate at all.[161] In a study that compared ART outcomes between a state with an insurance mandate (Massachusetts) and two without (Michigan and Florida), the researchers found several economic reasons for broader coverage.[162] They concluded that in the state with a mandate, fewer embryos were transferred and there were lower rates of multiple births and preterm delivery.[163] With a reduction in these outcomes, the total medical costs associated with them decreased as well.[164] This, in turn, correlated to a lower financial burden on the payer of these medical costs—the insurer.[165] By having a mandate that comprehensively regulates the utilization of ART services and provides "limitations on the number of embryos transferred," the state reduces the number of multiple births and therefore achieves a greater cost-saving effect compared to a non-mandate state.[166]

Due to the pivotal role costs play in access to ART, the economic benefit of mandating coverage throughout the United States is more persuasive.[167] While ART is expensive for individuals, research has shown that it is affordable for society.[168] Unfortunately, insurance mandates have excluded certain people from accessing ART. These

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[161] *See, e.g.,* Sheree L. Boulet et al., *Embryo Transfer Practice and Perinatal Outcomes by Insurance Mandate Status*, 104 FERTILITY & STERILITY 403 (2015).

[162] *Id.* (using birth certificate data to compare outcomes between a state with an insurance mandate requiring coverage of IVF services (Massachusetts) and two states without a mandate (Florida and Michigan), and finding the main outcomes measured were number of embryos transferred, multiple births, low birth weight, and preterm delivery).

[163] *Id.* (noting that while there were improved perinatal outcomes in the mandate state, there were also higher rates of ART use that offset the net reduction in multiple birth rates).

[164] *Id.* at 404.

[165] *Id.*

[166] *Id*. at 409.

[167] Chambers, *supra* note 7, at 2292 ("ART is expensive from an individual's perspective but not in terms of national healthcare expenditure. The financial burden placed on patients to pay for treatment was the most important driver of utilization False").

[168] Chambers, *supra* note 7, at 2292.

marginalized populations pay for health insurance that covers prenatal care and childbirth, but they fail to ever obtain those benefits themselves.[169] Instead of formulating mandates that exclude groups based on social preferences, the state legislatures should focus on requirements based on clinical criteria, like the number of embryos transferred, to prevent expensive outcomes. In order to relieve the financial burdens from these downstream medical costs, states should offer broader coverage as a more economically favorable option.

IV. SOCIAL ARGUMENTS FOR BROADER ACCESS

States that limit same-sex couples and unmarried persons from obtaining coverage marginalize these groups and prevent equitable access to ART. Social arguments for and against health insurance coverage for same-sex couples of ART focus on the health and well-being of the children.[170] Some believe that children are disadvantaged if they grow up with two parents of the same sex.[171] People with such a belief argue that a homosexual lifestyle is "unstable and . . . fundamentally incapable of providing children the security they need."[172] However, many studies show that same-sex marriages are not harmful to children and some even show that children thrive more in these households.[173] Furthermore, in light of *Obergefell v. Hodges*, the equal liberty of same-sex couples to marry has been formally recognized, and, therefore, the social construct of who makes up a family has changed.[174] This Section assesses the social and psychological reasons why broader access to ART for same-sex couples will not harm the children conceived through its methods.

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[169] Chambers, *supra* note 7, at 2288-90 (discussing factors related to the availability of healthcare).

[170] *See* Timothy J. Dailey, *Homosexual Parenting: Placing Children at Risk*, ORTHO DOXYTODAY.ORG, http://www.orthodoxytoday.org/articles/DaileyGayAdopt. php (last visit Oct. 21, 2017).

[171] *Id.*

[172] *Id.*

[173] Nicole Rank, *Barriers for Access to Assisted Reproductive Technologies by Lesbian Women: The Search for Parity Within the Healthcare System*, 10 HOUSING J. HEALTH L. & POL'Y 115, 128 (2010).

