

ARTICLES

THE OTHER SIDE OF HEALTH CARE REFORM: AN ANALYSIS OF THE MISSED OPPORTUNITY REGARDING INFERTILITY TREATMENTS

NIZAN GESLEVICH PACKIN*

I. Introduction.....	2
II. The Pain of Infertility and the Right to Procreate	11
III. Assisted Reproduction Treatment and its Accessibility in the United States	18
IV. The Affordable Care Act and its Implications on Reproductive Rights	25
A. Health Care Reform	25
B. The Negative Implications of the Affordable Care Act	29
C. Positive Aspects of the Reform for Fertility Care	30
V. Old Habits Are Hard to Change: Objections to Providing Coverage for Infertility Treatments.....	32
VI. The Story of a Missed Opportunity or the Policy Reasons to Mandate Coverage for Infertility Treatments	41
A. A Gender and Economic Equalities Related Policy ..	41
B. A Health Related Policy	44
C. A Social Justice Related Policy.....	46
i. Justice Claims Support Using Mandates to Address the Health Insurance Market.....	49

* University of Pennsylvania Law School. A special thanks to Prof. Anita L. Allen, Prof. Tom Baker, Prof. Eric A. Feldman, Yafit Lev Aretz, Erez Aloni, and Tamir G. Packin for helpful comments on prior drafts. Thanks to Prof. Gideon Parchomovsky, for his guidance and insight. The author, an associate at Skadden, Arps, Slate, Meagher & Flom LLP, is solely responsible for the content of this Article and in particular, for all errors and omissions. The views expressed in this Article are solely those of the author and do not represent the views and opinions of Skadden, Arps, Slate, Meagher & Flom LLP.

ii. Mandating Coverage for Infertility Treatments	
Promotes Cost-Efficiency	49
D. A Medical Related Policy	51
VII. International Coverage of Fertility Treatments	55
VIII. Conclusion	58

I. INTRODUCTION

“Give me children, or else I die.” (Genesis 30:1)

Each year, over one million Americans seek infertility treatment,¹ but society still takes the ability to become pregnant for granted. A recent report demonstrates that in the United States, 7.3 million women between the ages of fifteen and forty-four (11.8%) have an impaired ability to have children, and 2.1 million married couples—one out of eight couples—experienced infertility.² Nevertheless, society is much more focused on preventing undesired pregnancies than enabling the pregnancies desired by the millions of Americans suffering from infertility.

In March 2010, President Obama signed into law highly debated, sweeping health care reform.³ The Affordable Care Act primarily reforms the individual and small group insurance markets by incorporating more social insurance considerations into that part of the U.S. health insurance system.⁴ In addition, while the Affordable Care Act does include a number of provisions that are relevant to assisted reproduction, such as

1. Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 298 (2005).

2. NAT'L CTR. FOR HEALTH STATISTICS, FERTILITY, FAMILY PLANNING, AND REPRODUCTIVE HEALTH OF U.S. WOMEN, U.S. DEP'T FOR HEALTH AND HUM. SERVS. 106, 108 (2002), available at http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf.

3. The new law contains two components: The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act, containing fixes to the first and broader measure, signed into law on March 30, 2010. See Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 4207, 124 Stat. 119, 577–78 (2010) (to be codified at 29 U.S.C. § 207); Health Care Educ. & Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 26 U.S.C.). For purposes of this Article, “Affordable Care Act” will be used to refer to both components.

4. Tom Baker, *Health Insurance, Risks, and Responsibility After the Patient Protection and Affordable Care Act*, 1 (U. of Pa. Inst. for Law & Econ., Working Paper No. 11-03, 2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1759366###. Nevertheless, the Affordable Care Act does modify all four parts of the U.S. health insurance system: Medicare (for the elderly and disabled), Medicaid (for lower income families' children and certain classifications of the poor), the large group market, and the small group market. *Id.* at 1, 3. But although the Affordable Care Act's changes of Medicaid are very significant in historical terms—it recognizes on a national basis the eligibility for healthcare for all of the poor—the Affordable Care Act changes Medicaid only incrementally. *Id.* at 3.

the elimination of the pre-existing condition exclusion, it does not include any provisions specific to fertility care.⁵ The Affordable Care Act fails to address an issue that affects millions of Americans—infertility. That failure is especially troublesome because various proposed bills have attempted to provide coverage for infertility treatment since the early 1990s.⁶ The Family Building Act of 2009 was the latest legislative attempt to address infertility treatment coverage.⁷ Nevertheless, that proposed bill's content was not incorporated into the Affordable Care Act.⁸

The pain of infertility has long been socially and psychologically recognized.⁹ Relatedly, the importance of reproductive freedom is widely accepted; Justice Douglas long ago observed that reproduction is a

5. ASRM Off. of Pub. Aff., *Health Care Reform: Implications for Reproductive Health and Health Care Providers*, ASRM (Apr. 13, 2010), <http://www.asrm.org/news/article.aspx?id=3089>.

6. Family Building Act of 2007, H.R. 2892, 110th Cong. §§ 2707, 714 (reintroducing H.R. 2706, 106th Cong.); Family Building Act of 2005, H.R. 735, 109th Cong. §§ 2707, 714 (reintroducing H.R. 2706, 106th Cong.); Family Building Act of 2003, H.R. 3014, 108th Cong. §§ 2707, 714 (reintroducing H.R. 2706, 106th Cong.); Family Building Act of 2001, H.R. 389, 107th Cong. §§ 2707, 714 (reintroducing H.R. 2706, 106th Cong.); Fair Access to Infertility Treatment and Hope Act of 2000, S. 2160, 106th Cong. § 714; Family Building Act of 1999, H.R. 2706, 106th Cong. §§ 2707, 714; Federal Employees Family-Building Act of 1991, H.R. 927, 102d Cong. § 2.

7. See Family Building Act of 2009, H.R. 697, 111th Cong. §§ 1(b)(1), 1(b)(4). The bill was introduced in the House on January 26, 2009 and referred to the Subcommittee on Health. *Bill Summary & Status: All Congressional Actions*, THOMAS, <http://thomas.loc.gov/home/LegislativeData.php?&n=BSS&c=111> (last visited July 5, 2011) (under “Enter Search,” select “Bill Number,” then enter “H.R. 697” in the search box, then click “Search,” and finally on the next page click “All Congressional Actions”). The bill was intended to require coverage for the treatment of infertility, and the full text of the bill is available at <http://www.gpo.gov/fdsys/pkg/BILLS-111hr697ih/pdf/BILLS-111hr697ih.pdf>.

8. Sara Wildman, *Not Married? Your Insurance Might Not Cover Fertility Treatments*, SLATE (Mar. 17, 2010), <http://www.slate.com/id/2248051/> (discussing the missed opportunity to include infertility treatment coverage in the 2010 health care reform); see also Dana Goldstein, *Could Health Care Reform Prevent Another Octomom?* SLATE, (Sept. 16, 2009), <http://www.doublex.com/section/health-science/could-health-care-reform-prevent-another-octomom> (discussing current views of assisted reproduction and the potential for much-needed regulation that the pending Act could offer). Moreover, the proposed bill was never examined by the Congressional Budget Office (CBO), which commonly provides the information and estimates required for the Congressional budget process. *Bill Summary & Status*, *supra* note 7 (showing that there is no CBO analysis for the bill); *CBO Fact Sheet*, CBO, <http://www.cbo.gov/aboutcbo/factsheet.cfm> (last visited June 30, 2011). Often, a proposed bill will be analyzed by the CBO, which can conclude, in its objective, nonpartisan analysis, the economic and budgetary burden that may result from a proposed bill. *Id.* However, as it appears that the Family Building Act was never analyzed by the CBO there is no conclusion that it is over-burdensome.

9. See generally Linda M. Whiteford & Lois Gonzalez, *Stigma: The Hidden Burden of Infertility*, 40 SOC. SCI. MED. 27, 28–29 (1995) (discussing the stigmatizing condition of infertility).

fundamental human right.¹⁰ Similarly, the United States Supreme Court has ruled that reproduction is a major life activity.¹¹ But conceptualizing the right to procreate as a fundamental right,¹² without offering any active assistance to infertility patients is not enough.¹³ Without assistance, patients suffering from infertility are unable to naturally turn their basic human yearning for parenthood into a reality.

Individuals suffering from infertility—who are interested in becoming parents—need to think of alternative solutions such as adoption, or infertility treatments, which are the focus of this Article. Fortunately, methods of assisted reproductive technology (ART)¹⁴ show increasing

10. See *Skinner v. Oklahoma*, 316 U.S. 535, 536, 541 (1942). Referring to procreation, Justice William O. Douglas held that it “involves one of the basic civil rights of man . . . fundamental to the very existence and survival of the race.” *Id.* at 541. In addition, Justice Douglas referred to the case as “touch[ing] a sensitive and important area of human rights . . . the right to have offspring.” *Id.* at 536.

11. *Bragdon v. Abbott*, 524 U.S. 624, 638 n.5 (1998). The Supreme Court resolved a split among the circuits regarding whether reproduction is to be considered a major life activity, by ruling that it is indeed. *Id.* at 638. In the case, an HIV positive patient brought an action pursuant to the ADA after her dentist refused to treat her in his office. *Id.* at 629. The Supreme Court held that an HIV infection that “substantially limits a major life activity”—in this case, reproduction—to be a disability within the reach of the ADA, even when the patient is not so advanced as to show symptoms. *Id.* at 641.

