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## Closing the Reproductive Divide: Expanding Access to Fertility Services Beyond the White Nuclear Family

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## **Closing the Reproductive Divide: Expanding Access to Fertility Services Beyond the White Nuclear Family**

Julia Cummings<sup>†</sup>

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### Introduction

As the World Health Organization has recognized, “infertility is a global health issue.”<sup>1</sup> Millions of Americans are dealing with infertility issues, which can lead to significant secondary impacts including social, mental, and physical harm.<sup>2</sup> Despite the gravity of harms that can result from infertility, and the range of treatment options available, many people forgo treatment.<sup>3</sup> In fact, access to fertility services varies significantly by demographic group.<sup>4</sup> As will be detailed in the following discussion, fertility services are currently dominated by comparatively older white women with higher incomes.<sup>5</sup> Barriers in accessing fertility services are the result of both established laws excluding coverage for particular groups of people<sup>6</sup> and implicitly sanctioned discrimination by the health care system and its stakeholders.<sup>7</sup> This Article explores both forms of discrimination and argues that access should be expanded to reach currently excluded groups. In furtherance of this argument, this Article discusses one potential solution, the proposed Access to Infertility Treatment and Care Act,<sup>8</sup> but critiques the most recent framework of this proposed legislation. While many advocates support the Access to Infertility Treatment and Care Act, there is almost no literature critiquing

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1. *Infertility*, WORLD HEALTH ORG., [https://www.who.int/health-topics/infertility#tab=tab\\_1](https://www.who.int/health-topics/infertility#tab=tab_1) [<https://perma.cc/M2UT-9EQH>].

2. Ethics Comm. of the Am. Soc’y for Reprod. Med., *Disparities in Access to Effective Treatment for Infertility in the United States: An Ethics Committee Opinion*, 116 FERTILITY & STERILITY 54, 54 (2021).

3. *Id.*

4. *Id.*

5. See discussion *infra* Section I.B.

6. See discussion *infra* Part III.

7. See discussion *infra* Part IV.

8. See The Access to Infertility Treatment and Care Act, S. 2352, 117th Cong. (2021); H.R. 4450, 117th Cong. (2021).

its shortcomings. This Article seeks to provide these needed critiques so that the law can meaningfully address disparities in fertility services.

Part I provides a background on infertility, fertility treatments, and existing disparities in access to and success of fertility services. Part II argues that access to currently excluded groups should be expanded and justifies this view by borrowing from the existing literature in this area. Part III then explores the ways in which insurance laws can perpetuate existing disparities and reify the notion that fertility services are intended to promote the white, nuclear family. Part IV then examines other, more implicit forms of discrimination caused by socioeconomic and historical forces. Lastly, Part V discusses the potential for the proposed Access to Infertility Treatment and Care Act to address disparities in fertility services, but it also highlights certain flaws and suggests changes that will make the legislation more effective if enacted.

## I. Background on Infertility and Disparities

### A. Background on Infertility and Fertility Treatments

Infertility is a disease of the reproductive system.<sup>9</sup> Approximately one in four women in the United States have difficulty becoming pregnant or carrying their child to term,<sup>10</sup> amounting to over 43 million women suffering from fertility issues.<sup>11</sup> In addition, 9.4% of men report having fertility issues.<sup>12</sup> Further, single people and LGBTQIA+ couples often face issues getting pregnant without medical intervention.<sup>13</sup> Despite the impact of infertility on a significant portion of the U.S. population, it is an

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9. *E.g.*, *Infertility*, *supra* note 1.

10. *Infertility FAQs*, CDC (Apr. 26, 2023), [https://www.cdc.gov/reproductivehealth/infertility/index.htm#:~:text=Yes.,to%20term%20\(impaired%20fecundity\)](https://www.cdc.gov/reproductivehealth/infertility/index.htm#:~:text=Yes.,to%20term%20(impaired%20fecundity).). [<https://perma.cc/56JN-H4EV>] (stating that about 19% of married women 15 to 49 years of age are infertile, and approximately 26% have difficulty becoming pregnant or carrying a pregnancy to term); *see also* ANJANI CHANDRA, CASEY E. COPEN & ELIZABETH HERVEY STEPHEN, U.S. DEP'T HEALTH & HUM. SERVS., *INFERTILITY AND IMPAIRED FECUNDITY IN THE UNITED STATES, 1982–2010: DATA FROM THE NATIONAL SURVEY OF FAMILY GROWTH 15 (2013)* (finding among married women 15 to 44 years of age, between 2006 and 2010, 6% were infertile and 12% had difficulty becoming pregnant or carrying a pregnancy to term). Unfortunately, much of the literature and data in this area is framed in the context of the gender binary. The Author has tried to use more inclusive language where possible but uses the binary framework when discussing data points collected in this manner.

11. *Cf. QuickFacts*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/US/SEX255221> [<https://perma.cc/3VL4-QVRV>] (indicating that as of 2022, there are an estimated 168,310,216 women in the United States).

12. CHANDRA ET AL., *supra* note 10, at 18. This figure also encompasses fertility issues experienced by a man's partner in certain circumstances if the man is living with or married to a woman. *Id.* at 18 n.1.

13. Ethics Comm. of the Am. Soc'y for Reprod. Med., *Access to Fertility Treatment Irrespective of Marital Status, Sexual Orientation, or Gender Identity: An Ethics Committee Opinion*, 116 *FERTILITY & STERILITY* 326, 336 (2021).

issue that is largely ignored by state and federal policymakers.<sup>14</sup> Focus on reproductive health has mostly centered around abortion and contraception debates, leaving people with infertility issues in limbo.<sup>15</sup>

However, many options exist for people who cannot get pregnant without medical intervention or have difficulties becoming pregnant.<sup>16</sup> Diagnosis of infertility can involve a number of tests, such as semen analyses, lab tests, and physical examinations by a physician.<sup>17</sup> Treatments range from varying one's daily activities, to use of medication, surgery, or assisted reproductive technology (ART).<sup>18</sup> ART is defined as "all fertility treatments in which either eggs or embryos are handled."<sup>19</sup> One common form of ART is in vitro fertilization (IVF), which involves retrieving eggs from a person, fertilizing those eggs outside the body, and placing the fertilized egg(s) in utero.<sup>20</sup>

Despite their usefulness, fertility treatments can be extremely costly.<sup>21</sup> In 2023, one IVF cycle costs between \$15,000 to \$30,000.<sup>22</sup> While IVF is "the most effective form of [ART],"<sup>23</sup> several rounds of IVF are often needed for a person to become pregnant, exponentially increasing costs.<sup>24</sup> Many people are also required to attempt different types of treatment before receiving more invasive or costly fertility

14. Nitya Rajeshuni, *Infertility: A Plague Gone Unnoticed*, STAN. J. PUB. HEALTH (Mar. 25, 2013), <https://web.stanford.edu/group/sjph/cgi-bin/sjphsite/infertility-a-plague-gone-unnoticed/> [https://perma.cc/7EPU-H77D].

15. *Id.*

16. See *Fertility Treatments*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/pregnancy/fertility-treatments> [https://perma.cc/DR7H-KJ65].

17. Gabriela Weigel, Michelle Long & Alina Salganicoff, *Coverage and Use of Fertility Services in the U.S.*, KAISER FAM. FOUND. (Sept. 15, 2020), <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/> [https://perma.cc/KYY5-4RAA].

18. *E.g.*, *Infertility*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/infertility/diagnosis-treatment/drc-20354322> [https://perma.cc/QMC6-9VT3].

19. *What is Assisted Reproductive Technology?*, CDC, <https://www.cdc.gov/art/whatis.html> [https://perma.cc/F7FW-AX44]. ART does not encompass fertility treatments such as insemination where only sperm is being handled. *Id.*

20. *E.g.*, *In Vitro Fertilization (IVF)*, MAYO CLINIC, <https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384716> [https://perma.cc/5JJ8-H8D9].

21. See Weigel et al., *supra* note 17.

22. Marissa Conrad, *How Much Does IVF Cost?*, FORBES HEALTH (Mar. 7, 2023), <https://www.forbes.com/health/family/how-much-does-ivf-cost/> [https://perma.cc/VJQ7-Z7MV]; see also Alex K. Wu, Anobel Y. Odisho, Samuel L. Washington, Patricia P. Katz & James F. Smith, *Out-of-Pocket Fertility Patient Expense: Data from a Multicenter Prospective Infertility Cohort*, J. UROLOGY (2014) (finding that in 2014, the average out-of-pocket cost for IVF was \$19,234).

23. *In Vitro Fertilization (IVF)*, *supra* note 20.

24. Weigel et al., *supra* note 17. Over a decade ago, a study in Northern California found that the average total cost of IVF was \$61,377 for persons using their own eggs and \$72,642 for persons using a donor egg. *Id.*

treatments.<sup>25</sup> For example, a person may have to try taking medication to improve their chance of pregnancy before resorting to treatment like IVF.<sup>26</sup> These treatments can quickly become incredibly expensive for individuals trying to become pregnant.

*B. Disparities in Fertility Services*

Significant disparities exist in the rates that different demographic groups seek fertility services.<sup>27</sup> Scholar Dorothy Roberts has argued that modern fertility treatments “reflect and reinforce the racial hierarchy” in the United States.<sup>28</sup> People seeking medical advice tend to be higher-income white women above the age of thirty-five with private insurance.<sup>29</sup> One recent study found that fertility patients also tended to have a bachelor’s or master’s degree.<sup>30</sup> A separate study indicated that while Black, Latinx, and white women who sought out medical assistance were given fertility advice at comparable rates, only 47% of Black and Latinx women were tested for infertility.<sup>31</sup> In contrast, 62% of white women reported being tested.<sup>32</sup> Women of color also often wait longer to obtain medical advice, which may decrease their chances of becoming pregnant.<sup>33</sup> In one study, 14.7% of Black patients stated that their race was a barrier to receiving treatment, compared to 0% of white patients, 5.1% of Latinx patients, and 5.4% of Asian patients.<sup>34</sup> In addition to racial and ethnic disparities in treatment, studies have also demonstrated that people with disabilities, people identifying as LGBTQIA+, and people with low incomes obtain fertility treatments at low rates.<sup>35</sup>

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25. *Id.*

26. *See id.*

27. Ethics Comm. of the Am. Soc’y for Reprod. Med., *supra* note 2, at 55–57.

28. Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 937 (1996).