[174] Obergefell v. Hodges, 135 S. Ct. 2584, 2608 (2015).

A. Against Same-Sex Parenthood

One of the leading scholars who believes being parented by homosexuals hurts a child's development, and who has been cited in many legal forums, is Lynn D. Wardle, a Brigham Young University law professor.[175] Wardle believes that "the most obvious risk to children from their parents' homosexual behavior . . . [is that they] will develop homosexual interests and behaviors" themselves.[176] Other "risks" include boys having "a lower self-image regarding masculinity" and children of lesbian couples having more issues with stress, discipline, their own sexuality, and integrity of their family.[177] Wardle goes on to suggest that only heterosexual marriages, which are "deeply rooted in our society and legal system," are capable of experiencing "responsible sexual relations," whereas homosexual relationships are at greater risk of extramarital relationships that ultimately damage a child's faith in marriage.[178] Finally, Wardle states that since "there are gender-linked differences in child-rearing skills," having both a mother and father is most advantageous to maximizing a child's development.[179] He argues that the mere act of nurturing a child, which can be performed by either gender, is not enough to provide for healthy child development, and that "dual-gender parenting" is best to prevent the risks associated with homosexual parenting.[180]

Wardle attempts to discredit the studies that show positive child-rearing by homosexual parents because they are based on small sample sizes and not randomly selected participants.[181] On the other hand, proponents for same-sex parenting believe scholars like Wardle base their findings on "only limited, and often implicit, theoretical explanations,"[182] and stem from a time when discrimination against

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[175] *See* Lynn D. Wardle, *The Potential Impact of Homosexual Parenting on Children*, 1997 U. ILL. L. REV. 833, 833 (1997).
[176] *Id.* at 852.
[177] *Id.* at 854-55.
[178] *Id.* at 855-56.
[179] *Id.* at 857.
[180] *Id.* at 864.
[181] *Id.* at 845-46.
[182] Judith Stacey & Timothy J. Biblarz, *(How) Does the Sexual Orientation of Parents*

homosexuals had been "institutionalized."[183] Since the publication of Wardle's article in 1997, many studies have been published that not only counter Wardle's beliefs, but also disprove them.[184]

B. For Same-Sex Parenthood

Based on 2014 census data, same-sex households[185] accounted for approximately 1% of all households in the United States.[186] This percentage has only increased since then, particularly after the pivotal *Obergefell* decision that held same-sex couples were able to marry in every state.[187] Therefore, the relevance of same-sex parenthood is increasing, and the access to ART for same-sex couples as one of the only ways to start a family is becoming more important. The welfare of the children in these homes has been questioned, but for many reasons, same-sex parenthood has a positive and beneficial impact on children.[188]

Many studies have debunked the outdated assertions Wardle has made about opposite-sex couples and their providing a better, less risky living environment for children.[189] The most important notion to disprove first accounts for the most prejudicial views against same-sex parenthood: "children of [homosexual] parents suffer higher levels of emotional and psychological harm."[190] In an analysis of twenty-one studies dating back to 1980, the authors found no difference between children raised in same-sex households and opposite-sex households in

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Matter?, 66 AM. SOC. REV. 159, 162 (2001).

[183] *Id.* at 160.

[184] *See generally id.* (citing several studies in opposition to Wardle's view).

[185] *Glossary*, U.S. CENSUS BUREAU, https://www.census.gov/glossary/#term_House hold (last visited Oct. 22, 2017).

[186] Daphne Lofquist, *Same-Sex Couple Households*: *American Community Survey Briefs*, U.S. CENSUS BUREAU 1, 1 (2011), https://www.census.gov/ prod/2011pubs/ acsbr10-03.pdf.

[187] *See* Gary J. Gates & Taylor N.T. Brown, *Marriage and Same-Sex Couples After Obergefell*, THE WILLIAMS INST. 1, 1, 3-4 (2015), https://williamsinstitute.law.ucla.edu/ wp-content/uploads/Marriage-and-Same-sex-Couples-after-Obergefell-November-2015.pdf.