12. Rights claims can be categorized based on whether they make “positive” demands on other parties’ actions, or whether they make “negative” rights and solely require other parties to not take any harmful action and not harmfully interfere. See R.L. Lippke, *The Elusive Distinction Between Negative and Positive Rights*, 33 S. J. OF PHIL. 335, 335–46 (1995) (attempting to distinguish negative and positive rights, specifically relating to the political beliefs of libertarians). Accordingly, human rights are often classified as negative rights, because refraining from political oppressive actions is enough to satisfy the required negative duties. *Id.*

13. An individual’s right for no interference in the context of procreation does not mean that such individual has a positive right to receive assistance from the government to deal with her infertility via IVF or other ART methods. Such a right is therefore, a negative right. Daniel Statman, *The Right to Parenthood: An Argument for Narrow Interpretation*, 10 ETHICAL PERSPECTIVES 224 (2003), available at <http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=354>.

14. The definition of assisted reproductive technology (ART) varies from one agency to another. See *Assisted Reproductive Technology: Home*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/ART/> (last updated Aug. 19, 2011) (providing the definition of ART used by the CDC). In general, ART includes:

[A]ll treatments or procedures that include the in vitro handling of both human oocytes [eggs] and sperm or of embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy.

F. Zegers-Hochschild et al., *International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary of ART Terminology*, 2009, 92 FERTILITY & STERILITY 1520, 1521 (2009). Although “ART

technological promise for people that are prevented from naturally reproducing. ART methods range from limited and mild medical interventions, such as taking hormones, to the most invasive surgical procedures such as in vitro fertilization (IVF). IVF, which is often the last resort for infertile patients, is the process of retrieving a woman's egg, fertilizing it, and then transferring it into a uterus.¹⁵ This procedure is called a cycle, and infertility patients commonly need to undergo multiple cycles before achieving a successful birth of a child, if at all.¹⁶ Although commentators argue that this procedure might not be worth the effort, because of the mental toll it takes,¹⁷ IVF has great success rates.¹⁸ Nevertheless, despite the ray of hope that ART methods, and in particular IVF, offer, the access to these technologies is limited. Many barriers to ART exist: including wealth,¹⁹ race, sexual orientation, and marital status.²⁰

Unlike many other countries, the United States does not publicly fund infertility treatments and most health insurance plans do not directly

does not include assisted insemination (artificial insemination) using sperm from either a woman's partner or a sperm donor," throughout this Article, I also refer to artificial insemination as a form of ART. *Id.*

15. Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1216 (1997).

16. *Id.*

17. Much has been written about infertility's hope/despair cycle. Kimberly Monroe & Philip Monroe, *The Bible and the Pain of Infertility*, J. OF BIBLICAL COUNSELING, Winter 2005, at 50, 51, available at <http://abbafund.files.wordpress.com/2010/01/the-bible-and-the-pain-of-infertility1.pdf> ("At the beginning of her monthly cycle, a woman has great hope. *I'm going to get pregnant this month. I know it.* The month ends. No pregnancy. She despairs. The next month comes. Great hope again. But no pregnancy. Hope careens down to despair.") (emphasis in the original).

18. See *Clinic Summary Report*, SARTCORSONLINE, https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx?ClinicPKID=0 (last visited June 25, 2011) (showing success rates as high as 55.1% for donor oocyte transfers resulting in live births).

19. As further explained below, infertility treatments are extremely expensive, and each IVF cycle's cost is tremendously high. Most patients suffering from infertility need more than one cycle and require additional care, which makes the cost skyrocket even more. The difficulties that the high costs of infertility treatments cause were presented at a congressional hearing that took place on May 14, 2001:

Unfortunately, due to the high cost of treating this illness, only [twenty] percent of infertile couples seek medical treatment each year. Even worse, only four out of every ten couples that seek infertility treatment receive coverage from health insurers, and only one quarter of all health plans provide coverage for infertility services.

147 CONG. REC. S4892-01 (daily ed. May 14, 2001) (statement of Sen. Torricelli), 2001 WL 507957, at *S4893; see also Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER, L. & JUST. 18, 22 (2008) (addressing available access, and lack thereof, to assisted reproductive technologies).

20. Daar, *supra* note 19.

cover infertility treatments.²¹ Moreover, courts are split as to whether infertility is a disability, as defined by the Americans with Disabilities Act (ADA).²²

Supporters of coverage for infertility treatments have been lobbying regulators to conceptualize infertility as a disease, infertility treatment as a medical necessity, and to adopt mandates for infertility treatment coverage.²³ Their efforts have not been very fruitful. Currently, less than a third of states mandate that insurance plans cover fertility-related services or require that insurers offer such coverage.²⁴ But the supporters of intended-parents should not give up. The rates of access to assisted reproduction in the states with mandates have been significantly higher than in others.²⁵ However, even in the states that do mandate coverage for fertility-related services, many insured patients do not have insurance

21. Lucie Schmidt, *Effects of Infertility Insurance Mandates on Fertility*, 26 J. HEALTH ECON. 431, 432 (2007). Nearly a quarter of health-insurance plans cover some fertility diagnoses or treatments. *Id.*

22. Americans with Disabilities Act of 1990, 42 U.S.C. § 12102. Under the ADA a disability is defined as “a physical or mental impairment that substantially limited one or more . . . major life activities.” *Id.* Compare *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393, 1405 (N.D. Ill. 1994) (finding that infertility was a physical impairment of the reproductive system and that reproduction was a major life activity and, because the claimant’s infertility substantially limited the major life activity of reproduction, she had a recognizable disability under the ADA) with *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677 (8th Cir. 1996) (finding that reproduction was not a major life activity by definition under the ADA because it does not raise to the level of the listed activities of walking, seeing, speaking, breathing, learning, and working); see also *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243 (E.D. La. 1995), *aff’d*, 79 F.3d 1143 (5th Cir. 1996) (refusing to rule that infertility was not a physical impairment of the reproductive system, but also not recognizing reproduction as a major life activity).

23. See Neumann, *supra* note 15, at 1217; Sonia L. Nazario, *Infertility Insurance Gains Backing*, WALL ST. J., Dec. 5, 1989. See Margarete Sandelowski & Sheryl de Lacey, *The Uses of a “Disease”: Infertility as a Rhetorical Vehicle*, in INFERTILITY AROUND THE GLOBE: NEW THINKING ON CHILDLESSNESS, GENDER, AND REPRODUCTIVE TECHNOLOGIES 33, 36 (Marcia C. Inhorn & Frank van Balen eds., 2002) for a discussion of the efforts made to characterize infertility as a disease, and Melissa B. Jacoby, *The Debt Financing of Parenthood*, 72 L. & CONTEMP. PROBS. 147, 155 (2009) for studies that “suggest that mandating insurance coverage of assisted reproduction would impose relatively little cost.”

24. Jim Hawkins, *Doctors As Bankers: Evidence From Fertility Markets*, 84 TUL. L. REV. 841, 862 n.96 (2010). These fifteen states are Arkansas, California, Connecticut, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, Texas, and West Virginia. *Id.*; *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/default.aspx?tabid=14391> (updated Apr. 2011).

25. See, e.g., Neumann, *supra* note 15, at 1216–17 (reviewing studies of percentages of IVF treatments that are covered by insurance, one of which estimated that “30 to 40 percent of treatments [were] covered partially or completely by [presumably state-mandated] insurance” in 1995).

coverage for infertility treatments.²⁶ Individuals that are covered through self-insuring employers are not eligible for infertility treatments,²⁷ because mandatory coverage rules do not apply to self-insuring employers.²⁸ Additionally, many of the states that mandate coverage for infertility treatments impose different barriers to receive the treatment.²⁹ For example, no state requires insurance coverage of treatments such as IVF for same-sex couples.³⁰

The absence of mandates covering infertility treatments in most states is not surprising. Mandatory coverage of infertility treatments is highly controversial for reasons that go beyond whether or not infertility should be conceptualized as a disease.³¹ Traditionally, critics have argued that infertility treatment coverage is a hard sell since so many people do not have any health insurance at all.³² In addition, critics argued that mandates turn some intended parents toward assisted reproduction instead of encouraging them to consider adoption.³³ In fact, some critics even ar-

26. *Id.* (describing how some states “mandate that private insurers offer coverage for infertility services, which means that insurers must let employers know that such coverage is available, though insurers are not required to provide that coverage”) (emphasis added).

27. See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1371. About eighty-five percent of companies with more than 1000 employees self-insure, and, overall, self-insuring companies make up half the workforce employed by companies offering health insurance. Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. & REV. 340, 347 (2000).

28. A self-funded or self-insured “plan is one in which the plan sponsor, rather than a health insurer, assumes the risk of covering the costs of the health care benefits provided by the terms of the plan. The plan may be administered by an insurance company or other third party.” Remarks of Professor Elizabeth A. Pendo at the 2004 Association of American Law Schools Annual Meeting, in *Coverage of Reproductive Technologies Under Employer-Sponsored Health Care Plans: Proceedings of the 2004 Annual Meeting*, 8 EMP. RTS. & EMP. POL’Y J. 523, 541 (2004).

29. Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 185 (2009).