29. Weigel et al., *supra* note 17.

30. Isabel Galic, Olivia Negriz, Christopher Warren, Dannielle Brown, Alexandria Bozen & Tarun Jain, *Disparities in Access to Fertility Care: Who’s In and Who’s Out*, 2 FERTILITY & STERILITY REPS. 109, 111 (2021). Another study found that 80.8% of women with college degrees experiencing infertility sought treatment, compared to 33.1% of women with a high school degree or less experiencing infertility. Lisa Rapaport, *U.S. Women with Less Income, Education Often Lack Access to Infertility Care*, REUTERS (July 17, 2019), <https://www.reuters.com/article/us-health-infertility-disparities/u-s-women-with-less-income-education-often-lack-access-to-infertility-care-idUSKCN1UC2GB> [<https://perma.cc/F9KH-98QY>].

31. Weigel et al., *supra* note 17.

32. *Id.*

33. Ethics Comm. of the Am. Soc’y for Reprod. Med., *supra* note 2, at 55.

34. Galic et al., *supra* note 30, at 113.

35. CTR. FOR REPROD. RTS., ENSURING EQUITABLE ACCESS TO INFERTILITY CARE IN THE UNITED STATES: GUIDING PRINCIPLES FOR POLICIES MANDATING INSURANCE COVERAGE 1 (2020), <https://reproductiverights.org/ensuring-equitable-access-to-infertility-care-in-the-united-states-guiding-principles-for-policies-mandating-insurance-coverage/>

Disparities also exist in fertility treatment success rates.<sup>36</sup> A study comparing success rates between white and Black patients found that Black patients experienced miscarriages at rates of 28.9%, compared to 14.6% for white patients.<sup>37</sup> Black patients also had pregnancy rates and live birth rates of 24.4% and 16.9% respectively, compared to 36.2% and 30.7% for white patients.<sup>38</sup> Certain conditions that are more common among Black and Latinx patients, such as tubal factor infertility, may also reduce the success of fertility treatments if doctors do not treat the underlying condition first.<sup>39</sup> Because practitioners in states without insurance laws that mandate coverage of fertility services may be less likely to address underlying conditions before providing fertility treatment, people in these states may face even lower success rates.<sup>40</sup>

## II. Expanding Access to Fertility Services

Given the clear disparities in access to fertility services, this Article argues that access should be expanded to groups currently excluded from such services due to explicit and implicit sanctioned forms of discrimination. However, the question remains whether fertility services are the types of services that we should promote. This Article argues that access to fertility services should be increased for several reasons. First, infertility is a disability, and its treatment should be seen as essential rather than elective. Second, denying access to fertility treatments causes other, more amorphous harms. Finally, given the inequities involved, increasing access to fertility services is necessary to promote social justice. The following section elaborates on these arguments and potential criticisms of expanded access using the existing literature in this area.

### A. Rationales for Expanding Access

While fertility services are often seen as a luxury, infertility is arguably a disability under the Americans with Disabilities Act (ADA).<sup>41</sup> Law professor Nizan Geslevich Packin has argued that infertility is a disability, making this determination based in part on the effect of

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[<https://perma.cc/3XA6-TRCU>].

36. Iris G. Insogna & Elizabeth S. Ginsburg, *Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy*, 20 *AMA J. ETHICS* 1152, 1154 (2018).

37. *Id.*

38. *Id.*

39. *See id.* at 1155 (describing tubal factor infertility and disparities in treatment).

40. *Id.*

41. Nizan Geslevich Packin, *The Other Side of Health Care Reform: An Analysis of the Missed Opportunity Regarding Fertility Treatments*, 14 *SCHOLAR* 1, 54–55 (2011).

infertility on one's reproductive system.<sup>42</sup> Given that reproduction is a major life activity under the ADA,<sup>43</sup> infertility should not be dismissed as a personal problem with which one simply has to live.

Further, Packin also bases her analysis on the social stigma that people experience when dealing with infertility and the secondary effects of infertility, such as depression and anger.<sup>44</sup> These secondary effects can be comparable to those experienced by people with other serious conditions like cancer and heart disease.<sup>45</sup> Many people experiencing infertility also suffer from disenfranchised grief—"intense grief that others perceive as a minor loss."<sup>46</sup> Disenfranchised grief can be caused by different experiences, such as losing a relationship that is not socially recognized, or when a culture or community does not view one's loss as significant.<sup>47</sup> Scholars such as ART expert Judith Daar note that medical societies have advocated for framing infertility as a disease.<sup>48</sup> By relabeling the issue, we may be able to reduce the stigma of infertility that causes some people to avoid treatment.<sup>49</sup> Without broader recognition of infertility as a disability, many people suffering its effects will continue to feel unheard or stigmatized.

Daar also emphasizes the harm caused to prospective parents when they are denied fertility services.<sup>50</sup> In particular, prospective parents experiencing infertility could be left childless if they are denied treatment.<sup>51</sup> While adoption may be an alternative for some people, the same groups that are excluded from fertility services may also be excluded from adoption networks.<sup>52</sup> This harm supports expanding access to fertility treatments. Moreover, it is also important to recognize that people who do not experience infertility issues are generally able to have as many children as they would like, while those who experience added challenges must subject themselves to the will of third parties.<sup>53</sup>

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42. *Id.*

43. *E.g.*, *Bragdon v. Abbott*, 524 U.S. 624, 638–39 (1998).

44. *See* Packin, *supra* note 41, at 54–55.

45. Amelia Swanson & Andrea Mechanick Braverman, *Psychological Components of Infertility*, 59 *FAM. CT. REV.* 67, 68 (2021).

46. *Id.* at 68.

47. *See id.* at 68–69.

48. Judith Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 *BERKELEY J. GENDER L. & JUST.* 18, 30 (2008).

49. *Id.* at 30–31.

50. *See id.* at 49–62.

51. *Id.* at 50–51.

52. *Id.* at 51.

53. *Cf. id.* at 56–57 ("The burdens of ART treatment denials impose short-term economic and long-term physical and psychological injury to individuals whose ability to procreate rests largely in the hands of physician providers. The affront to personhood is especially grave when one considers that no similar screening mechanism exists for natural



Denying people access to fertility services, and thus limiting their right to have children, may also harm one's dignity.<sup>54</sup>

As previously noted, access to fertility services is currently split along socioeconomic lines.<sup>55</sup> Given these clear divides, forgoing the use of such services cannot merely be understood as a choice. Rather, the current system creates barriers that favor certain groups of people while marginalizing people who often belong to historically oppressed groups.<sup>56</sup> We should not be comfortable with continuing such clear unequal treatment. As race, gender, and legal scholar Dorothy Roberts argued:

Reproductive liberty must encompass more than the protection of an individual[s] choice to end [their] pregnancy. It must encompass the full range of procreative activities, including the ability to bear a child, and it must acknowledge that we make reproductive decisions within a social context, including inequalities of wealth and power. Reproductive freedom is a matter of social justice, not individual choice.<sup>57</sup>

Thus, we should look beyond the narrow framing of fertility services as elective and understand the broader rights and social harms at stake—this understanding reveals the necessity of increasing access to those currently excluded from such services.

### *B. Critiques of Increased Access*

Policies to increase access to fertility services may primarily benefit communities that are already the usual recipients of such services.<sup>58</sup> Dorothy Roberts raised similar concerns in a 1995 article, wherein she noted that emerging reproductive technologies predominantly allow affluent white people to continue their family lines, legitimizing “an oppressive social hierarchy.”<sup>59</sup> She also noted that services like surrogacy may not only commodify the womb, but also devalue Black women by exploiting their wombs in a manner akin to slavery.<sup>60</sup>

However, over a decade later, Roberts revisited her concerns with reproductive technologies.<sup>61</sup> She found that the fertility industry “no

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conception. Fertile prospective parents whom society may adjudge ‘unfit’ because of their social status are free to procreate without interference by the State or private actors.”).

54. *Id.* at 57–59.

55. See discussion *supra* Section I.B.

56. See Daar, *supra* note 48, at 38–43.

57. DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY* 6 (1997).

58. See discussion *infra* Part III.

59. Dorothy E. Roberts, *The Genetic Tie*, 62 U. CHI. L. REV. 209, 235, 244–45 (1995).

60. *Id.* at 249–52.

61. Dorothy E. Roberts, *Race, Gender, and Genetic Technologies: A New Reproductive Dystopia?*, 34 SIGNS 783, 784–88 (2009).

longer appeals to an exclusively white clientele.”<sup>62</sup> While whiteness has remained the focus of the industry, and Roberts remains cautious of these technologies, she notes that fertility services have diversified and that increased availability of services like genetic screening have made it possible for people with low incomes to receive such services.<sup>63</sup>

More recently, Professor Khiara M. Bridges similarly raised concerns that surrogacy arrangements could reinforce racial hierarchies and socioeconomic disparities.<sup>64</sup> For members of historically marginalized groups dealing with various sources of oppression, fighting for access to surrogacy might seem indulgent.<sup>65</sup> Despite these risks, however, Bridges argues that surrogacy should not be prohibited, and that doing so would not fix existing disparities.<sup>66</sup> Instead, she suggests the need to support and learn from marginalized groups, challenge hierarchical understandings of family relationships, and dismantle discriminatory adoption and foster laws.<sup>67</sup> Just as with surrogacy laws, limiting access to other forms of fertility services will not remedy existing disparities, and in fact, will likely create more inequity. Given that those who predominantly use fertility services are people with relatively greater privilege,<sup>68</sup> it is highly unlikely that advocates will be able to stop continued use of these services. Instead, comparatively older and higher-income white women will continue to benefit from fertility services, while many others will be forced to remain childless or pursue alternative avenues like adoption.<sup>69</sup> Based on this rationale, access to fertility services should be further expanded rather than reduced, while other tools are used to simultaneously lessen disparities in access.

A related concern about ART is that increasing access to fertility services over-emphasizes the importance of genetic connections to one’s children.<sup>70</sup> U.S. society often views a “shared genetic identity” as creating a special type of relationship between parent and child.<sup>71</sup> The weight that U.S. society places on this connection can be seen in our laws that afford certain parental rights based on a genetic tie.<sup>72</sup> For example, legal maternity has historically been presumed based on the act of birth and

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62. *Id.* at 787.

63. *Id.* at 788–92.

64. Khiara M. Bridges, *Compensated Surrogacy in the Age of Windsor: Windsor, Surrogacy, and Race*, 89 WASH. L. REV. 1125, 1127 (2014).

65. *Id.* at 1150.

66. *Id.* at 1152.

67. *Id.* at 1152–53.

68. See discussion *supra* Section I.B.

69. See Daar, *supra* note 48, at 40, 50.

70. Roberts, *supra* note 59, at 239.

71. *Id.* at 215.