[188] Stacey & Biblarz, *supra* note 182, at 171-72.

[189] *See* Stacey & Biblarz, *supra* note 182, at 160, 170-72.

[190] Stacey & Biblarz, *supra* note 182, at 171.

terms of many psychological determinants, including, but not limited to, "self-esteem, anxiety, depression, internalizing behavioral problems, . . . emotional difficulty, [and] conduct difficulty. . . ."[191] While the analysis accepted the evidence that these children are more often subject to homophobic teasing, the authors found children of same-sex parents display an "impressive psychological strength."[192] In fact, children of lesbian mothers report a "greater sense of overall well-being."[193] Furthermore, the analysis found no statistical difference between children of same-sex and opposite-sex couples firmly "identify[ing] as bisexual, lesbian, or gay."[194] This directly competes with Wardle's belief that children with homosexual parents will more likely develop homosexual interests themselves.[195]

Furthermore, the analysis reveals that nonbiological lesbian mothers have greater skill and involvement with children than stepfathers.[196] "Lesbian partners . . . [have] greater . . . synchronicity in parenting than . . . heterosexual [parents]."[197] These findings conflict with Wardle's belief that "dual-gender parenting" is more advantageous than same-sex parenting.[198] Lesbian mothers overall have more synergy "that brings more egalitarian, compatible, shared parenting and time spent with children, a greater understanding of children, and closeness and communication between parents and children."[199] This analysis of over twenty studies completed over a period of twenty years discredits traditional and outdated beliefs that same-sex couples cannot provide a stable home for children.[200] In fact, this conclusion aligns with the Supreme Court of Vermont's views of ART: there "is no reasonable basis to conclude that a same-sex couple's use of the same technologies would undermine the bonds of parenthood, or society's perception of

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[191] Stacey & Biblarz, *supra* note 182, at 169.
[192] Stacey & Biblarz, *supra* note 182, at 172.
[193] Stacey & Biblarz, *supra* note 182, at 171-72 n.12.
[194] Stacey & Biblarz, *supra* note 182, at 171-72.
[195] Wardle, *supra* note 175, at 852.
[196] Stacey & Biblarz, *supra* note 182, at 174.
[197] Stacey & Biblarz, *supra* note 182, at 174.
[198] Wardle, *supra* note 175, at 864.
[199] Stacey & Biblarz, *supra* note 182, at 175.
[200] Stacey & Biblarz, *supra* note 182, at 170.

parenthood."[201]

Ultimately, broadening access to ART to enable same-sex couples to create families will not socially harm the children born using these methods.

V. LEGAL ARGUMENTS FOR BROADER ACCESS

ART dates back to the 1970s with the birth of the first IVF baby, Louise Brown.[202] The advent of these technologies for purposes of artificially creating offspring created changes in the construct of the traditional family.[203] As seen with other science innovations, the law lagged, and legislators contemplated how the legal system would react and regulate these new life-changing technologies.[204] The first insurance mandates were not enacted until almost a decade after use of IVF began.[205] At this time, same-sex couples as possible users of these technologies were not a major focus of legislators.[206] Therefore, access to these technologies by same-sex couples was severely limited from the onset.

Over time, the lesbian and gay communities have celebrated the

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[201] Baker v. State, 744 A.2d 864, 882 (1999) (holding that excluding same-sex couples from legal benefits and protections was unconstitutional).

[202] Remah M. Kamel, *Assisted Reproductive Technology After the Birth of Louise Brown*, 14 J. REPROD. INFERTILITY 96, 96 (2013) (describing that the beginning of IVF began in the United Kingdom and spread throughout the world quickly after the birth of Louise Brown; and the first American IVF clinic was opened in 1980 and the first American IVF baby was born in 1981).

[203] *Id.* at 97.