30. *Id.*

31. Some of the controversy relates to the use of extra fertilized eggs that will not be discussed in this Article. See, e.g., Steven Goldberg, *Technology Unbound: Will Funded Libertarianism Dominate the Future?*, 18 STAN. L. & POL’Y REV. 21, 27–28 (2007) (“To many Americans, a ‘spare embryo’ is a human life. As a result, discarding an embryo is utterly unacceptable.”).

32. Carson Strong, *Too Many Twins, Triplets, Quadruplets, and So On: A Call for New Priorities*, 31 J.L. MED. & ETHICS 272, 276 (2003) (pointing out that some people argue that citizens having access to basic care takes priority over infertility treatment).

33. ELIZABETH BARTHOLET, *FAMILY BONDS: ADOPTION AND THE POLITICS OF PARENTING* 93, 213 (1993); Tanvi Nagarsheth, Comment, *Crossing the Line of Color: Revisiting the Best Interests Standards in Transracial Adoptions*, 8 SCHOLAR 45, 49 (2005) (discussing international adoptions and the fact that infertility is one of the reasons people choose to adopt).

gued that providing insurance for costly infertility treatments rather than sponsoring adoptions “ironically makes these technologies the only alternative some people can afford.”³⁴ Opponents to infertility treatment coverage have included religious organizations,³⁵ feminists,³⁶ and parties that advocated against paying higher insurance premiums and that have warned that the new fertility technologies may inappropriately allow intended parents to opt for children with specific traits.³⁷ Finally, some argue that ART should be made available only to patients who are fit for parenthood, to prevent harm to offspring and society.³⁸

Many developed countries around the world, such as Germany and Israel, have adopted publicly funded health care plans, which include medical services that treat infertility problems.³⁹ The United States, however, does not have such a health care plan or any other viable comprehensive solution for the increasing population of patients suffering from infertility. In this Article, I will argue that the Affordable Care Act missed an opportunity to finally mandate coverage for infertility treatments and reduce discrimination in the provision of ART services. But despite the failure to mandate coverage for infertility treatments, I will also argue that not all hope should be lost. The Affordable Care Act’s minimum essential coverage requirements set minimum standards on the health plans offered to the individual and small group market beginning in 2014 that include broad and undefined terms; those terms can and should be interpreted to include fertility care.

I will further argue in this Article that infertility resulting from the inability to conceive or carry a pregnancy to term after twelve months of

34. DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 290 (1997); BARTHOLET, *supra* note 33, at 34–35 (describing how society gives “preferred treatment to those who choose child production over child adoption”); Neumann, *supra* note 15, at 1232 (“Any decision by health insurers regarding IVF has implications for adoption.”).

35. Lyria Bennett Moses, *Understanding Legal Responses to Technological Change: The Example of In Vitro Fertilization*, 6 MINN. J. L. SCI. & TECH. 505, 522–23 (2005) (analyzing Catholic oppositions to IVF).

36. See CHARIS THOMPSON, *MAKING PARENTS: THE ONTOLOGICAL CHOREOGRAPHY OF REPRODUCTIVE TECHNOLOGIES* 56 (2005) (introducing traditional notions of gender roles as a reason for the tension between feminism and ART).

37. See Mary Crossley, *Dimensions of Equality in Regulating Assisted Reproductive Technologies*, 9 J. GENDER RACE & JUST. 273, 285 (2005) (discussing trait-selection practices).

38. See Daar, *supra* note 19, at 82. These critics, however, fail to understand that “it is essential to evaluate these actions using the same standards [society] would [use to] evaluate barriers to natural conception.” *Id.*

39. *How Does the US Compare to the Rest of the World for Infertility Coverage?*, NO BABY ON BOARD, <http://www.nobabyonboard.com/worldcompare.html> (last visited June 25, 2011).

attempted conception—or six months of attempted conception for individuals above the age of thirty-five—should be viewed as a disease. Infertility is a recognized medical condition in many developed countries and its treatment should be regarded in the same way as the treatment of any other diseases. It should be covered even if the chances to develop the disease increase as a result of aging, or result from individual choices, and regardless of whether the treatment brings relief via bypassing the medical condition rather than solving it. Moreover, infertility treatment helps resolve various psychological problems resulting from infertility, including depression, which financially impacts society.

Finally, I will argue that mandating coverage for infertility treatments will advance four highly desired policies: (1) the promotion of gender equality; (2) the promotion of a desired health related policy; (3) the promotion of social justice; and (4) the promotion of a desired medical related policy.

(1) The promotion of gender equality. Infertility, framed in medical or social terms, is a severe problem, which should be dealt with by our entire society rather than individual women, or women and their partners. Indeed, pursuant to contemporary social norms, women study and work outside the home, causing delays in childbearing. If today's women are encouraged and expected to study, work, and fulfill themselves (mentally, socially, and economically)—just as men are—society should not let women, or the women and their partners, pay the price for delaying childbearing on their own.

(2) The promotion of a desired health related policy. Studies have shown that pregnancies resulting from assisted reproduction have a high probability of including multiple embryos, which result in multiple births.⁴⁰ Currently, the high cost of infertility treatment pushes patients to pressure their physicians to maximize the chances of pregnancy on each cycle, through multiple-embryo transfer, despite the associated health risks. The resulting multiple pregnancies, which are pregnancies in which women carry a number of fetuses, have various risks associated with them. Health care coverage for infertility treatment would encourage approaches that are common in Europe which, promote single-embryo transfers, instead of multiple embryo implants, which lead to multiple pregnancies.⁴¹ As empirical studies show, this decision and pressure on the treating physicians are the result of the patients' inability to

40. See Urska Velikonja, *The Costs of Multiple Gestation Pregnancies in Assisted Reproduction*, 32 HARV. J.L. & GENDER 463, 471 (2009).

41. Theresa Glennon, *Choosing One: Resolving the Epidemic of Multiples in Assisted Reproduction*, 55 VILL. L. REV. 147, 150 (2010). In Belgium, for example, by expanding coverage for IVF and including limits on the number of embryos transferred depending on patient age, the twinning rate related to IVF and other fertility treatments was dramatically

pay for additional treatment cycles. Providing coverage for infertility treatments would remove the financial fear factor from the decision-making process. In addition, the cost-savings that would result from dramatically reducing the health risks associated with multiple pregnancies is an important economic incentive that would greatly benefit society.

(3) The promotion of social justice. In many ways, the debate over financing infertility treatments mirrors a larger debate over financing costly medical technologies that benefit a small group of people. The core of such debates is determining as a society how much we should favor producing the best outcomes with our limited resources. This debate is a balance of what priority we should give to treating the most disabled people—i.e., in which instances should we allow modest benefits for a larger group of people to outweigh more significant benefits for a smaller group of people?⁴² When choosing between the ideological visions in the health care system, a preference should be given to consider infertility treatments as a social good. Such a social good should be something to which everyone should be entitled, and for which society as a whole should be responsible, especially given the centrality of parenting for the “normal functioning” of people.⁴³

(4) The promotion of a desired medical related policy. Infertility should be recognized as a disease and a disability, and infertility treatment should be viewed as a legitimate medical solution for a valid medical problem.⁴⁴ Accordingly, patients suffering from medical infertility should be entitled to receive proper medical treatment and should be protected from any discrimination resulting from their infertility.

This Article is structured as follows: Part II discusses the pain of infertility and the right to procreate. Part III describes available assisted re-

reduced. *Id.* at 201. Moreover, in several European countries, women normally “use IVF to transfer only one embryo at a time.” *Id.* at 150.

42. Scholars of the sociology of insurance argue that the way society designs its insurance institutions greatly affects the way that individuals think about responsibility and suffering, and can increase the perceived legitimacy of using insurance to spread and allocate economic risks. Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 33, 46–47 (Tom Baker & Jonathan Simon eds., 2002) [hereinafter *EMBRACING RISK*]. Tom Baker and Jonathan Simon call this “the use of risk in the social construction of reality.” Tom Baker & Jonathan Simon, *Embracing Risk in EMBRACING RISK*, *supra* at 18.

43. NORMAN DANIELS, *JUST HEALTH CARE*, 34 n.9 (1995). As expressed by one observer, if 100 percent of couples were infertile, fertility treatment would be America’s number-one priority. Andrea L. Bonnicksen, *IN-VITRO FERTILIZATION: BUILDING POLICY FROM LABORATORIES TO LEGISLATURES* 103 (1989).

44. Infertility is defined as “a *disease* of the reproductive system defined by the failure to achieve a clinical pregnancy after [twelve] months or more of regular unprotected sexual intercourse.” F. Zegers-Hochschild et al., *supra* note 14, at 1522 (emphasis added).

production treatments and how they can be accessed in the United States, while analyzing state mandated insurance coverage, and past attempts to enact laws that would provide coverage for fertility care. Part IV discusses the Affordable Care Act and highlights its implications on reproductive rights. Part V examines the merit of the objections to providing coverage for infertility treatments, while focusing on why infertility should be considered as a disease. Part VI details the desired policy reasons, which will be promoted by mandating coverage of infertility treatments. Part VII provides a comparative analysis of international coverage of infertility treatments.