72. See *id.* at 252–55.

genetic connection.<sup>73</sup> This phenomenon also plays out in custody battles between adoptive and biological parents<sup>74</sup> and instances where fertility clinics use the wrong genetic material.<sup>75</sup> Both society and the law may presuppose a parental connection based solely on a genetic connection.

Given that we may already overestimate the extent to which our genetic connections define who we are,<sup>76</sup> increasing access to fertility services may further promote these ideals. However, this is not something that should prevent increased access to currently excluded groups. People without fertility issues are not scrutinized for their desire to have genetically-related children.<sup>77</sup> Holding people experiencing such issues to a different standard seems neither logical nor fair.<sup>78</sup> Just like people without fertility issues, people experiencing infertility should have the choice to either have genetically-related children or have children through other means (or both). Moreover, as discussed earlier, it is highly unlikely that maintaining the status quo or even attempting to discourage fertility services will decrease their use.<sup>79</sup> Increased access, along with other remedial measures, provides the best chance for decreasing disparities.<sup>80</sup>

### III. Insurance Laws as Gatekeepers to Access

Cost is one of the biggest obstacles for people seeking fertility treatments.<sup>81</sup> Most people seeking IVF have to pay the full cost of the treatment because they do not have health insurance, or because their insurance plan does not cover fertility treatment, specifically excludes IVF, or only covers diagnosis of infertility.<sup>82</sup> The need for multiple rounds

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73. *See id.* at 253–54 (detailing how an automatic social and legal relationship is formed between a mother and the child she birthed).

74. *See id.* at 212–13 (describing the contentious custody case between the adoptive and biologic parents of “Baby Jessica”).

75. *See* Raizel Liebler, *Are You My Parent? Are You My Child? The Role of Genetics and Race in Defining Relationships After Reproductive Technological Mistakes*, 5 DEPAUL J. HEALTH CARE L. 15, 21–28 (2001).

76. Roberts, *supra* note 59, at 222–33 (linking the prioritization of genetic ties to efforts to establish racial classifications and hierarchies in U.S. society).

77. Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CAL. L. REV. 623, 628 (1991).

78. *Id.*

79. *See* Roberts, *supra* note 61, at 784–86 (explaining that low-income people and people of color have been historically discouraged from using fertility services yet increasingly use them); Weigel et al., *supra* note 17 (“The CDC finds that use of IVF has steadily increased since its first successful birth in 1981.” (citation omitted)).

80. *See* Ethics Comm. of the Am. Soc’y for Reprod. Med., *supra* note 2, at 55 (noting the vitality of improved access and utilization in combination with further demographic research and treatment).

81. *See id.* at 54.

82. *Id.* at 55.

of treatment in some cases can make treatment cost-prohibitive.<sup>83</sup> In addition, treatments like IVF are more costly if donor eggs or sperm are used, which imposes a heavier financial burden on LGBTQIA+ couples.<sup>84</sup> There are also external costs, such as missing work for treatments, which can place a particularly heavy toll on people with low incomes who are trying to become pregnant.<sup>85</sup> In fact, one study found that 70% of women incurred debt from their IVF treatments.<sup>86</sup> Further, the racial wealth gap may also cause reliance on one's ability to pay for services to act as a proxy for race to a certain extent.<sup>87</sup>

Insurance laws mandating coverage of particular health benefits seek to reduce costs for patients and improve access to services.<sup>88</sup> Several states have implemented mandates requiring insurers to cover or offer fertility services.<sup>89</sup> However, while state mandates have improved access and outcomes of fertility treatments, disparities in such treatments persist in these states.<sup>90</sup> The increased use of fertility services is largely attributed to comparatively older white women with higher incomes and levels of education.<sup>91</sup>

Persistent disparities may be caused, in part, by limitations built into state laws, such as waiting periods and marriage requirements.<sup>92</sup> A 2019 study found that comprehensive mandates—defined as mandates that require coverage of four or more cycles of IVF—increased use of IVF, while “limited mandates” have not had a substantial effect on IVF usage.<sup>93</sup> Moreover, given racial disparities in public and private insurance usage,<sup>94</sup>

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83. Weigel et al., *supra* note 17.

84. *Id.*

85. *Id.*

86. Ethics Comm. of the Am. Soc'y for Reprod. Med., *supra* note 2, at 55.

87. JUDITH DAAR, *THE NEW EUGENICS: SELECTIVE BREEDING IN AN ERA OF REPRODUCTIVE TECHNOLOGIES* 86 (2017).

88. See Sheree L. Boulet, Jennifer Kawwass, Donna Session, Denise J. Jamieson, Dmitry M. Kissin & Scott D. Gross, *US State-Level Infertility Insurance Mandates and Health Plan Expenditures on Infertility Treatments*, 23 *MATERNAL & CHILD HEALTH J.* 623, 624 (2019).

89. Weigel et al., *supra* note 17.

90. See CTR. FOR REPROD. RTS., *INFERTILITY AND IVF ACCESS IN THE UNITED STATES: A HUMAN RIGHTS-BASED POLICY APPROACH* 5 (2020), <https://reproductiverights.org/fact-sheet-infertility-and-ivf-access-in-the-united-states-a-human-rights-based-policy-approach/> [<https://perma.cc/GK7C-7U9T>].

91. Ethics Comm. of the Am. Soc'y for Reprod. Med., *supra* note 2, at 56; CTR. FOR REPROD. RTS., *supra* note 90.

92. DAAR, *supra* note 87, at 87.

93. Boulet et al., *supra* note 88, at 628–29.

94. KATHERINE KEISLER-STARKEY & LISA N. BUNCH, U.S. CENSUS BUREAU, *HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2020*, at 6 (2021), <https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf> [<https://perma.cc/T7YD-7E4Z>] (“In 2020, Blacks had the highest rate of public coverage (41.4 percent) followed by Hispanics (35.9 percent), non-Hispanic Whites (33.8 percent), and Asians (27.0 percent). In the same year, non-Hispanic Whites had the highest rate of private coverage (73.9 percent),

state mandates that only regulate private plans may not be effective in significantly increasing access for members of BIPOC communities.<sup>95</sup> This section analyzes particular insurance provisions and how they center the standard of the white nuclear family and perpetuate disparities in access to fertility treatment.

#### A. *Analysis of Coverage of Fertility Services by State*

Private insurance plans are often subject to state regulation mandating coverage of certain services. Nineteen states currently require some level of coverage for fertility treatment or diagnosis, fourteen of which include an explicit provision for IVF coverage.<sup>96</sup> Two of these states, California and Texas, require group insurers to offer coverage for fertility treatments, but group policyholders can decide whether or not to include this benefit in the plans they offer.<sup>97</sup>

The scope and amount of coverage varies widely between states.<sup>98</sup> Narrowly-crafted state insurance laws can exclude certain groups from coverage, making treatment unattainable for many prospective parents.<sup>99</sup> For example, marriage requirements historically excluded LGBTQIA+ couples, and they also adversely impact non-married persons whether they are single or in a non-marital relationship with someone with whom they would like to have a child.<sup>100</sup> Arkansas law, for instance, requires insurance companies to cover IVF<sup>101</sup> but only if a person seeking

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followed by Asians (72.4 percent), Blacks (54.6 percent), and Hispanics (49.9 percent).”).

95. DAAR, *supra* note 87, at 86–87.

96. *Insurance Coverage by State*, RESOLVE: NAT’L INFERTILITY ASS’N, <https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/> [<https://perma.cc/8CMW-37KJ>]; *see also infra* Appendix. This discussion focuses on coverage of fertility diagnosis and treatment. It does not include a discussion on coverage of fertility preservation services such as cryopreservation (i.e., preserving cells or other parts of the body to be used in the future). *See Cryopreservation*, NAT’L CANCER INST., <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/cryopreservation> [<https://perma.cc/N4M8-QYYR>]. While differences in coverage of these services also raise concerns, a detailed discussion is outside the scope of this Article. In addition, Louisiana’s insurance law regarding fertility services only provides that coverage cannot be denied for “diagnosis and treatment of a correctable medical condition otherwise covered by the policy, contract, or plan solely because the condition results in infertility.” See LA. STAT. ANN. § 22:1036 (2001). Thus, it is not included in this count.

97. Weigel et al., *supra* note 17.

98. *See State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONF. ST. LEGS. (Mar. 12, 2021), <https://web.archive.org/web/20220306021615/https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx> [[perma.cc/5G4N-EPBK](https://perma.cc/5G4N-EPBK)].

99. *See* Weigel et al., *supra* note 17.

100. Four states have restrictions based on marital status. *See infra* Appendix (Arkansas, Hawaii, Maryland, and Texas).

101. ARK. CODE ANN. § 23-85-137 (2016).

IVF is using their spouse's sperm.<sup>102</sup> Some states also use a heteronormative definition of infertility or require same-sex couples to pay out-of-pocket for fertility treatments for a certain period of time prior to being considered infertile.<sup>103</sup> For example, California's mandate defines infertility as "(1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception."<sup>104</sup> If two cis-women sought coverage under the California statute, they likely would be unable to do so unless their sexual orientation was classified as a "condition"<sup>105</sup>—an outcome that seems unlikely and potentially problematic. A state's definition of infertility may also be unduly restrictive, even if not using a heteronormative framework. For example, a Maine bill, which ultimately did not become law, included an exemption from coverage for people whose infertility was caused by a sexually transmitted disease.<sup>106</sup>

Age restrictions are also relatively common. Four states currently impose some type of age limitation on coverage.<sup>107</sup> Rhode Island, for example, limits coverage of infertility diagnosis and treatment to women ages twenty-five to forty-two.<sup>108</sup>

Other provisions do not necessarily explicitly exclude certain groups but may do so in practice. For example, state caps on costs or number of treatments may negatively impact groups that experience more difficulty achieving successful treatment outcomes.<sup>109</sup> Eleven states currently either limit the number of treatments that a person may receive or cap the cost of treatment.<sup>110</sup> For instance, Arkansas regulations allow

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102. 054-00-001 ARK. CODE R. § 5(B) (LexisNexis 1991).