[204] *See Assisted Reproductive Technology Laws and Representation*, NEXT PHASE LEGAL & DISP. RESOL., https://www.nextphaselegal.com/services/family-law/assisted-reproductive-technology. (last visited Nov. 5, 1017).

[205] NAT'L CONF. OF ST. LEGISLATURES, *supra* note 51 (depicting the first mandates were enacted in 1987 in Montana, Texas, Massachusetts and Arkansas).

[206] Jillian Casey et al., *Assisted Reproductive Technologies*, 17 GEO. J. GENDER & L. 83, 116 (2016) ("Because the legal structure surrounding assisted reproductive technology was crafted largely without same-sex couples in mind, and in isolation from other regulations of family relationships, the legal regime has provided same-sex couples substantially less security and protection than it has to opposite-sex couples.").

recognition of equal rights in many social contexts like marriage and reproductive privacy.[207] In terms of sexual orientation, the Supreme Court has reviewed state laws with a slightly higher standard than rational basis review, but nevertheless refused to validate laws created for impermissible purposes like animus.[208] In terms of marital status, the Court has used a general rational basis review.[209] The developing equitable legal treatment of these historically slighted populations should encourage insurance companies and states to increase access to ART, no matter their sexual orientation, gender identity, or marital status.

This section will relate insurance coverage for ART to cases that have afforded equality to same-sex couples[210] as well as precedent that has expanded reproductive rights.[211]

A. Skinner v. Oklahoma and Others

As one of the first Supreme Court cases that recognized a right to reproduce, *Skinner* guaranteed the equal protection of laws designed to limit an individual's decision to procreate.[212] The Court heard this case after recognizing that Oklahoma had "deprive[d] certain individuals of a right which is basic to the perpetuation of a race—the right to have offspring."[213] This case established procreation as a fundamental right.[214] Furthermore, it recognized that when a law "lays an unequal hand" on an issue, it contradicts the "guaranty of 'equal protection of the laws'" that

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[207] *See* Obergefell v. Hodges, 135 S. Ct. 2584, 2588 (2015); Stanley v. Illinois, 405 U.S. 645, 651 (1972) (quoting Skinner v. Oklahoma, 316 U.S. 535, 541 (1942)) ("The rights to conceive and to raise one's children have been deemed essential, 'basic civil rights of man,' and rights far more precious than property rights.").

[208] Romer v. Evans, 517 U.S. 620, 632 (holding a state law that disadvantaged gays and lesbians invalid, in part because it seemed "inexplicable by anything but animus toward the class it affect[ed]; it lack[ed] a rational relationship to legitimate state interests.").

[209] Eisenstadt v. Baird, 405 U.S. 438, 447 (1972) ("[T]he question for our determination in this case is whether there is some ground of difference that rationally explains the different treatment accorded married and unmarried persons . . . .").

[210] *See Obergefell*, 135 S. Ct. at 2584; Lawrence v. Texas, 539 U.S. 558, 575 (2003).

[211] 405 U.S. at 438; Skinner v. State, 316 U.S. 535, 541 (1942).

[212] *Skinner*, 316 U.S. at 541.

[213] *Id*. at 536.

[214] *Id.* at 541.

the Constitution requires in the Fourteenth Amendment.[215] While this case referred specifically to sterilization laws, it recognized the Supreme Court's concern for reproductive rights and the invalidity of laws that attempt to treat people differently by limiting some individuals' choices to procreate and not others.[216] The insurance mandates, particularly those with spousal restrictions like Texas and Hawaii, explicitly restrict unmarried persons from access to coverage while permitting access to married couples. This exclusion on its face "lays an unequal hand" and creates an "unmistakable discrimination" against single individuals.[217] Therefore, according to *Skinner*, states that adopt limitations on the right to reproduce have the burden of proving their statutory scheme does not violate "the constitutional guaranty of just and equal laws."[218]