II. THE PAIN OF INFERTILITY AND THE RIGHT TO PROCREATE

Infertility is defined as “the inability to conceive after one year of unprotected intercourse (six months if the woman is over age [thirty-five]) or the inability to carry a pregnancy to live birth.”⁴⁵ This definition can be expanded to encompass primary infertility, in which a pregnancy has never taken place, and secondary infertility, in which a couple was able to conceive at some point, “but [is] unable to conceive again”⁴⁶ Infertility impacts about one out of eight couples in the United States.⁴⁷ Pursuant to a recent report, approximately twelve percent of U.S. women between the ages fifteen and forty-four experienced an “impaired ability to have children.”⁴⁸

Infertility can result from various known and unknown abnormalities in the female or male reproductive system. For example, a woman may have difficulty ovulating, or a woman’s fallopian tubes could be scarred, which inhibits the eggs passage “from the ovaries to the uterus.”⁴⁹ In other situations, women may be infertile as a result of having had abdominal surgery, pelvic surgery, or a ruptured appendix; women can also suffer from infertility as a result of having uterine cells grow outside the uterus.⁵⁰ Men can suffer from infertility too, which commonly results from a low sperm count or dysfunctional sperm caused by sexually trans-

45. *Fast Facts About Infertility*, RESOLVE (Feb. 2, 2008), <http://www.resolve.org/about/fast-facts-about-fertility.html>.

46. *Definition of Infertility*, THE FREE DICTIONARY, <http://medical-dictionary.thefreedictionary.com/infertility> (last visited June 25, 2011).

47. *Id.*

48. *Infertility*, CTRS. FOR DISEASE CONTROL & PREVENTION/NAT’L CTR. FOR HEALTH STATISTICS (Apr. 2, 2009), <http://www.cdc.gov/nchs/fastats/fertile.htm>.

49. David Orentlicher, *Discrimination Out of Dismissiveness: The Example of Infertility*, 85 IND. L.J. 143, 154 (2010).

50. *Id.*

mitted diseases, mumps during teenage years, chemotherapy, and all sorts of different testicular injuries.⁵¹

Dealing with infertility is extremely difficult. Many people view having children, and parenting them, as tightly related to self-fulfillment.⁵² Therefore, for individuals who want to have children the inability to reproduce can be completely devastating.⁵³ Dating back to biblical times, the expectation was that individuals needed to fulfill themselves by becoming parents, and the first commandment that is given in *Genesis* is: “Be fruitful and multiply.”⁵⁴ Therefore, the understanding that being infertile is a cause of severe pain and sorrow has always been widely accepted. Indeed, Hannah, Sarah, Rachel, and other characters in the Bible testified to the deep anguish and heartache experienced from infertility.⁵⁵

51. *Id.*

52. It has been stated that “reproductive experiences . . . are central to personal conceptions of meaning and identity. To deny procreative choice is to deny or impose a crucial self-defining experience, thus denying persons respect and dignity at the most basic level.” See JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 4 (1994) (discussing the importance of procreative liberty).

53. Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CALIF. L. REV. 623, 629 (1991); Katherine T. Pratt, *Inconceivable? Deducing the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1127–29 (2004).

54. *Genesis* 1:28. “And God blessed them, and God said unto them, Be fruitful, and multiply, and replenish the earth, and subdue it: and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth.” *Id.*

55. There are several Biblical stories which exemplify the despair felt by women who cannot conceive. In the days of the Old Testament, Hannah felt human isolation. *1 Samuel* 1:7. She was infertile and felt completely alone, even though she was Elkanah’s favorite wife. *Id.* at 1:4, 1:7. Peninnah, Elkanah’s other wife, taunted Hannah since she had no children. *Id.* at 1:6. In addition, her husband did not understand her. *Id.* at 1:8. He would wonder why she was so upset, and ask, “Am I not more to you than ten sons?” *Id.* Similarly, Eli, a priest, confused her deep sorrow with being drunk. *Id.* at 1:3,–1:4. Hannah prayed to and pleaded with God to give her a son. *Id.* at 1:11. She promised to give her son back to God to serve him. *Id.* Eventually, God answered her prayers and gave her Samuel, who was the last and greatest judge of Israel. *Id.* at 1:20. Much like Hannah, Abraham and Sarah had given up hope of ever having their own children. *Genesis* 18:12. In fact, Sarah laughed at the promise of God that she will have a son, Isaac, because she was well past a child-bearing age. *Id.* Similar to his parents, Isaac, who married Rebekah, pleaded to God for his wife who was barren. *Genesis* 25:21. Eventually, twenty years after their marriage they were blessed with twin sons, Jacob and Esau. *Id.* at 25:25–25:26. One of Jacob’s wives, Rachel, was also barren, unlike her sister, Jacob’s second wife Leah, who had six sons and a daughter. *Id.* at 25:31. Rachel tried everything she could think of in order to conceive, and even cried out to Jacob, “[g]ive me children, or else I die.” *Id.* at 30:1. Jacob replied, “Am I in God’s stead, who hath withheld from thee the fruit of the womb?” *Id.* at 30:2. Eventually, Rachel finally had Joseph and another son, Benjamin. *Id.* at 30:22–24, 30:24, 30:16–30:18.

Suffering from deep anguish is not unique to biblical times. Many infertility patients suffer from extreme emotional disorders resulting from their inability to fulfill their basic need to procreate. The spectrum of emotions they experience is immense. Patients feel anger, depression, isolation, helplessness, and suffer from low self-esteem.⁵⁶ One author wrote that infertility patients cannot even find comfort in church because their childlessness is highlighted even more in church, and the patients, or others around them, link infertility to faith.⁵⁷

Numerous scholars have also written about the grief that women experience when their efforts to become pregnant by use of infertility treatments fail.⁵⁸ Indeed, this grief is so tremendous that women who experienced a chronic or a life-threatening disease, such as cancer, HIV, or rehabilitation following a heart attack, rated the emotional pain resulting from their infertility at an equivalent level as they ranked their terminal illness.⁵⁹ Similarly, pursuant to a different study, the majority of women who experienced infertility and also had gone through a divorce rated their infertility as more painful than their divorce.⁶⁰ Moreover, when the patients' infertility resulted from cancer or its treatment, these patients rated the loss of their fertility as more painful than the actual cancer illness itself.⁶¹ In another study, participants rated infertility as their most stressful experience, placing its effect as high as the death of a child or a spouse.⁶² According to one professional, the likelihood of depression is twice as high for women suffering from infertility than for

56. ALINE P. ZOLDBROD, MEN, WOMEN, AND INFERTILITY: INTERVENTION AND TREATMENT STRATEGIES 3 (1993); Linda D. Applegarth, *The Psychological Aspects of Infertility*, in INFERTILITY: EVALUATION AND TREATMENT 25, 27 tbl. 4-2 (William R. Keye Jr. et al. eds., 1995). See also Lynn White & Julia McQuillan, *No Longer Intending: The Relationship Between Relinquished Fertility Intentions and Distress*, 68 J. MARRIAGE & FAM. 478, 487 (2006) (studying the effects of infertility on relationships); Sara L. Berga et al., *Psychiatry and Reproductive Medicine*, in 2 KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2293, 2300 (Benjamin J. Sadock & Virginia A. Sadock eds., 8th ed. 2005) (discussing the self-loathing women experience when they are unable to conceive).

57. Monroe & Monroe, *supra* note 17, at 52.

Alice D. Domar et al., Special Issue, *The Psychological Impact of Infertility: A Comparison with Patients with Other Medical Conditions*, J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY, 45, 49, 49 tbl. 1 (1993).

58. *Id.*

59. *Id.*

60. Monroe & Monroe, *supra* note 17, at 50.

61. Carrie L. Nieman et al., *Fertility Preservation and Adolescent Cancer Patients: Lessons from Adult Survivors of Childhood Cancer and Their Parents*, in ONCOFERTILITY: FERTILITY PRESERVATION FOR CANCER SURVIVORS 201, 201 (Steven T. Rosen et al. eds., 2007).

62. Orentlicher, *supra* note 49, at 155.

healthy women, who did not suffer from infertility.⁶³ Finally, in a research study conducted among women suffering from infertility, approximately half of the women surveyed indicated that their infertility was the most upsetting event of their lives.⁶⁴ Similarly, studies have shown that men suffering from infertility also express feelings of deep pessimism, especially if these men are members of a culture that considers itself pronatalist, one in which genetic parenting and procreation awards a sought-after social status.⁶⁵

While much has been written about the basic human need to be a parent, ethical and legal aspects of the right to procreate are much less explored. Natural biological consequences of human reproductive activities, therefore, do not affect human rights. In a reality in which having children is merely the desired, or not desired, result of having sexual intercourse, the right to procreate is not a relevant issue. After all, infertility is not the result of denying one's right to procreate and, similarly, having an unwanted pregnancy is not the result of denying one's right not to procreate. As such, the discourse regarding human rights and liberties is relevant only in the context of human interactions, and not in the context of what is purely nature taking its course.

The biblical Sarah could not make any claims (except for claims to God) about the denial of her right to parent. However, Nadya Suleman, also known as Octomom, could have had a legitimate claim against society as a whole, if the reason she would have ended up being childless, despite her desire to parent, was because she lacked the financial resources needed to fulfill this basic yearning. Therefore, the discourse regarding the fundamental right to procreate only became relevant once ART became available and treatment for infertility was developed. Following the ART developments, the right to procreate is becoming a relevant issue around the world.⁶⁶ And, as some libertarian-liberal scholars

63. Domar et al., *supra* note 57, at 1160–61.

64. See Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 *FERTILITY & STERILITY* 48, 50 (1985).

65. Marcia C. Inhorn & Michael Hassan Fakh, *Arab Americans, African Americans, and Infertility: Barriers to Reproduction and Medical Care*, 85 *FERTILITY & STERILITY* 844, 845 (2006).