103. See Dan Avery, *Gay Couples Face Added Hurdle When Trying to Start a Family: Insurance Policies*, NBC NEWS (Dec. 17, 2020), <https://www.nbcnews.com/feature/nbc-out/gay-couples-face-added-hurdle-when-trying-start-family-insurance-n1251394> [<https://perma.cc/A4HW-YMMQ>] (describing how a same-sex male couple was denied insurance coverage for egg retrieval because the couple did not meet the insurer's infertility requirements); see also First Amended Complaint ¶¶ 2, 8, 29–30, 34–35, *Goidel v. Aetna Life Ins., Co.*, No. 1:21-cv-07619 (S.D.N.Y. filed Sep. 13, 2021) (alleging Aetna's definition of "infertility," which mirrors the state definition, and corresponding out-of-pocket cost determinations discriminate against LGBTQIA+ people). Eight states currently have such heteronormative definitions. See *infra* Appendix (California, Connecticut, Delaware, Illinois, Massachusetts, New Hampshire, Rhode Island, and Utah).

104. CAL. INS. CODE § 10119.6(b) (2014).

105. *Id.*

106. DAAR, *supra* note 87, at 87.

107. See *infra* Appendix (Connecticut, Delaware, New Jersey, and Rhode Island).

108. 27 R.I. GEN. LAWS § 27-18-30(a) (1989).

109. See discussion *supra* Section I.B.

110. See *infra* Appendix (Arkansas, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, New Jersey, New York, Rhode Island, and Utah).

insurers to place a lifetime cap on IVF coverage of \$15,000,<sup>111</sup> while Hawaii provides for one-time coverage of IVF.<sup>112</sup> California's law, previously discussed, explicitly excludes IVF from covered fertility treatments.<sup>113</sup> Exclusion of coverage for IVF may similarly harm people who have substantial difficulties getting pregnant, as it is the most effective form of ART and thus may help people become pregnant when other treatment options are unsuccessful.<sup>114</sup>

Waiting periods may negatively impact older prospective parents, since delaying treatment may make it less likely that such treatment will be successful.<sup>115</sup> Moreover, since people of color may be more likely to delay seeking fertility services, they may face the brunt of these exclusionary policies.<sup>116</sup> Four states that mandate coverage for fertility services currently impose a waiting period.<sup>117</sup> Hawaii, for example, requires that both the person seeking treatment and their spouse be considered infertile for at least five years prior to treatment, unless the infertility is caused by one of four enumerated conditions.<sup>118</sup>

### B. Scope of State Insurance Mandates

Even if a state adopts a comprehensive mandate requiring coverage of fertility services, such mandates do not extend to all policies within the state's boundaries.<sup>119</sup> For example, the Massachusetts insurance mandate, considered an inclusive policy, only covers 36.3% of "reproductive aged women."<sup>120</sup> Most insurance mandates only regulate private insurance plans.<sup>121</sup> This excludes Medicare and Medicaid, which are two of the three most common types of insurance.<sup>122</sup> The other

111. 054-00-001 ARK. CODE R. § 06 (LexisNexis 1991).

112. HAW. REV. STAT. § 431:10A-116.5(a) (1987).

113. CAL. INS. CODE § 10119.6(a) (2014).

114. See *In Vitro Fertilization (IVF)*, *supra* note 20; AM. SOC'Y FOR REPROD. MED., AGE & FERTILITY: A GUIDE FOR PATIENTS 4 (2012), [https://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/Age\\_and\\_Fertility.pdf](https://www.reproductivefacts.org/globalassets/rf/news-and-publications/bookletsfact-sheets/english-fact-sheets-and-info-booklets/Age_and_Fertility.pdf) [<https://perma.cc/HZ8Q-AXWG>].

115. See *id.*

116. See Ethics Comm. of the Am. Soc'y for Reprod. Med., *supra* note 2, at 55.

117. See *infra* Appendix (Arkansas, Connecticut, Hawaii, and Texas).

118. HAW. REV. STAT. § 431:10A-116.5(a)(4) (2013).

119. See DAAR, *supra* 87, at 91.

120. Katherine Koniars, Alan S. Penzias & Eli Adashi, *Has the Massachusetts Infertility Mandate Lived Up to Its Promise?*, 112 FERTILITY & STERILITY e41, e41-42 (2019).

121. See *State Insurance Mandates and the ACA Essential Benefits Provisions*, NAT'L CONF. ST. LEGS. (Apr. 12, 2018), <https://web.archive.org/web/20221217214734/https://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx> [<https://perma.cc/BJEW-9266>].

122. See Sydney Garrow, *What Is Private Health Insurance?*, EHEALTH (Oct. 27, 2022), <https://www.ehealthinsurance.com/resources/individual-and-family/what-is-private-health-insurance> [<https://perma.cc/2US8-TTV6>].

common type of insurance is an employer-sponsored health plan.<sup>123</sup> Employer-sponsored health plans are private insurance plans that employers offer to their employees.<sup>124</sup> Under these arrangements, employers will choose the particular plans that they would like to offer and may also pay a portion of the employees' premiums.<sup>125</sup> Despite the prevalence of these plans, certain employer-sponsored health plans may also be exempt from state mandates.<sup>126</sup>

There are three common types of employer-sponsored health plans: fully-insured, self-insured, or level-funded.<sup>127</sup> If an employer adopts a fully-insured plan, it pays a fixed monthly premium to an insurance company, which is used to cover claims for health benefits.<sup>128</sup> The premiums are put into a pool with other employers, and any claims filed within those employers' policies are paid out from the collective pool.<sup>129</sup> In contrast, if an employer self-insures a plan, the employer pays the insurance company the expected cost of covering its employees' medical claims along with administrative fees, and the employer will usually get a rebate if it does not spend the full amount.<sup>130</sup> The level-funded plan is essentially a modified self-insured plan that allows employers to pay fixed monthly premiums based on their anticipated costs of coverage.<sup>131</sup>

Self-insured plans are exempt from complying with state-mandated health benefits because the federal Employee Retirement and Income Security Act (ERISA) preempts such plans from certain state laws regulating insurance.<sup>132</sup> While there are mandated health benefits for self-insured plans, they come from the federal level rather than the state

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123. *Id.*

124. *Employer vs. Individual Health Insurance Plans*, MED. MUT., <https://www.medmutual.com/for-individuals-and-families/health-insurance-education/health-insurance-basics/employer-vs-individual-health-insurance.aspx> [<https://perma.cc/5ALK-T3FP>].

125. *Id.*

126. See KAISER FAM. FOUND., *EMPLOYER HEALTH BENEFITS: 2020 ANNUAL SURVEY* 161, 165 (2020), <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf> [<https://perma.cc/2EA3-SLHF>].

127. Kelsey Waddill, *3 Types of Funding for Employer-Sponsored Health Plan Claims*, HEALTH PAYER INTEL. (Apr. 8, 2021), <https://healthpayerintelligence.com/news/3-types-of-funding-for-employer-sponsored-health-plan-claims> [<https://perma.cc/T35P-UVTK>].

128. *Self-Insured vs. Fully Insured*, SOC'Y FOR HUM. RES. MGMT. (Sept. 1, 2009), <https://www.shrm.org/hr-today/news/hr-magazine/pages/0909wellsc.aspx> [<https://perma.cc/WGL9-59K4>].

129. *A Self-Funded Plan Can Be Part of Your Strategy to Lower Health Care Costs*, AETNA, <https://www.aetna.com/employers-organizations/self-insurance-plans.html> [<https://perma.cc/4XJW-GD4L>].

130. *Self-Insured vs. Fully Insured*, *supra* note 128.

131. *Staying on the Level: Keeping Your Level-Funded Plan Compliant*, HUB INT'L LTD. (Mar. 20, 2019), <https://www.hubinternational.com/products/employee-benefits/compliance-bulletins/2019/03/level-funded-plans/> [<https://perma.cc/EN5G-MD95>].

132. *FMC Corp. v. Holliday*, 498 U.S. 52, 64–65 (1990).



level.<sup>133</sup> Because level-funded plans are considered a form of self-insured plans, they are also exempt from state-mandated insurance benefits.<sup>134</sup> This exemption is substantial, as self-insured and level-funded plans make up a significant amount of the insurance market.<sup>135</sup> 67% percent of people covered by an employer-sponsored health plan are covered by a self-insured plan.<sup>136</sup> In addition, 31% of people working in companies with less than two hundred employees are covered either by a self-insured plan or a level-funded plan.<sup>137</sup> Because of ERISA preemption, state mandates requiring plans to cover fertility treatment or diagnosis do not reach a large swath of insureds.

In addition, many state laws exempt religious organizations from covering fertility treatments.<sup>138</sup> Employers who have below a certain number of employees may also be exempt from coverage requirements.<sup>139</sup> Likewise, states may make mandates applicable to certain types of plans or exempt certain plans.<sup>140</sup> For example, New York requires large group policies to cover three rounds of IVF, exempting small group plans and plans from the individual market.<sup>141</sup>

Even in states with seemingly mandated fertility benefits, employers may read the law narrowly and decline to provide such benefits.<sup>142</sup> In these cases, employers are often betting that employees will decline to challenge the legality of the employer's policy given the risks of such action.<sup>143</sup>

### C. Access to Fertility Services in Mandate States

Despite their many limitations, state-mandated coverage of fertility services has caused use of such services to almost triple.<sup>144</sup> Studies focused on IVF use have also noted better health outcomes for both parents and babies in states with mandated coverage.<sup>145</sup> Prospective

133. See Louise Norris, *What Is Self-Insured Health Insurance?*, VERYWELL HEALTH (Mar. 19, 2023), <https://www.verywellhealth.com/what-is-self-insured-health-insurance-and-how-is-it-regulated-4688567> [<https://perma.cc/Z7E6-WKBC>].

134. *Staying on the Level: Keeping Your Level-Funded Plan Compliant*, *supra* note 131.

135. See KAISER FAM. FOUND., *supra* note 126, at 161, 165.

136. *Id.* at 161.

137. *Id.* at 165.

138. See *State Laws Related to Insurance Coverage for Fertility Treatment*, *supra* note 98.

139. See *id.*

140. See *e.g.*, N.Y. INS. LAW § 3221 (McKinney 1984).

141. See *id.*

142. *Infertility Treatment & In Vitro Fertilization – IVF – Insurance Coverage Issues*, ADVANCED FERTILITY CTR. CHI., <https://advancedfertility.com/fertility-treatment/affording-care/fertility-insurance/> [<https://perma.cc/82UX-XM86>].

143. *Id.*

144. Ethics Comm. of the Am. Soc'y for Reprod. Med., *supra* note 2, at 56.

145. *Id.*

parents in mandate states were more likely to transfer fewer embryos during IVF treatment compared to those in states with no mandate.<sup>146</sup> Because of the high cost of treatment, people are incentivized to transfer more embryos at once, hoping this will improve the chances of becoming pregnant.<sup>147</sup> However, transferring multiple embryos increases the chance of a multiple birth, which increases the risk of complications.<sup>148</sup> Reducing the financial pressure of treatment gives prospective parents more flexibility to transfer significantly fewer embryos, promoting parental and fetal health.<sup>149</sup> Although state regulation has its benefits, the current regime continues to exclude people of color, people with comparatively lower incomes and/or education levels, single people, and LGBTQIA+ couples.