Some states require ART insurance coverage be limited to "medically necessary" services,[219] and in the eyes of the public, procreating is a voluntary choice and not deemed necessary to living a healthy life.[220] However, this contradicts the Supreme Court's view in *Skinner* that recognized procreation as "fundamental to the very existence and survival of the race."[221] While no court has stated that procreation specifically using ART is a fundamental right, the states that place these unequal coverages limit the basic procreative liberty afforded to homosexual, and unmarried persons under *Skinner*. At the very least, the

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[215] *Id.*

[216] Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457, 1474-75 (2008) (recognizing that there is "no constitutional right to engage in assisted reproduction as a matter of reproductive autonomy" but argues that government, nevertheless, does not have "free rein" to allow ARTs in some situations but forbid it in others).

[217] *Skinner*, 316 U.S. at 541.

[218] *Id.* at 541; *see also* Catherine DeLair, *Ethical, Moral, Economic and Legal Barriers to Assisted Reproductive Technologies Employed by Gay Men and Lesbian Women*, 4 DEPAUL J. HEALTH CARE L. 147, 178 (2000) ("If the Supreme Court were to adopt a broad interpretation of the right to procreate to include a right to procreate using assisted reproductive technologies, states would have the burden of justifying any restriction on access to assisted reproductive technology.").

[219] *Supra* notes 131-33 (describing Connecticut, Massachusetts, Ohio, and Rhode Island all only cover "medically necessary" infertility services).

[220] Rank, *supra* note 173, at 131.

[221] Skinner, 316 U.S. at 541.

dictum in *Skinner* offers protection against laws that offer "no redemption for the individual whom the law touches" and who is "forever deprived of a basic liberty."[222] By restricting ART coverage to "medically necessary" services, people with healthy reproductive systems that lack the contribution from the opposite sex to naturally conceive may not qualify and, therefore, may be left with no alternative, but to seek outside financial assistance. This creates a high risk that these neglected populations—same-sex couples and unmarried persons—are "forever deprived" of this fundamental right to procreate.[223]

Opponents will argue that while there exists a basic right to reproduce, the government does not have to provide assistance for its exercise. In *Maher v. Roe*, the Court recognized the "difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy."[224] In this case, the Court upheld a state law that conditioned its public financial aid for abortion on a showing of "medical necessity" because the state had a "reasonable basis for the classification."[225] Therefore, the Court allowed the state to exclude funding for nontherapeutic abortions.[226]

Here, however, several differences exist between *Maher* and the insurance mandates expanding coverage to ART. States that have adopted spousal restrictions for ART have decided to encourage access to these technologies, but in a way that directly interferes with its use among certain groups and violates the fundamental principle in *Skinner*—the right of procreation and its protection against state interference.[227] Further, *Maher* dealt with public funds whereas many

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[222] *Id.*

[223] *Id.*

[224] 432 U.S. 464, 475 (1977); *see also* Harris v. McRae, 448 U.S. 329, 347 (1980) ("Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom.").

[225] *Maher*, 432 U.S. at 479.

[226] *Id.* at 480.

[227] Skinner v. State, 316 U.S. 535, 541 (1942).

insurance mandates extend to any health plan offered in the state.[228] Therefore, the holding in *Maher* to specially "not proscribe government funding" would not apply to any insurance mandate relating to private insurance contracts in the state.[229]

Finally, *Maher* did not involve discrimination of a "suspect class" based on financial need and thus did not violate the Equal Protection Clause.[230] While homosexuals have not explicitly been deemed a suspect class, the Supreme Court in *Romer v. Evans* explained how a law that imposed a "broad and undifferentiated disability" on homosexuals, a group deemed "politically unpopular," was not rationally related to any "legitimate state interests."[231] This case suggested that the Supreme Court may apply heightened scrutiny when resolving issues of discrimination based on sexual orientation.[232] Similarly, the Supreme Court in *Lawrence v. Texas* invalidated another state law for criminalizing only homosexual sodomy because it did not further any "legitimate state interest which can justify its intrusion into the personal and private life of the individual."[233] As Justice O'Connor noted in her

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[228] 27 R.I. GEN. LAWS § 27-18-30(a) (2016) ("Any health insurance contract, plan or policy delivered or issued for delivery or renewed in this stateFalse").