66. See *Parenthood and Procreation*, *STANFORD ENCYCLOPEDIA OF PHILOSOPHY*, <http://plato.stanford.edu/entries/parenthood> (last updated May 30, 2006).

Social changes often throw into question a phenomenon that previously seemed natural or trivial, turning what was an uninteresting subject of philosophical discussion into a topic of controversy. The rise of “Assisted Reproductive Technologies” (ARTs), increasing multiculturalism, and the explosion of interest in “applied” philosophy have all contributed to a rise of interest in philosophical questions surrounding parenthood and procreation.

Id.

such as John Harris believe, the right should be analyzed considering the values of equality and autonomy.⁶⁷ Therefore, ART methods should be widely available because any restrictions on the right to procreate, would constitute discriminatory and unfair treatment of infertility patients, who cannot conceive naturally.⁶⁸ Currently, the right to procreate also referred to as the right to parent, is promoted by different organizations,⁶⁹ decisions by courts from countries around the world,⁷⁰ and human-rights related manifestos and declarations.⁷¹

In the United States, as the Supreme Court has held, the right to procreate is a fundamental interest.⁷² In 1942, Justice Douglas described “the right to have offspring” as “a sensitive and important area of human rights.”⁷³ Similarly, in 1965, Justice Goldberg categorized the act of procreating as undividable from other behavior, such as “the right ‘to marry, establish a home and bring up children.’”⁷⁴ Moreover, in 1992,

67. See generally John Harris, *Rights and Reproductive Choice*, in *THE FUTURE OF HUMAN REPRODUCTION: CHOICE AND REGULATION* 34–36 (John Harris & Soren Holm, eds., 1999) (discussing theories relating to reproduction).

68. *Id.*

69. Such organizations include, inter alia, ASRM, International Federation of Fertility Societies, and RESOLVE: The National Infertility Association Surveillance.

70. *Bragdon v. Abbott*, 524 U.S. 624, 638 n.5 (1998) (holding that HIV infection which impairs reproduction, a major life activity, was a disability under the ADA); *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393, 1405 (N.D. Ill. 1994) (determining that infertility qualified as a disability under the ADA); *CA 2401/95 Nahmani v. Nahmani* 50(4) PD 661 [1996] (Isr.) (upholding a woman’s right to be a parent, on appeal in Israel).

71. See Universal Declaration of Human Rights, G.A. Res. 217 (III) A, art. 16(1), U.N. Doc. A/RES/217(III) (Dec. 10, 1948), available at <http://www.un.org/Overview/rights.html> (pledging that “[m]en and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family”); International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), art. 23(2), U.N. Doc. A/RES/2200A(XXI) (Mar. 23, 1976), available at <http://www2.ohchr.org/english/law/ccpr.htm> (requiring “[t]he right of men and women of marriageable age to marry and to found a family shall be recognized”); International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), art. 10(1), U.N. Doc. A/RES/2200A(XXI) (Jan. 3, 1976), available at <http://www2.ohchr.org/english/law/cescr.htm> (“The widest possible protection and assistance should be accorded to the family . . . particularly for its establishment and while it is responsible for the care and the education of dependent children.”); Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, art. 16(1)(e), U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/36 (Sept. 3, 1981), available at <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm> (requiring signatories to ensure that men and women have “[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education, and means to enable them to exercise these rights”).

72. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

73. *Id.* at 536.

74. *Griswold v. Connecticut*, 381 U.S. 479, 495 (1965) (Goldberg, J., concurring) (quoting *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923)).

the Court determined that “[i]f the right of privacy means anything, it is the right of the *individual*, married or single . . . ? to bear or beget a child.”⁷⁵ And, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁷⁶ the Supreme Court refers to procreation as a privacy right.⁷⁷ Legislators and policy makers have also agreed that the right to parent is a basic one, stating that “[a] fundamental part of the human experience is fulfilling the desire to reproduce,”⁷⁸ and that “[t]here is nothing more basic to human beings than the desire to have a family.”⁷⁹

Indeed, in the last several decades, the right to procreation has been garnering broader support.⁸⁰ In analyzing the right to procreate, Professor John Robertson argued that although procreative liberty is not a “positive right to have the state or particular persons provide the means or resources necessary to have or avoid having children,” still “it is a negative right against state interference with choices to procreate or to avoid procreation.”⁸¹ However, other scholars have argued that the right includes the expansive concept of reproductive rights, which entails negative and positive rights ensuring free choice whether to conceive or not to conceive and to become pregnant or not to become pregnant.⁸²

In fact, even those who view the right to procreate as a limited right recognize its importance and that it should be protected and promoted.⁸³

75. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (emphasis added).

76. 505 U.S. 803.

77. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

78. Family Building Act of 2009, H.R. 697, 111th Cong. § 1(b)(4).

79. 145 CONG. REC. E1749-04 (daily ed. Aug. 4, 1999) (statement of Rep. Weiner), 1999 WL 575840, at *E1749.

80. See Developments in the Law, *The Constitution and the Family*, 93 HARV. L. REV. 1161, 1161–67 (1980) (outlining the development of fundamental rights relating to “marriage, procreation, contraception, abortion, family relationships, and the rearing and education of children.”).

81. ROBERTSON, *supra* note 52, at 23.

82. See *Davis v. Davis*, 842 S.W.2d 588, 601 (Tenn. 1992) (“[T]he right of procreational autonomy is composed of two rights of equal significance—the right to procreate and the right to avoid procreation.”); Lauren Gilbert et al., *Preface to the Conference on the International Protection of Reproductive Rights*, 44 AM. U. L. REV. 963, 963 (1995) (referring to the “concept of reproductive rights”); Kimberly A. Johns, *Reproductive Rights of Women: Construction and Reality in International and United States Law*, 5 CARDOZO WOMEN’S L.J. 1, 3 (1998) (analyzing reproductive rights as very broad and comprehensive rights, which include rights to sexual and reproductive health, as well as rights to be free from sexual discrimination).

83. Some critics argued that the Supreme Court’s *Skinner* decision refers to “procreation for social survival,” not for maximum population, and that therefore the right to procreate is not all-inclusive and unlimited. See Lynn Wardle, *Multiply and Replenish: Considering Same-Sex Marriage in Light of State Interests in Marital Procreation*, 24 HARV. J.L. & PUB. POL’Y 771, 782 (2001) (arguing, inter alia, that states have authority to regulate marriage in order to promote responsible procreation). Other critics argued that *Skinner*

Indeed, the “‘right’ to found a family and have children” entails a wide range of privileges, immunities, and disabilities.⁸⁴ It is a universally broad claim right,⁸⁵ which places a duty on others to, at the minimum, not obstruct attempts to procreate, and gives the advantaged procreator a power to create and change the legal relations of the future children. Moreover, some argue that the correlated “entitlement to family planning services”⁸⁶ also includes another claim right, which is a positive right, placing a duty on the government to assist in procreation or avoiding procreation. This is actually the legal reality in Israel, where the right to parent is considered to be a basic and fundamental human right, to which everyone is entitled.⁸⁷ Courts interpreting the right to parent have held that it is twofold: first, it includes a negative right that the government would protect individuals’ right to parent; and second, it includes the right to decide when, if, with whom, and in what way one should realize and fulfill their right to parent. This right incorporates a positive right to receive assistance from the government against any barriers preventing individuals to realize their right to parent.⁸⁸

Therefore, the right to parent is a fundamental right that society should promote, and, as suggested by one scholar, “procreative liberty [should]

can be viewed mainly as an equal protection case, and that it does not provide a broad constitutional right to procreate. These critics argue that despite the assumption that procreative rights are expansive in scope, that the protected procreative behavior is much narrower, and reflects competing rights and duties. *See generally* Carter J. Dillard, *Rethinking the Procreative Right*, 10 *YALE HUM. RTS. & DEV. L.J.* 1, 63 (2010) (stating that it is a right “at least to replace oneself, and at most to procreate up to a point that optimized the public good”).

84. Johnson C. Montgomery, *The Population Explosion and United States Law*, 22 *HASTINGS L.J.* 629, 629 (1971) (stating “[t]hat there is a ‘right’ to found a family and have children [that] cannot be seriously questioned”); Amartya Sen, *Fertility and Coercion*, 63 *U. CHI. L. REV.* 1035, 1041 (1996) (explaining that some advocates of assisted reproduction believe in a “personal right to decide freely how many children to have”); Note, *Reproductive Technology and the Procreation Rights of the Unmarried*, 98 *HARV. L. REV.* 669, 678 (1985) (“The Supreme Court has clearly guaranteed, at least for married persons, the fundamental right to procreate.”).

85. Academics differentiate claim rights from liberty rights. *Human Rights*, *INTERNET ENCYCLOPEDIA OF PHILOSOPHY*, <http://www.iep.utm.edu/hum-rts/#SH3b> (last updated July 5, 2005). Stating that the former is a duty owed to an individual while the later is a right which exists “in the absence of any duties not to perform some desired activity.” *Id.* Claim rights can be either a positive claim right or a negative claim right. *Id.*

86. *See* Paula Abrams, *Population Politics: Reproductive Rights and U.S. Asylum Policy*, 14 *GEO. IMMIGR. L.J.* 881, 890 (2000) (using the phrase “entitlement to family planning services” to explain one of two “core reproductive rights” that people have).