#### IV. Socioeconomic and Historical Barriers Causing Disparities in Access

While insurance laws with limitations represent explicitly sanctioned barriers to fertility services, implicitly sanctioned discrimination prevents access to fertility services as well. This Part analyzes some of these barriers and their impact on different groups in accessing fertility services.

##### A. Provider Discrimination

Medical providers themselves may discriminate against people who they do not believe should be having children.<sup>150</sup> For example, Guadalupe T. Benitez was denied intrauterine insemination by doctors who claimed their religious beliefs prevented them from treating lesbian patients.<sup>151</sup> Benitez sued the clinic for sexual orientation discrimination under

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146. Press Release, Am. Soc’y for Reprod. Med., State Insurance Mandates Have a Positive Impact on Fertility Treatment Success (Oct. 17, 2021), <https://web.archive.org/web/20220930033510/https://www.asrm.org/news-and-publications/news-and-research/press-releases-and-bulletins/state-insurance-mandates-have-a-positive-impact-on-infertility-treatment-success/> [https://perma.cc/AH4C-SURJ].

147. CTR. FOR REPROD. RTS., *supra* note 90, at 5.

148. *Id.*

149. Ethics Comm. of the Am. Soc’y for Reprod. Med., *supra* note 2, at 56.

150. See DAAR, *supra* note 87, at 79, 99–100, 132 (noting that medical professionals may make judgments of parental fitness based on their assumptions of certain BIPOC communities or people with disabilities); see also Roberts, *supra* note 59, at 240–41 (“[F]ertility clinics routinely deny their services to single women, lesbians, women with genetic disorders, and women who are not considered good mothers.”); CTR. FOR REPROD. RTS., *supra* note 90, at 6 (“Provider bias has also been documented against persons who are HIV positive, have an intellectual disability, or are bipolar.”).

151. N. Coast Women’s Care Med. Grp. v. San Diego Cnty. Superior Ct., 189 P.3d 959, 963–64 (Cal. 2008).

California law.<sup>152</sup> Although the court ultimately concluded that the right to religious freedom and the right to exercise free speech did not exempt the doctors from such law, her victory took nearly a decade.<sup>153</sup> Given that fertility treatments may become less successful as one ages,<sup>154</sup> such a delayed win is hardly a victory.

People with disabilities may also face barriers created by individuals who think such a person is unfit to parent because of their disability. Kijuana Chambers's story is especially telling, and unfortunately not unique.<sup>155</sup> Chambers was a blind woman who sought fertility treatments from a Colorado fertility clinic.<sup>156</sup> The clinic deemed her unfit to parent because of her blindness.<sup>157</sup> Chambers ultimately sued the clinic, alleging that it had violated the ADA and Section 504 of the Rehabilitation Act of 1976.<sup>158</sup> The clinic claimed that they also had concerns with Chambers's personal hygiene and mental state, and argued that "[the] case [was] about the moral and ethical responsibility of a physician."<sup>159</sup> The court dismissed Chambers's ADA claim, finding "sufficient evidence that a reasonable jury could have concluded that [the clinic] did not discriminate against Chambers *solely* on the basis of her blindness."<sup>160</sup> As Professor Kimberly M. Mutcherson notes, the system for seeking fertility services allows providers to make normative judgments about who is fit to parent based on "amorphous concerns about the parenting skills of the patient and the best interests of the potential child."<sup>161</sup>

Providers may also offer different care to patients based on race. Primary care physicians can refer patients of color to infertility specialists at lower rates compared to white patients and may also "deliberately steer Black patients away from reproductive technologies."<sup>162</sup> A person's source of income may also prevent them from receiving fertility services. In one study, almost half of the doctors surveyed indicated that they

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152. *Id.* at 964.

153. *See id.* at 962.

154. AM. SOC'Y FOR REPROD. MED., *supra* note 114.

155. NAT'L COUNCIL ON DISABILITY, ROCKING THE CRADLE: ENSURING THE RIGHTS OF PARENTS WITH DISABILITIES AND THEIR CHILDREN 167 (2012), [https://www.ncd.gov/sites/default/files/Documents/NCD\\_Parenting\\_508\\_0.pdf](https://www.ncd.gov/sites/default/files/Documents/NCD_Parenting_508_0.pdf) [<https://perma.cc/K49G-KY72>].

156. *Id.*

157. DAAR, *supra* note 87, at 132.

158. *Chambers v. Melmed*, 141 F. App'x 718, 719–20 (10th Cir. 2005).

159. *Blind Woman Loses Fertility Lawsuit*, NBC NEWS (Nov. 21, 2003), <https://www.nbcnews.com/id/wbna3541401> [<https://perma.cc/TK5L-UFD>].

160. *Chambers*, 141 F. App'x at 724 (emphasis added).

161. *See* Kimberly M. Mutcherson, *Disabling Dreams of Parenthood: The Fertility Industry, Anti-Discrimination, and Parents with Disabilities*, 27 LAW & INEQ. 311, 311–12 (2009).

162. DAAR, *supra* note 87, at 91 (quoting Roberts, *supra* note 28, at 940).

would decline treating a patient who receives public assistance.<sup>163</sup> Like cost, use of public assistance to determine who receives treatment disproportionately excludes members of BIPOC communities.<sup>164</sup> Lastly, white patients are often diagnosed with infertility conditions that IVF can overcome, while Black patients experiencing infertility are more likely to be diagnosed with pelvic inflammatory disease, a condition that is frequently treated using sterilization.<sup>165</sup>

### B. Location and Advertisement of Fertility Services

Fertility clinics are disproportionately located in higher income areas, creating a geographic barrier to these services.<sup>166</sup> The need for frequent visits during treatment also worsens the impact of geographic barriers.<sup>167</sup> In addition, fertility clinic advertisements perpetuate the notion that fertility treatment is a white service.<sup>168</sup> A 2013 study found that 97.28% of clinics included in the study featured white babies on their website.<sup>169</sup> Of those clinics, 62.93% featured white babies exclusively, compared to 1.02% of websites featuring either only Black babies or only Asian babies, and 0.34% featuring only Latinx babies.<sup>170</sup> These disparities may cause prospective white parents to feel more welcome at fertility clinics while marginalizing prospective parents of color.<sup>171</sup> These figures may also indicate that fertility clinics are targeting prospective white parents and perpetuating racist narratives regarding parental fitness.<sup>172</sup>

### C. Cultural and Social Barriers

Cultural and social barriers also inhibit access to fertility treatment for members of many historically marginalized groups.<sup>173</sup> Black women have been stereotyped as being hyper-fertile or being “baby-making machines.”<sup>174</sup> However, research shows that married Black women are

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163. *Id.* at 102.

164. *Id.*

165. *Id.* at 95.

166. John A. Harris, Marie N. Menke, Jessica K. Haefner, Michelle H. Moniz & Chithra R. Perumalswami, *Geographic Access to Assisted Reproductive Technology Health Care in the United States: A Population-Based Cross-Sectional Study*, 107 *FERTILITY & STERILITY* 1023, 1023 (2017).

167. *Id.*

168. See DAAR, *supra* note 87, at 101.

169. Jim Hawkins, *Selling ART: An Empirical Assessment of Advertising on Fertility Clinics' Websites*, 88 *IND. L.J.* 1147, 1169 (2013).

170. *Id.*

171. *Id.* at 1169–70.

172. *Id.* at 1170.

173. DAAR, *supra* note 87, at 93.

174. Alexia Fernández Campbell & Nat'l J., *Five Myths About Women of Color, Infertility, and IVF Debunked*, *ATLANTIC* (Sept. 3, 2015), <https://www.theatlantic.com/politics/archive/>

almost two times more likely to have infertility issues compared to married white women.<sup>175</sup> In discussing her struggles and the stigma behind seeking treatment for infertility, Reverend Stacey Edwards-Dunn describes pouring her life savings into fertility treatments before being diagnosed as having a single fallopian tube and a unicornuate uterus.<sup>176</sup> She emphasizes the failures of the medical system to properly diagnose Black patients and the secrecy of infertility in the Black community that stems from racist assumptions of fertility.<sup>177</sup>

The racist history of the U.S. health care system may also contribute to mistrust and consequent avoidance of the system by members of historically marginalized groups.<sup>178</sup> One of the most prominent examples of this behavior was the U.S. Public Health Service (USPHS) Syphilis Study at Tuskegee.<sup>179</sup> This study began in 1932 and followed about 600 Black men, most of whom were diagnosed with syphilis, over the course of forty years.<sup>180</sup> Despite penicillin being accessible and the “treatment of choice for syphilis” by 1943, the men were not treated and were left to suffer until a 1972 exposé revealed the details of the study.<sup>181</sup> The men never gave informed consent to participate in the study.<sup>182</sup> Many of the participants were “poor and illiterate,” and the USPHS provided incentives to participate.<sup>183</sup>

Unfortunately, the USPHS syphilis study was far from the only example of researchers’ exploitation of BIPOC reproductive health. In the 1950s, eugenicists crafted and executed a plan involving widespread sterilization and the experimental use of contraception on Puerto Rican women to develop a low-cost birth control pill.<sup>184</sup> One of the researchers felt that “Puerto Ricans and others living in poverty should be wiped out to make room for more ‘fit’ members of the population, and birth control

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2015/09/five-myths-about-women-of-color-infertility-and-ivf-debunked/432711/  
[<https://perma.cc/M96L-GEQX>].

175. *Id.*

176. *Fighting for Fertility*, PBS (May 12, 2021), <https://www.pbs.org/wgbh/nova/video/fighting-for-fertility/> [<https://perma.cc/S9D7-S9JJ>].

177. *Id.*

178. See DAAR, *supra* note 87, at 93.

179. See *The U.S. Public Health Service Syphilis Study at Tuskegee*, CDC, <https://www.cdc.gov/tuskegee/timeline.htm> [<https://perma.cc/TG4U-RFA7>].

180. *Id.*

181. *Id.*

182. *Id.*

183. Marcella Alsan & Marianne Wanamaker, *Tuskegee and the Health of Black Men*, 133 Q.J. ECON. 407, 414 (2018) (quoting JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (1992)).