[229] 432 U.S at 480.

[230] *Id.* at 470-71.

[231] 517 U.S. 620, 632, 634 (1996) (invalidating a Colorado state law that prohibited any state action to protect homosexual persons).

[232] Jeremy B. Smith, *The Flaws of Rational Basis with Bite: Why the Supreme Court Should Acknowledge its Application of Heightened Scrutiny to Classifications Based on Sexual Orientation*, 73 FORDHAM L. REV. 2769, 2770 (2005); *see* United States v. Windsor, 133 S. Ct. 2675, 2693 (2013) (holding that the Defense of Marriage Act ("DOMA") is unconstitutional as a violation of the Due Process Clause, stating that "[i]n determining whether a law is motivated by an improper animus or purpose. . .'[d]iscriminations of an unusual character' especially require careful consideration."); *see also* Windsor v. United States, 699 F.3d 169, 181-82 (2d Cir. 2012) (applying "heightened scrutiny" to the review of DOMA after finding that homosexuals are a quasi-suspect class based on factors set forth by the Supreme Court: "A) homosexuals as a group have historically endured persecution and discrimination; B) homosexuality has no relation to aptitude or ability to contribute to society; C) homosexuals are a discernible group with nonobvious distinguishing characteristics, especially in the subset of those who enter same-sex marriages; and D) the class remains a politically weakened minority.").

[233] 539 U.S. 558, 578 (2003).

concurring opinion in *Lawrence*, "[w]hen a law exhibits such a desire to harm a politically unpopular group, we have applied a more searching form of rational basis review to strike down such laws under the Equal Protection Clause."[234] Therefore, laws that prejudice sexual orientation may require states to show a greater governmental interest than laws implicating non-suspect classes.[235]

In addition to the fundamental right to procreate, the Court in *Eisenstadt v. Baird* protected the intimate decision to procreate beyond *Skinner*.[236] In *Eisenstadt*, the Court equated a ban on contraceptives for unmarried persons to the decision made in *Griswold v. Connecticut* that invalidated such a rule for married persons.[237] The Court in *Eisenstadt* explained that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[238] Ultimately, the Court held that "providing dissimilar treatment for married and unmarried persons who are similarly situated . . . violate[d] the Equal Protection Clause."[239]

The reasoning in *Eisenstadt* shows that the Supreme Court did not find any legitimate governmental interest that "rationally explain[ed] the different treatment" of individuals based on marital status.[240] Insurance mandates that explicitly restrict unmarried individuals from accessing ART, like the one in Texas,[241] are at risk of courts invalidating them as seen in *Eisenstadt*. Furthermore, the mere suggestion that unmarried couples cannot procreate with their own gametes is unreasonable.[242] By

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[234] *Id.* at 580; *see also* Smith, *supra* n. 232, at 2774.

[235] Smith, *supra* n. 232, at 2772.

[236] 405 U.S. 438, 453 (1972).

[237] *Id.* at 454; *see generally* Griswold v Connecticut, 381 U.S. 479, 485 (1965) (striking down a state law that criminalized the use of contraceptives by married couples because it violated their "penumbral rights of 'privacy'").

[238] 405 U.S. at 453.

[239] *Id.* at 454-55 (citations omitted).

[240] *Id.* at 447; *see* Rao, *supra* note 216, at 1475.

[241] TEX. INS. CODE ANN. § 1366.005(1)-(3) (West 2017).