87. *See* CA 2401/95 *Nahmani v. Nahmani* 50(4) PD 661 [1996] (Isr.) (holding that the right of a woman to be a parent outweighed the husband’s right not to be a parent).

88. DC 3419/04 *Unknown v. Minister of Health*, PM (2005) (Isr.).

be given presumptive priority in all conflicts, with the burden on opponents . . . to show” the harm that justifies limiting the right.⁸⁹

III. ASSISTED REPRODUCTION TREATMENT AND ITS ACCESSIBILITY IN THE UNITED STATES

Thanks to the wide range of medical solutions available infertility can be defeated much more easily today than in the past. These treatment options range from the minimally invasive, such as drugs and hormonal treatment, to medical solutions that require surgery, or even surrogacy. Overall, infertility treatments enable eighty-five percent of infertile couples to have a child of their own.⁹⁰

IVF, which is probably the most widely-known infertility treatment, involves injecting a woman with medications that stimulate her eggs.⁹¹ Subsequently, a surgical removal of several eggs from the woman’s ovaries takes place, and then the woman’s egg and a man’s sperm are combined in appropriately supervised laboratory conditions.⁹² To increase the procedures success rates, usually all eggs are fertilized.⁹³ A number of days later, after the embryos develop, the physicians select the healthiest ones for implantation in the woman’s uterus.⁹⁴ Then, patients will

89. See ROBERTSON, *supra* note 52, at 16 (encouraging society to adopt his standard for procreative liberty in order to determine the scope of procreative liberty).

90. Clare Bates, *Fertility Treatments Show Diminishing Returns the More Times They are Tried, Couples Warned*, MAIL ONLINE (Aug. 6, 2010, 8:04 AM), <http://www.dailymail.co.uk/health/article-1300529/Fertility-treatments-half-effective-just-attempts-couples-warned.html> (stating that there is an eighty-five percent success rate for couples who undergo treatment twice, a seventy-one percent success rate for single treatments, but the success rates inevitably drop with increased treatment cycles).

91. Alan H. DeCherney et al., *In Vitro Fertilization & Related Techniques*, in CURRENT OBSTETRIC & GYNECOLOGIC DIAGNOSIS AND TREATMENT 1026 (A. DeCherney & M. Pernoll eds., 1994).

92. *Id.* at 1027

93. See *id.* (“Between 10,000 and 50,000 motile sperm are placed within each egg.”).

94. *Id.* Two variations of IVF also exist. One is gamete intrafallopian transfer (GIFT), a procedure in which eggs and sperm are transferred to the fallopian tubes separately, therefore making the fertilization take place inside the body rather than outside. *Id.* at 1028. The other variation is known as zygote intrafallopian transfer (ZIFT), and it is a procedure where a catheter is used to transfer the embryo into the fallopian tube about eighteen hours after the embryo has been fertilized. R. BLANK & J. MERRICK, HUMAN REPRODUCTION, EMERGING TECHNOLOGIES, AND CONFLICTING RIGHTS 87 (1995). In the last ten years, the use of GIFT and ZIFT has decreased dramatically as IVF technology and success rates have improved—now they account for less than one percent of ART. See 2006 ART Section 2: ART Cycles Using Fresh, Nondonor Eggs, CTRS. FOR DISEASE CONTROL (Sept. 1, 2009), http://www.cdc.gov/art/ART2006/sect2_fig27-41.htm [hereinafter 2006 Art Section 2] (showing a circle graph depicting the types of ART procedures performed in 2006).

typically freeze some of the unused embryos so that they will be available for additional IVF attempts if the current attempt fails.⁹⁵

The reasons for using IVF include: the failure to ovulate, refractory endometriosis, advanced age in which the woman tries to conceive, absent or nonpatent fallopian tubes, as well as previously unsuccessful infertility treatments.⁹⁶ Using IVF, physicians can inject a single sperm into every single one of the woman's retrieved eggs, and by doing so, they enable men with a low sperm count to procreate.⁹⁷ IVF was first used in 1978 and led to the birth of Louise Brown, the first IVF baby in the United Kingdom.⁹⁸ The prevalence of IVF has increased rapidly and it is now the most common type of ART.⁹⁹ According to data reported by 361 U.S. fertility clinics, in 2008, 140,795 treatment cycles were conducted, which led to the births of 56,790 babies.¹⁰⁰ According to estimates, ARTs are responsible for three out of every hundred births nationwide.¹⁰¹ In addition, although the success rate varies by age, the IVF success rates for women under thirty-five who were in good health have been reported to be almost as high as fifty percent.¹⁰²

As explained above, infertility is more than a mere disease; it is a devastating life crisis that can greatly affect one's health, relationships, success at work, and social interactions.¹⁰³ But added to the emotional and physical toll exacted by infertility are the barriers standing in the way of the many treatment seekers. Infertility treatments, and in particular IVF treatments, are very expensive. The average cost for one IVF cycle in the United States is about \$12,400,¹⁰⁴ but "accessory procedures," which in-

95. See 147 CONG. REC. S7846-01 (daily ed. July 18, 2001) (statement of Sen. Frist), 1999 WL 810829, at *S7850 (discussing stem cell research and desirability of utilizing frozen embryos unused during IVF).

96. Orentlicher, *supra* note 49.

97. *Id.*

98. Neumann, *supra* note 15, at 1216.

99. 2006 ART Section 2, *supra* note 94 (showing a circle graph depicting the types of ART procedures performed in 2006).

100. ASRM Off. of Pub. Aff., *56,790 Children Born in 2008 from ART; Society for Assisted Reproductive Technology Releases Data from 2008 Clinic Outcome Reports*, 12 ASRM BULL. 4 (Feb. 19, 2010), <http://www.asrm.org/news/article.aspx?id=2497>.

101. Daar, *supra* note 19, at 21.

102. See *Clinic Summary Report*, *supra* note 18 (reporting that at SART member clinics, 47.6% of fresh embryos from non-donor oocytes resulted in pregnancies and a fifty-five percent rate of live births was recognized when the donor's oocytes were used regardless of age).

103. Frank M. Andrews et al., *Stress from Infertility, Marriage Factors and Subject Well-Being of Wives and Husbands*, 32 J. HEALTH & SOC. BEHAV. 238, 238-39 (1991).

104. Debora L. Spar, *Where Babies Come From: Supply and Demand in an Infant Marketplace*, HARV. BUS. REV., Feb. 1, 2006, at 133, 135. These costs, however, do not include the cost of several IVF cycles, the cost of prenatal care and delivery, and the higher

clude sperm injection and hatching the egg, can dramatically raise the cost.¹⁰⁵ Therefore, pursuant to recent approximations, an all-inclusive infertility treatment cycle is valued at about \$21,000 per couple.¹⁰⁶ That high price often makes IVF too expensive for more than a single try.

Moreover, the extraordinary costs of IVF treatments in the United States are much less affordable than they are in many other developed countries. For example, in 2003, the average U. S. cost in dollars for an IVF cycle was much higher than the average costs in Canada, the United Kingdom, Scandinavia, and Japan, which were about \$8,500, \$6,500, \$5,500, and \$4,000, respectively.¹⁰⁷ In particular, producing “a live birth through IVF . . . cost[s] an individual (on average) between \$66,667 and \$114,286” in the United States.¹⁰⁸ These high costs, without a doubt, reduce infertility patients’ access to ART. According to a study conducted by RESOLVE in 2009, which surveyed approximately 400 respondents, close to thirty-seven percent of the patients said they had to hold back or stop their infertility treatment because of the economy; forty percent needed financial assistance to be able to continue with the treatment; and eleven percent were contemplating “going out of the country” in order to find less costly treatment.¹⁰⁹ Indeed, this financial difficulty has led to reproductive tourism, resulting in greater inequality of cost.¹¹⁰

Health care plans typically do not cover the costs of expensive infertility treatments, such as IVF.¹¹¹ Less than a fifth of large U.S. employers—those with 500 or more employees—provide any coverage for IVF.¹¹²

cost associated with multiple births. *See also* Kansal-Kalra et al., *In Vitro Fertilization (IVF) Versus Gonadotropins Followed by IVF as Treatment for Primary Infertility: A Cost-Based Analysis*, 84 FERTILITY & STERILITY 600, 604 (2005) (estimating the cost of an IVF cycle to be about \$11,432, which only includes the direct costs of the treatment).

105. Susan Donaldson James, *Health Care Bill Offers Little Comfort to Infertile Couples*, ABC NEWS (Apr. 23, 2010), <http://abcnews.go.com/Health/ReproductiveHealth/infertility-health-care-bill-longer-pre-existing-condition/story?id=10451369> (on page 1).

106. *See* Glennon, *supra* note 41, at 172.

107. Georgina Chambers et al., *The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries*, 91 FERTILITY & STERILITY 2281, 2288 (2009).

108. Glenn Cohen & Daniel L. Chen, *Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?* 95 MINN. L. REV. 485, 486 (2010), available at <http://www.duke.edu/~dlc28/papers/Adoption.pdf>.

109. Donaldson James, *supra* note 105 (on page 2).

110. *See generally* Lisa C. Ikemoto, *Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services*, 27 L. & INEQUALITY 277 (2009) (providing a snapshot account of reproductive tourism and examining the material and normative equality concerns embedded in reproductive tourism).