184. See Erin Blakemore, *The First Birth Control Pill Used Puerto Rican Women as Guinea Pigs*, HISTORY (Mar. 11, 2019), <https://www.history.com/news/birth-control-pill-history-puerto-rico-enovid> [<https://perma.cc/WR86-8C23>].

was part of that vision.”<sup>185</sup> In fact, the United States blatantly imposed restrictions on reproduction for people of color and other marginalized groups during the eugenics movement to “stav[e] off the birth of ‘undesirables.’”<sup>186</sup>

Members of BIPOC communities also face worse health outcomes compared to white people, which can increase mistrust of the health care system.<sup>187</sup> On average, Black and Indigenous women are approximately two to three times more likely than white women to die either during pregnancy or from complications arising from pregnancy.<sup>188</sup> When narrowing the discussion to women over thirty years old, Black and Indigenous women are about four to five times more likely to face such outcomes.<sup>189</sup> BIPOC patients may face better health outcomes and achieve better communication if they visit a doctor who looks like them.<sup>190</sup> Having a doctor with a similar background can also help patients develop a sense of security and trust.<sup>191</sup> Unfortunately, fertility specialists are overwhelmingly white,<sup>192</sup> which leaves patients of color with little choice when looking for such a connection.

## V. Improving an Imperfect Solution: The Access to Infertility Treatment and Care Act

State insurance laws have not significantly reduced barriers to accessing fertility treatments for members of currently excluded groups.<sup>193</sup> Moreover, while these laws may address issues of cost for those included in their coverage, they fail to address implicitly sanctioned barriers to access, such as geographical or cultural limitations. A bill introduced in the 117th Congress, the Access to Infertility Treatment and Care Act (the Act), sought to fill some of the gaps left by state

185. *Id.*

186. See DAAR, *supra* note 87, at 93, 28–53.

187. See Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed, Carrie Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 762 (2019).

188. *Id.*

189. *Id.*

190. See Austin Frakt, *Bad Medicine: The Harm That Comes from Racism*, N.Y. TIMES (July 8, 2020), <https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html> [<https://perma.cc/3U48-84T9>].

191. Verónica Zaragovia, *Trying to Avoid Racist Health Care, Black Women Seek Out Black Obstetricians*, NPR (May 28, 2021), <https://www.npr.org/sections/health-shots/2021/05/28/996603360/trying-to-avoid-racist-health-care-black-women-seek-out-black-obstetricians> [<https://perma.cc/L3P8-DJ76>].

192. DAAR, *supra* note 87, at 102–03; see also Michael A. Thomas, *Making an African American REI Physician: A Story of Mentorship*, 116 FERTILITY & STERILITY 281, 282–83 (2021) (describing the lack of Black male doctors in obstetrics and gynecology).

193. See discussion *supra* Section III.C.

legislatures.<sup>194</sup> However, this formulation of the Act still would have been an imperfect solution. Iterations of this bill have been introduced in multiple sessions of Congress, and thus will likely be introduced in the future.<sup>195</sup> However, while many advocates were in favor of this proposed legislation,<sup>196</sup> there is almost no existing literature critiquing the Act or suggesting potential improvements to its provisions. This Part explains the provisions of the most recently introduced version of the Act and provides suggestions for creating a more inclusive and effective law.

A. *The Terms of the Access to Infertility Treatment and Care Act*

The Access to Infertility Treatment and Care Act was most recently introduced in the U.S. House and Senate in July of 2021.<sup>197</sup> The Act recognizes the prevalence of infertility in the United States and the limits of the current legislative regime in affording people meaningful access to fertility treatments.<sup>198</sup> Given these findings, this version of the proposed Act would have required insurers to cover fertility treatments, including non-experimental ART procedures and other services deemed appropriate.<sup>199</sup> This iteration of the proposed Act defines infertility as “a disease, characterized by the failure to establish a clinical pregnancy,” either “after 12 months of regular, unprotected sexual intercourse,” or “due to a person’s incapacity for reproduction either as an individual or with his or her partner, which may be determined after a period of less than 12 months of regular, unprotected sexual intercourse, or based on medical, sexual and reproductive history, age, physical findings, or diagnostic testing.”<sup>200</sup>

Under its most recent formulation, the Act would apply to insurers offering individual or group plans, along with Federal Employees Health Benefits Program (FEHBP) plans for federal employees, TRICARE plans for military members, veterans plans administered by the United States Department of Veterans Affairs (VA), and state Medicaid plans.<sup>201</sup>

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194. See Access to Infertility Treatment and Care Act, H.R. 4450, 117th Cong. (2021).

195. See Access to Infertility Treatment and Care Act, H.R. 2803, 116th Cong. (2019); Access to Infertility Treatment and Care Act, H.R. 5965, 115th Cong. (2018).

196. See, e.g., Booker, *DeLauro Re-Introduce Bill to Increase Access to Infertility Treatment*, CORY BOOKER (July 16, 2021), <https://www.booker.senate.gov/news/press/booker-delauro-re-introduce-bill-to-increase-access-to-infertility-treatment> [<https://perma.cc/M2S7-L2GH>] (announcing re-introduction of the bill with a list of co-sponsors and endorsing organizations).

197. See Access to Infertility Treatment and Care Act, H.R. 4450, 117th Cong. (2021).

198. *Id.* § 2.

199. *Id.* § 3(a). The most recent version of the proposed Act would also require coverage for iatrogenic infertility, which is infertility due to a medical service such as chemotherapy. *Id.* However, discussion of this provision is beyond the scope of this Article.

200. *Id.*

201. See *id.* §§ 3–7.

Notably, the most recent version of the proposed Act does not limit its reach to larger group plans or fully-insured plans,<sup>202</sup> as many state plans do.<sup>203</sup> It would also impose limits on cost-sharing.<sup>204</sup> For group and individual plans, cost-sharing cannot be greater than what is imposed for “similar services” or have any limits that are “different from limitations imposed with respect to such similar services.”<sup>205</sup> Notably, the most recent iteration of the Act would prohibit cost-sharing of fertility treatments for state Medicaid plans.<sup>206</sup> It would also prohibit insurers from offering incentives to avoid coverage of fertility treatment or otherwise discouraging use of such services.<sup>207</sup>

The passage of this Act would make fertility treatments available to a much larger segment of the U.S. population. It would replace the current patchwork of state laws with a uniform nationwide framework. Moreover, its provisions would reach most of the plans that state mandates currently exempt or cannot regulate—namely, state Medicaid plans, certain federally-sponsored plans, self-insured plans, and small group employer-based plans.<sup>208</sup> Senators who sponsored the most recent version of the proposed Act noted that “[t]hese important and life-changing services strengthen families and should be accessible and affordable for all.”<sup>209</sup> The proposed Act was also endorsed by several advocacy organizations, including prominent entities in reproductive health policy such as RESOLVE: The National Infertility Association, the American Society for Reproductive Medicine, and the Society for Assisted Reproductive Technology.<sup>210</sup> However, despite the Act’s apparent breadth, its most recent formulation may not remedy all barriers to

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202. *See id.* § 3(a).

203. *See discussion supra* Section III.B.

204. H.R. 4450 §§ 3–7.

205. *Id.* § 3(a).

206. *Id.* § 7(a).

207. *Id.* § 3(a).

208. *See id.* §§ 3–7; *see also* discussion *supra* Section III.B (describing the different types of insurance plans and how ERISA and religious exemptions can supersede state mandates). While the Act would presumably apply to plans offered by religious organizations as well, such organizations would likely challenge the mandate given similar battles over coverage of contraceptives. *See* Timothy S. Jost, *Supreme Court Excuses Organizations with Religious or Moral Objections from Covering Workers’ Birth Control*, COMMONWEALTH FUND (July 9, 2020), <https://www.commonwealthfund.org/blog/2020/supreme-court-excuses-organizations-religious-or-moral-objections-covering-workers-birth> [<https://perma.cc/N6NZ-MRLU>] (describing the issue of compliance with the mandate by employers that object to contraceptive use on moral or religious grounds as “the most litigated Affordable Care Act (ACA) issue”). However, the Act would still provide significantly more Americans with coverage for fertility services, thus it should not be abandoned if a religious exemption is required.

209. *Booker, DeLauro Re-Introduce Bill to Increase Access to Infertility Treatment, supra* note 196.

210. *Id.*



access discussed previously in this Article. The following section elaborates on issues that the most recently introduced iteration of the Act failed to address and suggests revised and additional provisions for future re-introduction of the Act that will ensure inclusivity.

*B. A Model for Improving the Access to Infertility Treatment and Care Act*

While the most recent iteration of the Act is a step in the right direction to addressing disparities in fertility services, it would not provide a comprehensive solution to the multiple barriers to care previously discussed. First, some provisions may continue to exclude certain groups or may limit covered services. Second, the most recent iteration of the Act did not address factors other than cost that may cause people to avoid seeking fertility services.<sup>211</sup>

*i. Exclusionary Aspects of the Most Recent Version of the Act*

The language of the most recent iteration of the Act is certainly more inclusive compared to several state mandates. For example, its definition of infertility allows provider discretion “based on medical, sexual and reproductive history, age, physical findings, or diagnostic testing,” which may allow for coverage of LGBTQIA+ individuals who cannot typically achieve pregnancy through unprotected sex, or allow coverage for single persons who desire to become pregnant.<sup>212</sup> This inclusion is a significant improvement from the gendered or heteronormative language employed by many state laws.<sup>213</sup> Still, legislators could improve the terms of the Act in several ways.

First, the definition of infertility could be made more inclusive. Despite the expansiveness of the Act’s definition in its most recent iteration, use of the term “disease” may allow insurers to avoid coverage for people whose infertility is “caused” by their sexual orientation or gender identity.<sup>214</sup> Moreover, given that scientists are only recently recognizing the injury and trauma that can come from labeling same-sex preferences as a mental disability,<sup>215</sup> language like “disease” should be removed to avoid reinforcing these outdated and harmful beliefs.

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211. See H.R. 4450.

212. *Id.* § 3(a).

213. See discussion *supra* Section III.A; see also *infra* Appendix (listing the eight states that have restrictive definitions of infertility).

214. H.R. 4450 § 3(a).

215. See Daniel Trotta, *U.S. Psychoanalysts Apologize for Labeling Homosexuality an Illness*, REUTERS (June 21, 2019), <https://www.reuters.com/article/us-usa-lgbt-stonewall-psychoanalysts/u-s-psychoanalysts-apologize-for-labeling-homosexuality-an-illness-idUSKCN1TM169> [https://perma.cc/Q2J7-DRZ8].