[242] Rao, *supra* note 216, at 1475-76 (believing that laws governing ART "must at the

creating ART laws that allow for the inclusion rather than the exclusion of these disparate populations, legislatures can align more with the policy rationales set forth by the Supreme Court and subsequently increase access to these important technologies.

B. Obergefell v. Hodges

The most recent landmark decision to impact the rights of homosexuals has offered more legal persuasion to broaden insurance coverage for ART. The case originated from states that only recognized marriage "as a union between one man and one woman."[243] In dictum, the Court explained that the definition of freedom recognized by the Framers of the Constitution and Bill of Rights changes with each generation and adapts to new insights over time.[244] The Court even commented on fundamental rights beyond marriage by stating that decisions, such as those concerning procreation and childrearing, "are among the most intimate that an individual can make" and are "a central part of the liberty protected by the Due Process Clause."[245] Furthermore, the Court recognized the injustice of invalidating same-sex marriage by stating that "[s]ame[-]sex couples are consigned to an instability many opposite-sex couples would deem intolerable in their own lives."[246] The Court relied on the Equal Protection Clause and the Due Process Clause to "prohibit[] this unjustified infringement of the fundamental right to

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very least be based upon a legitimate governmental interest in order to be constitutional." Therefore, any law "limiting ARTs to married persons or to heterosexual persons should fail because it would treat . . . [people] . . . differently based upon marital status or sexual preference . . . ."); *see also* Blake, *supra* note 54, at 685.

[243] *Obergefell*, 135 S. Ct. at 2593. (reviewing cases that arose from Michigan, Kentucky, Ohio, and Tennessee).

[244] *Id.* at 2598 ("The generations that wrote and ratified the Bill of Rights and the Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning. When new insight reveals discord between the Constitution's central protections and a received legal structure, a claim to liberty must be addressed.").

[245] *Id.* at 2599-2600.

[246] *Id.* at 2601.

marry."[247] As such, the Court firmly recognized the right to marriage for same-sex couples.[248]

The *Obergefell* decision has profoundly disrupted the legal barriers same-sex couples once dealt with on a daily basis in society. The Court's opinion serves as a major protection against any denial of fundamental rights on the basis of gender or sexual orientation, and grouping the right to marry with procreation and childrearing may have a notable influence on ART access.[249] While the effects may take time to realize, the spousal restrictions and inequitable effects that several insurance mandates have on same-sex couples may be the first to be challenged after *Obergefell*.

The dissent in *Obergefell* believed the states that have failed to provide licenses to marry to same-sex couples have merely "refused to grant them governmental entitlements" that the fundamental right to marriage does not involve.[250] However, this belief fails to recognize the liberties associated with legal marriage like "taxation; inheritance and property rights; . . . hospital access; medical decision making authority; . . . the rights and benefits of survivors; [and] birth and death certificates . . . ."[251] Without the state's legal recognition of marriage,

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[247] *Id.* at 2604 ("It is now clear that the challenged laws burden the liberty of same-sex couples, and it must be further acknowledged that they abridge central precepts of equality. Here the marriage laws enforced by the respondents are in essence unequal: same-sex couples are denied all the benefits afforded to opposite-sex couples and are barred from exercising a fundamental right.").

[248] *Id.* at 2599 ("[S]ame-sex couples may exercise the right to marry. . . . [T]he reasons marriage is fundamental under the Constitution apply with equal force to same-sex couples.").

[249] *See* Jillian Casey et al., *Assisted Reproductive* Technologies, 17 GEO. J. GENDER & L. 83, 114 (2016) ("Now that same-sex marriage is legalized in all states, insurance companies and state legislatures will need to navigate the complicated implications *Obergefell* has on insurance. . . . [S]tates may transition their policy changes over several years, to allow couples to make decisions about marriage in their own time.").

[250] *Obergefell*, 135 S. Ct. at 2634-35 ("[L]iberty has long been understood as individual freedom from governmental action, not as a right to a particular governmental entitlement); *see also* Kenji Yoshino, *A New Birth of Freedom?: Obergefell v. Hodges*, 129 HARV. L. REV. 147, 167 (2015).