111. Neumann, *supra* note 15, at 1217.

112. Joseph C. Isaacs, *Infertility Coverage Is Good Business*, 89 FERTILITY & STERILITY 1049, 1049 (2008).

Similarly, only a quarter of smaller employers—those with less than 500 employees—provide coverage for infertility treatments.¹¹³ IVF and other ART methods are commonly not covered by smaller employers.¹¹⁴

Supporters have had only limited success in getting legislation passed to support coverage for infertility treatments.¹¹⁵ Only fifteen states mandate insurance coverage for infertility treatments,¹¹⁶ and specifically, only two states require that coverage actually be offered.¹¹⁷ Mandated health benefits laws, which are primarily enacted by states, are aimed at advancing important policy goals, and while they are often efficient, it is important that they are tailored to solve the problems which justify their existence.¹¹⁸ Mandated benefit laws require health insurers to cover specific medical services or treatments.¹¹⁹ For example, mandated health benefit laws require coverage of diabetes testing supplies and mental health care.¹²⁰ However, because coverage for infertility treatments is much more controversial, in most states there is currently no coverage for infertility treatments at all.

Amid the states that offer health care insurance mandates relating to infertility, the laws range from providing full coverage for all infertility treatments, to coverage for only infertility diagnoses.¹²¹ Even when broad coverage is legislated, the law is riddled with barriers to, or caps on coverage. For example, in Hawaii, women are limited to one attempt at IVF.¹²² In Connecticut, the treatment coverage is only available for individuals below forty and there is a limitation on the number of treatment cycles.¹²³ In Texas, the mandate is limited to married couples.¹²⁴ In Illinois, coverage is only available for heterosexuals; it is only given when conception is impossible “after one year of unprotected sexual inter-

113. *Id.*

114. *Id.*

115. See Jessica L. Hawkins, Note, *Separating Fact from Fiction: Mandated Coverage of Infertility Treatments*, 23 WASH. U. J.L. & POL'Y 203, 204 (2007) (explaining that although infertility treatments are being used more often, health plans that include coverage of such treatments are only provided by twenty-five percent of employers in the United States).

116. *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 24.

117. *Id.*; see CAL. HEALTH & SAFETY CODE § 1374.55 (Deering 2010); CAL. INS. CODE § 10119.6 (Deering 2009); TEX. INS. CODE ANN. §§ 1366.001–.007 (West 2009), for state specific insurance coverage provisions.

118. Monahan, *supra* note 29, at 128.

119. *Id.*

120. *Id.*

121. *State Laws Related to Insurance Coverage for Infertility Treatment*, *supra* note 24.

122. HAW. REV. STAT. ANN. § 431:10A–116.5(a) (LexisNexis 2008).

123. CONN. GEN. STAT. ANN. §§ 38a–509(b) & 38a–536(b) (West 2007).

124. TEX. INS. CODE ANN. § 1366.005 (West 2009).

course,”¹²⁵ which is defined as “sexual union between a male and a female, without the use of any process, device or method that prevents conception”¹²⁶ In Arkansas, insurers can cap the IVF payments at \$15,000.¹²⁷ In Maryland and Rhode Island, there is a \$100,000 lifetime maximum.¹²⁸ States like California and New York specifically exclude IVF from the mandate.¹²⁹ And certain states’ statutes, like the ones in Texas and California, also allow exceptions for employers and insurance providers whose religious affiliation includes moral objections to various infertility treatments.¹³⁰ Finally, certain states require couples to attempt pregnancy for a specific period of time in order to be eligible for the benefits; these requirements vary from one year to five years.¹³¹ In all the states that have mandated benefit laws that define infertility as the inability to become pregnant after efforts to conceive fail, homosexual couples are not eligible to receive any benefits.

125. 215 ILL. COMP. STAT. ANN. 5/356m(c) (LexisNexis 2000); *see also* Bebe J. Anderson, *Lesbians, Gays, and People Living with HIV: Facing and Fighting Barriers to Assisted Reproduction*, 15 CARDOZO J.L. & GENDER 451, 461 (2009) (explaining that homosexuals face many discriminatory barriers that limit their ability to seek assisted reproduction).

126. ILL. ADMIN. CODE tit. 50, § 2015.30 (2010); Anderson, *supra* note 125.

127. JANET L. KAMINSKI, *INSURANCE COVERAGE FOR INFERTILITY TREATMENT*, OLR RESEARCH REPORT (2005) (providing information on Arkansas coverage, among other states).

128. MD. CODE ANN., INS. § 15-810(d) (LexisNexis 2006); R.I. GEN. LAWS §§ 27-18-30(d), 27-41-33(c), 27-19-23(c) (2008).

129. CAL. HEALTH & SAFETY CODE § 1374.55(a) (Deering 2010); CAL. INS. CODE § 10119.6(a) (Deering 2009); N.Y. INS. LAW §§ 3221(6)(C)(v), 4303(3)(E) (Consol. 2011).

130. CAL. HEALTH & SAFETY CODE § 1374.55(f); TEX. INS. CODE ANN. § 1366.006; *see also* CAL. INS. CODE § 10119.6(e) (permitting employers or issuers of health care plans to opt out of coverage for infertility treatments if the treatments are contrary to their beliefs).

131. *Insurance Coverage: State Mandated Insurance Coverage*, FERTILITY LIFELINES, <http://www.fertilitylifelines.com/payingfortreatment/state-mandatedinsurancelist.jsp> (last visited June 27, 2011) (providing the limitations/guidelines for all states mandating coverage for infertility treatments and noting that, under Arkansas law, treatment is only available to those who are infertile for two years); CONN. GEN. STAT. ANN. § 38a-536(a) (West 2007) (limiting coverage to those with infertility or inability to sustain a pregnancy for a one-year period); HAW. REV. STAT. ANN. § 431:10A-116.5(a)(4)(A) (LexisNexis 2008) (limiting coverage to married couples who have been infertile for at least five years); 215 ILL. COMP. STAT. ANN. 5/356m(c) (LexisNexis 2000) (requiring infertility of at least one year before coverage is possible); MD. CODE ANN., INS. § 15-810(c)(3)(i) (limiting coverage to married couples who have been infertile for at least two years); MASS. ANN. LAWS ch. 175, § 47H, ch. 176B, § 4J (LexisNexis 2008) (limiting coverage to those with infertility or inability to sustain a pregnancy for a certain time period); N.J. STAT. ANN. § 17:48A-7w (West 2007) (limiting coverage to couples experiencing infertility for two years, if the woman is below thirty-five, and one year if she is above thirty-five); R.I. GEN. LAWS §§ 27-18-30(b), 27-41-33(b), 27-19-23(b) (limiting coverage to married couples who have been infertile for at least two years).

There are also national barriers to infertility treatments, which prevent individuals from eligibility for coverage even if they are fortunate enough to overcome the legal barriers in a state that mandates coverage. The Employee Retirement Income Security Act of 1974 (ERISA),¹³² a federal law, preempts state insurance laws and mandates for employees who receive benefits through self-insured medical plans.¹³³ Therefore, ERISA allows employers who implement such plans to limit coverage or even refuse to pay for infertility treatments because “there is no clear-cut federal statutory or regulatory authority controlling their actions.”¹³⁴

The employers, rather than the insurance companies, determine who gets benefits.¹³⁵ If the employers do cover infertility treatments, they only cover particular diagnostic treatments because of the added cost associated with the purchase of a package of services.¹³⁶ Given this concerning reality, since the late 1990s—long before the debate regarding the recent Affordable Care Act began—attempts to pass a federal mandate for infertility coverage were made.¹³⁷

In an effort to assist the millions of Americans struggling to have access to infertility treatments, the Family Building Act of 2009, much like the Family Building Act of 2007 and those before it, attempted to address the lack of coverage.¹³⁸ The proposed bill mandated infertility treatment

132. 29 U.S.C. §§ 1001–1461 (1994).

133. See 29 U.S.C. § 1144(b)(2)(A) (1994) (stating that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” governed by ERISA); Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 398 (2005) (emphasizing that in regard to self-insured benefits, EIRSA has allowed federal insurance law to displace state insurance law); Peter K. Rydel, *Redefining the Right to Reproduce: Asserting Infertility as a Disability Under the Americans with Disabilities Act*, 63 ALB. L. REV. 593, 595 (1999) (explaining that although some states mandate coverage of in vitro fertilization procedures, EIRSA does not allow coverage for individuals who receive benefits under self-insured plans).

134. Rydel, *supra* note 133.

135. Monahan, *supra* note 29, at 165. See America’s Health Insurance Plans (AHIP), at www.ahip.org, for a list of AHIP member companies that provide self-insured health plans to individuals across the nation.

136. See Monahan, *supra* note 29, at 164–65 (noting that coverage does increase with the employer’s size, as well as with a higher average salary).

137. See ASRM Off. of Pub. Aff., *supra* note 5 (describing the health care reform legislation that President Obama recently signed into law, which includes multiple provisions that address reproductive health).