Additionally, the Act's definition of infertility in its most recent iteration did not include a provision allowing people over a certain age to seek treatment earlier after failed attempts to conceive through unprotected sex.<sup>216</sup> Although the second prong of the definition allows for provider discretion, older patients may face pushback by providers or insurance companies if such an exception is not explicitly written into the law.<sup>217</sup> Given that the success of fertility treatments can decrease as one ages,<sup>218</sup> barriers to access could prevent older patients from seeking services in time to achieve results. Thus, Congress should adopt a shorter time period for establishing infertility for patients over a certain age. Congress can follow guidance from state mandates that require only six months of unprotected sex for women over the age of thirty-five.<sup>219</sup> However, such a provision must be crafted more inclusively and avoid gendered language, such as by substituting "person" or "patient" for "women."<sup>220</sup>

Next, despite the most recent iteration of the Act's broad applicability to FEHBP, TRICARE, VA, and state Medicaid plans, it would not apply to Medicare plans.<sup>221</sup> Medicare is a federally sponsored program that covers people over the age of sixty-five and people with disabilities.<sup>222</sup> As previously mentioned, it is also one of the largest providers of insurance.<sup>223</sup> The federally-sponsored program currently only covers "[r]easonable and necessary services" to treat infertility,<sup>224</sup>

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216. H.R. 4450 § 3.

217. *Cf.* First Amended Complaint *supra* note 103, ¶¶ 51–53, 66–69 (alleging that Aetna continued to deny coverage of fertility treatments despite guidance from the New York Department of Financial Services clarifying the scope of New York's mandated coverage of fertility benefits); *see also* N.Y. DEP'T FIN. SERVS., INSURANCE CIRCULAR LETTER NO. 3, HEALTH INSURANCE COVERAGE OF INFERTILITY TREATMENTS REGARDLESS OF SEXUAL ORIENTATION OR GENDER IDENTITY (2021), [https://www.dfs.ny.gov/industry\\_guidance/circular\\_letters/cl2021\\_03](https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_03) [<https://perma.cc/D99Q-8FU3>] ("[S]ince the definition of infertility expressly contemplates coverage for infertility treatment earlier than 12 months, issuers should be mindful that, with respect to some individuals, earlier evaluation and treatment may be justified. It has come to the Department's attention that some issuers may be requiring some individuals to incur costs, due to their sexual orientation or gender identity, that heterosexual individuals do not incur in order to meet the definition of infertility.").

218. *See* AM. SOC'Y FOR REPROD. MED., *supra* note 114.

219. *See infra* Appendix.

220. *See* Lynne Bowker, *Terminology and Gender Sensitivity: A Corpus-Based Study of the LSP of Infertility*, 30 LANGUAGE IN SOC'Y 589 (2001); Emily Hill, *The Fight to Stop Gendered Language*, RACONTEUR (Mar. 12, 2020), <https://www.raconteur.net/healthcare/fertility/gendered-language-infertility/> [[perma.cc/2GQU-AJEB](https://perma.cc/2GQU-AJEB)].

221. *See* H.R. 4450.

222. *What's the Difference Between Medicare and Medicaid?*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/answers/medicare-and-medicare/what-is-the-difference-between-medicare-medicare/index.html> [<https://perma.cc/W359-KVBC>].

223. *See* discussion *supra* Section III.B.

224. CTRS. FOR MEDICARE & MEDICAID SERVS., NO. 100-02, MEDICARE BENEFIT POLICY MANUAL § 20.1(B) (2019).

which does not include IVF or, in most cases, drugs to stimulate or increase fertility.<sup>225</sup> While Congress may have determined that people over the age of sixty-five either would be unlikely to use fertility services or that the costs of offering such services would outweigh the benefits, the primary issue is the exclusion of people with certain disabilities from the protections of the Act. Given the current limitations on coverage of fertility services imposed by Medicare, along with discrimination that people with disabilities may face in accessing such services,<sup>226</sup> Congress should prioritize increasing access for those who receive such coverage.

Lastly, the most recent iteration of the Act would only require coverage of fertility treatments for most insurance plans,<sup>227</sup> rather than *mandating* coverage of infertility diagnosis and treatment. While many plans currently cover services needed to diagnose infertility,<sup>228</sup> such coverage is not universal. For people who do not have plans that cover infertility diagnostic services, the out-of-pocket costs for these services may act as another barrier to access. Although providers and insurers may interpret the term “treatment” as encompassing diagnosis, for the reasons noted previously, an explicit provision to clarify this will ensure that patients do not face unjust delays or denials in coverage.

#### ii. Addressing Factors Other Than Cost

While cost is a major barrier to accessing fertility services, it is not the only one. As previously discussed, people may be discriminated against by providers who deem them unfit to parent, may face geographical barriers, or may be dissuaded from seeking fertility services based on cultural or societal norms.<sup>229</sup> Congress should attempt to address these non-monetary barriers as well in the Act.

Although patients are already protected from discrimination in health care settings,<sup>230</sup> Congress should include an explicit provision in the Act prohibiting such discrimination in the provision of fertility

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225. 42 U.S.C. § 1396r-8(d)(2)(B); *Does Medicare Cover Fertility Treatments?*, MEDICARE.ORG, <https://www.medicare.org/articles/does-medicare-cover-fertility-treatments/> [https://perma.cc/CDK9-BFEW].

226. See discussion *supra* Section IV.A.

227. See Access to Infertility Treatment and Care Act, H.R. 4450, 117th Cong. § 3–7 (2021).

228. *Infertility Treatment & In Vitro Fertilization – IVF – Insurance Coverage Issues*, *supra* note 142.

229. See discussion *supra* Part IV.

230. MaryBeth Musumeci, Jennifer Kates, Lindsey Dawson, Alina Salganicoff, Laurie Sobel & Samantha Artiga, *The Trump Administration’s Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KAISER FAM. FOUND. (Sept. 18, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/> [https://perma.cc/8GAR-TW2P].

services. Such a provision would be similar to Section 1557 of the Affordable Care Act, which adds to and incorporates the protections of other anti-discrimination laws.<sup>231</sup> As the federal Department of Health and Human Services noted, while its final rule implementing Section 1557 “incorporate[s] long-standing principles and protections of civil rights law,” it “provides additional guidance in areas for which application of these principles may not be as familiar.”<sup>232</sup> Having a similar provision in the Act will remind insurers and providers of their obligations under federal civil rights law and will allow them to understand their obligations in the more specific context of fertility services.

Given that decreasing cost may not limit the geographic barriers of getting to and from fertility clinics, Congress should provide financial incentives for providers to establish clinics in currently underserved areas. Fertility clinics are currently located in predominantly higher income areas.<sup>233</sup> This arrangement is likely convenient for the majority of their existing clientele—upper-income white women.<sup>234</sup> However, traveling to upper-income neighborhoods for treatment will still impose significant costs, such as transportation costs and time, on members of currently excluded groups.<sup>235</sup> In addition, prospective patients may continue to avoid visiting these centers due to feeling like they do not belong in a particular neighborhood or area.<sup>236</sup> Establishing clinics in currently underserved areas could reduce these costs and potential anxieties. Moreover, visiting a fertility specialist in one’s own neighborhood may help to lessen issues of mistrust, which also prevent some prospective patients from seeking health care.

In addition to increasing the number of clinics in underserved neighborhoods, Congress should also increase funding for students looking to pursue careers in medicine as a means of increasing trust in the health care system. There are significant benefits for BIPOC patients to have doctors who look like them.<sup>237</sup> However, most physicians are white,<sup>238</sup> and racial disparities can be especially stark among fertility

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231. *Id.*

232. *Section 1557: Frequently Asked Questions*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html> [<https://perma.cc/M2FV-S7YE>].

233. See discussion *supra* Section IV.B.

234. See discussion *supra* Section I.B.

235. Harris et al., *supra* note 166, at 1026.

236. See Hawkins, *supra* note 169, at 1169–70 (discussing the effects of the high frequency of white babies appearing in fertility clinic marketing).

237. See sources cited *supra* notes 190–91 and accompanying text.

238. *Diversity in Medicine: Facts and Figures 2019*, ASS’N AM. MED. COLLS., <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018> [<https://perma.cc/EGH7-6424>].

specialists.<sup>239</sup> One doctor suggests addressing this problem by increasing exposure to the medical field through pipeline programs.<sup>240</sup> Advocates can also work to reduce barriers to higher education and encourage members of currently underrepresented backgrounds to apply to medical programs.<sup>241</sup> For example, St. George's University attempts to reduce barriers for low-income students interested in medicine through its City Doctors Scholarship Program.<sup>242</sup> This program allows students to attend medical school for free or reduced rates if they commit to working at a public hospital in the New York City metropolitan area after graduation.<sup>243</sup> While pipeline programs, scholarship programs, and similar efforts may help to reduce racial, economic, and other disparities among physicians, they also impose significant costs.<sup>244</sup> Congress should support further development of such programs by making additional funding available. While this solution may seem tangential to the goal of increasing access to fertility services, it would promote systemic change that would help to achieve this goal in the long-term.

The latter two proposals would require time to be fully implemented and to generate meaningful changes in access to fertility services. However, this hurdle should not stop Congress from taking these actions. All structural changes take time to implement, and without proper structural change, smaller solutions fail to address the full scope of a problem. While reducing the cost of fertility services will help more members of currently excluded groups access such services, full equity cannot be realized without structural changes. By reforming the Act to address smaller- and larger-scale issues, Congress can take a significant step to reducing disparities in fertility services.

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239. *ASRM Task Force on Diversity, Equity and Inclusion Statement of Interest and Concern*, AM. SOC'Y FOR REPROD. MED. (Nov. 30, 2020), <https://www.asrm.org/globalassets/asrm/asrm-content/about-us/pdfs/asrm-dei-task-force-report-11-30-2020.pdf> [<https://perma.cc/WP4W-XCGS>].

240. *The Importance of Diversity in Health Care: Medical Professionals Weigh In*, ST. GEORGE'S UNIV.: MED. SCH. BLOG (Aug. 19, 2021), <https://www.sgu.edu/blog/medical/pros-discuss-the-importance-of-diversity-in-health-care/> [<https://perma.cc/U7FZ-S3JW>].

241. *Diversity in Healthcare and the Importance of Representation*, UNIV. OF SAINT AUGUSTINE FOR HEALTH SCIS.: BLOG (Mar. 1, 2021), <https://www.usa.edu/blog/diversity-in-healthcare/> [<https://perma.cc/A8BX-VCFE>].

242. G. Richard Olds, *How to Diversify America's Doctor Workforce*, FORTUNE (Feb. 7, 2021), <https://fortune.com/2021/02/07/black-hispanic-doctors-diversity-medicine/> [<https://perma.cc/9G8Y-222C>].