[251] *Obergefell*, 135 S. Ct. at 2601.

same-sex couples lack these rights that opposite-sex couples freely enjoy. Furthermore, opposite-sex couples would never tolerate the inability to exercise these rights.

The same is true for access to ART. Insurance coverage for ART, while it may seem like an entitlement on its face, is so intertwined with the fundamental right to procreate because it is the only possible means to have genetically related children. Without its access, same-sex couples are deprived of their equal right to procreate, a situation that opposite-sex couples would never accept themselves. Therefore, once a state mandates or offers ART coverage, the law should provide for equitable access to it in order to avoid the equal protection and due process issues raised in *Skinner*,[252] *Lawrence,*[253] *Eisenstadt*,[254] and *Obergefell*.[255] Insurance mandates should not discriminate on its face or in its effect and purpose based on marital status or sexual orientation.

VI. CONCLUSION

Some of the most personal and intimate decisions an individual makes in their life revolve around the choice to procreate and raise a family. For same-sex couples and unmarried individuals without a partner, the ability to reproduce genetically related offspring depends on access to ART. As discussed above, health insurance coverage for these technologies may relieve the individual's financial burden while only causing a small fractional burden on the total health expenditures of the population.[256] This minimal expense would have a great impact on the social and legal equality afforded to same-sex couples, and unmarried persons if ART insurance coverage were expanded.

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[252] Skinner v. Oklahoma, 316 U.S. 535, 538 (1942) (finding that the equal protection clause requirements failed).

[253] Lawrence v. Texas, 539 U.S. 558, 578 (2003) (finding that the due process clause was implicated).

[254] Eisenstadt v. Baird, 405 U.S. 438, 443 (1972) (finding that the equal protection clause was violated).

[255] 135 S. Ct. at 2602-03 (discussing the interrelationship between the equal protection clause and due process clause).

[256] Chambers et al., *supra* note 7, at 2292.

Insurance mandates that currently require the contribution of both gametes from a spouse, or require the couple to prove medical necessity of ART, restrict these individuals from access.[257] By treating these populations differently from a heterosexual, married couple, the mandates risk invalidation by the Supreme Court based on precedents that applied various degrees of rational basis review.[258] As such, mandates should remove any requirement of a spousal donation of a gamete because it unfairly denies unmarried individuals and same-sex couples who cannot provide both gametes themselves.

Other considerations include offering a broad definition of infertility that does not limit same-sex and unmarried persons access. For example, the American Society of Reproductive Medicine's definition of infertility may apply to all groups of people: "the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination."[259] This definition encompasses unmarried individuals failure to conceive via artificial insemination and same-sex couples inevitable failure to achieve pregnancy after twelve months of unprotected sex.[260] States should also consider offering a benefit cap that allows for multiple attempts of IVF rather than only one.[261] By formulating these mandates in ways that include, rather than exclude, same-sex, and unmarried couples, states may avoid constitutional challenges, decrease downstream health care expenditures, and afford all people the right to procreate. This Article helps us understand the benefits of expanding ART coverage and the equal protection it affords people slighted by the traditional underpinnings of legal constructs that have long stigmatized their lifestyles.

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[257] *See, e.g., Rule and Regulation 1: In Vitro Fertilization*, *supra* note 127; OHIO REV. CODE ANN. § 1751.01(A)(1) (West 2016).

[258] Smith, *supra* note 232, at 2814; *see also* Lawrence v. Texas, 539 U.S. 558, 578 (2003).

[259] *Definitions of Infertility and Recurrent Pregnancy Loss: A Committee Opinion*, 99 FERTILITY AND STERILITY, 63, 63 (2013).

[260] *See generally id.* (analyzing the implication of the definition of infertility).

[261] Blake, *supra* note 54, at 710.