243. *Id.*

244. *See More Than \$1.5 Million in "CityDoctors" Scholarships Awarded to Students Committed to Practicing Primary Care at NYC Health + Hospitals*, NYC HEALTH + HOSPITALS (Apr. 4, 2017), <https://www.nychealthandhospitals.org/pressrelease/twelve-students-awarded-1-5-million-in-citydoctors-scholarships/> [<https://perma.cc/WFZ4-ZFYF>].

**Conclusion**

Clear disparities exist in access to fertility services. These disparities are caused by both explicitly and implicitly permitted forms of discrimination. To remedy these disparities, we must increase access to groups currently excluded from fertility services. Previously introduced federal legislation provides a promising framework to do so, but it is lacking in several respects. In light of the considerations raised in this Article, Congress should reassess its most recent version of the Access to Infertility Treatment and Care Act and reintroduce the Act with the changes described earlier to ensure that the Act's implementation will effect meaningful change. This reassessment should involve not only changes to the financing of fertility services, but also more structural changes aimed at improving access to such services.

**Appendix: Common Provisions in State Infertility Mandates**

<b>Insurance Provision</b>	<b>States with Insurance Provision</b>	<b>Number of States (% of Mandate States)</b>
Provision Mandating Some Coverage for Fertility Services (“Mandate” States)	Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New York, Ohio, Rhode Island, Texas, Utah, West Virginia <sup>245</sup>	19
Caps On Number or Cost of Treatments	Arkansas, <sup>246</sup> Colorado, <sup>247</sup> Connecticut, <sup>248</sup> Delaware, <sup>249</sup> Hawaii, <sup>250</sup> Illinois, <sup>251</sup> Maryland, <sup>252</sup> New Jersey, <sup>253</sup> New York, <sup>254</sup> Rhode Island, <sup>255</sup> Utah <sup>256</sup>	11 (64.71%)

245. See *Insurance Coverage by State*, *supra* note 96.

246. 054-00-001 ARK. CODE R. § 6 (LexisNexis 2022) (\$15,000).

247. COLO. REV. STAT. § 10-16-104(23)(b) (2023) (covers three oocyte retrievals).

248. CONN. GEN. STAT. § 38a-509 (2023) (various limits depending on type of procedure).

249. DEL. CODE ANN. tit. 18, § 3342 (2018(i)(2)(i) (2023) (six egg retrievals).

250. HAW. REV. STAT. § 431:10A-116.5 (2013) (one time IVF treatment).

251. 215 ILL. COMP. STAT. 5/356m (b)(1)(B) (West 2022) (for plans that include pregnancy benefits, up to four oocyte retrievals, “except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered”).

252. MD. CODE ANN., INS. § 15-810(e) (LexisNexis 2023) (three rounds of IVF per live birth and lifetime cap of \$100,000).

253. N.J. STAT. ANN. § 26:2J-4.23(a) (West 2023) (four egg retrievals).

254. N.Y. INS. LAW § 3221 (McKinney 2023) (three cycles of IVF for large group plans, no mandate for other types of plans).

255. 27 R.I. GEN. LAWS § 27-18-30(g) (2023) (insurers may impose cap of \$100,000).

256. UTAH CODE ANN. § 49-20-418(2)(b) (LexisNexis 2022) (\$4,000).

Mandate Only Applies to Certain Types of Insurance Plans (Does Not Include Plans Excluding Medicare or Medicaid)	Arkansas, <sup>257</sup> California, <sup>258</sup> Delaware, <sup>259</sup> Illinois, <sup>260</sup> Maryland, <sup>261</sup> Montana, <sup>262</sup> New Hampshire, <sup>263</sup> New Jersey, <sup>264</sup> New York, <sup>265</sup> Ohio, <sup>266</sup> Rhode Island, <sup>267</sup> Texas, <sup>268</sup> Utah, <sup>269</sup> West Virginia <sup>270</sup>	14 (73.68%)
Spousal requirements	Arkansas, <sup>271</sup> Hawaii, <sup>272</sup> Maryland, <sup>273</sup> Texas <sup>274</sup>	4 (23.53%)

257. 054-00-001 ARK. CODE R. § 4 (LexisNexis 2022) (applies only to “individual, group or blanket disability insurance polic[ies]”).

258. CAL. HEALTH & SAFETY CODE § 1374.55(a) (Deering 2023) (excludes health maintenance organizations (HMOs)).

259. DEL. CODE ANN. tit. 18, § 3556(i)(6) (2023) (excludes individual and small group plans (under 50 employees)).

260. 215 ILL. COMP. STAT. 5/356m (a) (West 2022) (excludes individual and small group plans (under 25 employees)).

261. MD. CODE ANN., INS. § 15-810(c)(1) (LexisNexis 2023) (excluding small group plans “for which the Administration has determined that in vitro fertilization procedures are not essential health benefits.”).

262. MONT. CODE ANN. § 33-31-102 (2021); MONT. ADMIN. R. 6.6.2508 (1987) (only applies to HMOs).

263. N.H. REV. STAT. ANN. § 417-G:2(IV) (2023) (excludes Small Business Health Options Program (SHOP) plans and certain Affordable Care Act (ACA) transition plans).

264. N.J. STAT. ANN. § 26:2J-4.23(a) (West 2023) (excludes small group plans (under 50 employees)). Additionally, there is no provision applicable to individual plans.

265. N.Y. INS. LAW § 3221(k)(6)(C) (McKinney 2023) (does not cover IVF, gamete intrafallopian tube transfers (GIFT), or zygote intrafallopian tube transfers (ZIFT) for individual and small group plans).

266. OHIO REV. CODE ANN. § 1751.01(a)(1)(i) (West 2023) (only mandates coverage for health insuring corporations).

267. 27 R.I. GEN. LAWS § 27-18-30(f) (2023) (excludes individual plans).

268. TEX. INS. CODE ANN. § 1366.003 (West 2021); *id.* § 1366.002 (only applies to private group plans).

269. UTAH CODE ANN. § 49-20-418(2) (LexisNexis 2022) (pilot program applicable to state employees only).

270. W. VA. CODE § 33-25A-2 (2022) (applying only to HMOs); W. VA. CODE R. § 151-01 Attachment A (July 1, 2022) (state employee plan does not cover “[s]ervices intended to enhance fertility or to treat or [sic] sterility”).

271. 054-00-001 ARK. CODE R. § 5(b) (LexisNexis 2022) (“[T]he patient’s oocytes [sic] are fertilized with the sperm of the patient’s spouse . . .”)

272. HAW. REV. STAT. § 431:10A-116.5 (2013) (patient and spouse must have a history of infertility and “[t]he patient’s oocytes are fertilized with the patient’s spouse’s sperm”).

273. MD. CODE ANN., INS. § 15-810 (LexisNexis 2023). While this statute is crafted broadly, it seems to equate the terms “married” and “unmarried” with “not-single” and “single,” i.e., it requires unmarried patients to either have a specified medical condition or undergo three rounds of artificial insemination prior to coverage for IVF. *Id.* § 15-810(d)(4).

274. TEX. INS. CODE ANN. § 1366.005 (West 2021) (patient and spouse must have a history



Waiting periods	Arkansas, <sup>275</sup> Connecticut, <sup>276</sup> Hawaii, <sup>277</sup> Texas <sup>278</sup>	4 (23.53%)
Excludes IVF or other service	California, <sup>279</sup> New York <sup>280</sup>	2 (11.76%)
Restrictive definition of infertility	California, <sup>281</sup> Connecticut, <sup>282</sup> Delaware, <sup>283</sup> Massachusetts, <sup>284</sup> New Hampshire, <sup>285</sup> Rhode Island, <sup>286</sup> Utah <sup>287</sup>	7 (36.84%)

of infertility and IVF is only covered if “fertilization of the patient’s oocytes is made . . . with the sperm of the patient’s spouse”).

275. 054-00-001 ARK. CODE R. § 5(c) (LexisNexis 2022) (two years unless patient has certain enumerated medical conditions).

276. CONN. GEN. STAT. § 38a-509 (2023) (must be policyholder for at least twelve months).

277. HAW. REV. STAT. § 431:10A-116.5(a)(4) (2013) (five years unless patient has certain enumerated medical conditions).

278. TEX. INS. CODE ANN. § 1366.005(3) (West 2021) (five years unless patient has certain enumerated medical conditions).

279. CAL. HEALTH & SAFETY CODE § 1374.55(a) (Deering 2023).

280. N.Y. INS. LAW § 3221(k)(6)(C) (McKinney 2023) (excludes ZIFT and GIFT).

281. CAL. INS. CODE § 10119.6 (West 2023) (“[I]nfertility’ means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.”).

282. CONN. GEN. STAT. § 38a-509 (2023). (“[I]nfertility’ means the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.”).

283. DEL. CODE ANN. tit. 18, § 3556(j)(1)(b) (2023) (“‘Infertility’ means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth . . .”).

284. MASS. GEN. LAWS ch. 176A, § 8K (2023) (“[I]nfertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35.”).

285. N.H. REV. STAT. ANN. § 417-G:1(V) (2023) (“‘Infertility’ means a disease, caused by an illness, injury, underlying disease, or condition, where an individual’s ability to become pregnant or to carry a pregnancy to live birth is impaired, or where an individual’s ability to cause pregnancy and live birth in the individual’s partner is impaired.”).

286. 27 R.I. GEN. LAWS § 27-18-30 (2023) (defining infertility as “the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year”).

287. UTAH CODE ANN. § 49-20-418 (LexisNexis 2022) (coverage if “(i) the patient’s physician verifies that the patient or the patient’s spouse has a demonstrated condition recognized by a physician as a cause of infertility; or (ii) the patient attests that the patient is unable to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception”).

Age restrictions	Connecticut, <sup>288</sup> Delaware, <sup>289</sup> New Jersey, <sup>290</sup> Rhode Island <sup>291</sup>	4
Gender Restrictions	Rhode Island <sup>292</sup>	1

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288. CONN. GEN. STAT. § 38a-509 (2023) (allows insurer to limit coverage after forty).

289. DEL. CODE ANN. tit. 18, § 3342(i)(3)(c) (2023) (egg retrieval must occur before patient is forty-five and egg transfer must occur before age fifty).

290. N.J. STAT. ANN. § 26:2J-4.23(a) (West 2023) (must be under forty-five).

291. 27 R.I. GEN. LAWS § 27-18-30(a) (2023) (covers ages twenty-five to forty-two).

292. *Id.* (covers only women).