138. Family Building Act of 2009, H.R. 697, 111th Cong. §§ 2707, 714 (amending the Public Health Service Act, Chapter 89 of Title 5 of the United States Code, and the Employee Retirement Income Security Act to mandate infertility treatment coverage). Rep. Weiner (D-NY) introduced similar legislation six times between the years of 1999 and 2009. Family Building Act of 1999, H.R. 2706, 106th Cong. §§ 2707, 714; Family Building Act of 2001, H.R. 389, 107th Cong. §§ 2707, 714; Family Building Act of 2003, H.R. 3014,

coverage under any plan that offers coverage for obstetrical services.¹³⁹ The proposed bill characterized infertility as “the inability to conceive after [one] year of unprotected intercourse or . . . the inability to carry a pregnancy to live birth.”¹⁴⁰ Pursuant to the proposed bill, patients would only be eligible for IVF treatments if they first failed to conceive and give birth by using “less costly medically appropriate infertility treatments” covered by their insurance.¹⁴¹ In addition, the proposed bill imposed a coverage cycle limit of four completed egg retrievals.¹⁴² Under the proposed bill, if a full egg retrieval resulted in a live birth delivery, then no less than two additional egg retrievals will be covered, up to a lifetime maximum of six retrievals.¹⁴³ Finally, the proposed bill did not include any provisions regarding marital status or age restrictions, and it did not contain any limitations directed at lowering the number of the high risk multiple births.¹⁴⁴ Unfortunately, this bill, like the ones that preceded it, was never enacted. Since it was proposed in January 2009 and referred to the Subcommittee on Health, no notable legislative attempts to promote the bill were made. Nevertheless, given the recent financial crisis, the financial ability of most Americans to afford infertility treatments have only diminished since the bill’s proposal.

In an effort to fill the financing gap formed by the lack of infertility treatment coverage, fertility refund programs were created for patients undergoing IVF.¹⁴⁵ Amy Monahan, Professor at the University of Minnesota Law School, discusses in detail the financing of infertility treatment. She discusses that for eligible patients—who meet strict eligibility criteria established by the insurance provider—these “shared-risk” programs commonly charge a fixed amount for a specific number of IVF cycles.¹⁴⁶ The price charged for a single IVF cycle is significantly lower

108th Cong. §§ 2707, 714; Family Building Act of 2005, H.R. 735, 109th Cong. §§ 2707, 714; Family Building Act of 2007, H.R. 2892, 110th Cong. §§ 2707, 714.

139. H.R. 697 §§ 2707, 714.

140. *Id.* at § 2708(a)(2)(A).

141. *Id.* at § 2708(b)(2)(A)(i).

142. *Id.* at § 2708(b)(2)(A)(ii).

143. *Id.*

144. *See* Family Building Act of 2009, H.R. 697, 111th Cong. § 2708(b)(2) (detailing all limitations that apply to assisted reproductive technology and advocating required benefits for all insured individuals who are eligible).

145. *See generally* Jim Hawkins, *Financing Fertility*, 47 HARV. J. ON LEGIS. 115 (2010) (providing an in-depth evaluation of fertility refund programs that refund patients when their treatment fails and are often used to finance in vitro fertilization (IVF)).

146. Monahan, *supra* note 29, at 166 (citing John A. Robertson & Theodore J. Schneyer, *Professional Self-Regulation and Shared-Risk Programs for In Vitro Fertilization*, 25 J.L. MED. & ETHICS 283, 284 (1997)) (explaining that age is one of the most important factors for determining eligibility for a shared-risk, because only women below the age of thirty-eight qualify for most plans).

than that charged for a shared-risk program.¹⁴⁷ Therefore, a patient that paid for a shared-risk program and is successful in her first IVF round pays a significantly higher amount for the treatment than she would have if she had just paid for one IVF round.¹⁴⁸ But, if the same patient ends up needing all the IVF cycles that are covered by the shared-risk program and is not successful, a certain part of the enrollment fee is refunded.¹⁴⁹ Shared-risk programs are problematic because they do not address the possibility of additional costs that may be incurred during treatment.¹⁵⁰ In addition, these programs are not very useful in expanding access, as they require eligible patients to meet a high financial threshold.¹⁵¹ Moreover, empirical research shows that “these refund programs currently operate in a regulatory vacuum . . . [which results in the failure] to promote accurate and effective disclosures.”¹⁵² And, as empirical studies show, patients make foreseeable, systematic mistakes while trying to evaluate these programs, because often the clinics offering the programs exploit the patients’ deficient reasoning.¹⁵³

IV. THE AFFORDABLE CARE ACT AND ITS IMPLICATIONS ON REPRODUCTIVE RIGHTS

A. *Health Care Reform*

Prior to the enactment of Health Care Reform, different organizations focusing on infertility met with members of Congress to advocate for the millions of individuals suffering from infertility and to better explain their needs.¹⁵⁴ Despite this fact, the Affordable Care Act does not provide any coverage for the “soaring cost of assisted reproduction procedures

147. *Id.* at 165. For example, IntegraMed, the biggest U.S. infertility treatment network, charges double the cost of one IVF cycle to participate in the refund program. See Attain Fertility Health Desk, *Attain IVF Costs Make Treatment Manageable*, ATTAIN FERTILITY, <http://attainfertility.com/article/ivf-costs> (last visited June 25, 2011) (indicating that the Attain IVF Refund Program offered by IntegraMed costs about \$24,000).

148. Monahan, *supra* note 29, at 165–66 (citing John A. Robertson & Theodore J. Schneyer, *Professional Self-Regulation and Shared-Risk Programs for In Vitro Fertilization*, 25 J.L. MED. & ETHICS 283, 284 (1997)) (describing a typical shared-risk plan that charges \$17,000 for three IVF cycles, refunding ninety percent of the payment if the woman does not deliver a baby).

149. *Id.* at 166.

150. *Id.* at 155–56.

151. *Id.* at 183.

152. Hawkins, *supra* note 145.

153. *Id.*

154. *Statement: Healthcare Reform*, RESOLVE.ORG, <http://www.resolve.org/about/state-ment-healthcare-reform.html> (last visited June 25, 2011).

...”¹⁵⁵ Instead, much of the debate leading to the final Affordable Care Act has focused on divisive issues such as limits on abortion.¹⁵⁶

As described more specifically below, the Affordable Care Act dramatically impacts providers and suppliers of health care services, mainly focusing on the individual and the small group insurance market. It introduces authoritative enforcement tools; modifies initiatives to improve program integrity; mandates compliance programs; creates additional provisions regarding disclosure; and provides more funding for enforcement actions such as fighting fraud, waste, and abuse of federally funded health care programs.

The Affordable Care Act’s greatest changes can be placed into six main categories. First, the Affordable Care Act significantly increases access to coverage.¹⁵⁷ Under the law, coverage to millions of Americans is extensively expanded by mandating that individuals obtain health insurance, and that health plan providers will pay penalties if they are not in compliance with the Affordable Care Act’s standards by 2014.¹⁵⁸ Individuals who cannot afford to obtain coverage will be subsidized.¹⁵⁹ Moreover, coverage will also be obtainable via new state chartered exchanges; eligibility for Medicaid is expanded;¹⁶⁰ shared responsibility mandates will require large employers to offer coverage to employees, or to pay a penalty;¹⁶¹ and pending certain conditions, small employers will receive tax credits for providing coverage to their employees.¹⁶² In addition, a “temporary high risk health insurance pool program” will be cre-

155. Donaldson James, *supra* note 105.

156. Jon O. Shimabukuro, *Abortion and the Patient Protection and Affordable Care Act*, HEALTH LEGISLATION (Sept. 27, 2010), <http://healthlegislation.blogspot.com/2010/09/abortion-and-patient-protection-and.html> (providing an overview of the much-contested abortion provisions in the Acts).

157. *About the Affordable Care Act*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/about/index.html> (last visited June 25, 2011) (providing general information from the government about the Affordable Care Act). The Affordable Care Act will expand coverage “through state Exchanges — giving millions of Americans and small businesses access to affordable coverage, and the same choices of insurance that members of Congress will have.” *Id.*

158. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, §1104(j)(1)(A) 124 Stat. 119, 151 (2010) (to be codified at 18 U.S.C. § 18003).

159. Patient Protection & Affordable Care Act § 1413(a).

160. Patient Protection & Affordable Care Act §§ 1411-1413.

161. Patient Protection & Affordable Care Act § 1104(h).

162. *See Small Business Health Care Tax Credit for Small Employers*, IRS.GOV, <http://www.irs.gov/newsroom/article/0,,id=223666,00.html> (last updated Apr. 12, 2011) (listing eligibility rules, including limitations on business size and average annual wage, that apply to small businesses applying for health care tax credits); *see also* Patient Protection & Affordable Care Act §§ 1401-1402 (outlining specific tax credit options that are available through qualified health plans).

ated to provide uninsured individuals that have pre-existing conditions with health insurance coverage.¹⁶³

Second, the Affordable Care Act drastically modifies the insurance market.¹⁶⁴ Under the law, pre-existing condition exclusions for children below the age of nineteen are prohibited, and similar exclusions for adults will be prohibited in the future as well.¹⁶⁵ Moreover, lifetime limits and annual benefit caps on “essential” health benefits are prohibited,¹⁶⁶ as well as cost sharing for preventative services, and premium rate differences that are gender or health status based.¹⁶⁷ In addition, the Affordable Care Act guarantees direct access to OB-GYNs, protects OB-GYN ultrasounds from coverage cuts,¹⁶⁸ and ensures that care be given to dependents up to age twenty-six.¹⁶⁹ The Affordable Care Act also requires states to create new Health Insurance Exchanges—to help individuals and small employers obtain insurance—and establishes a federal agency to oversee multi-state private plans.¹⁷⁰

163. Patient Protection & Affordable Care Act § 1101(a).

164. See *About the Affordable Care Act*, *supra* note 157 (explaining that the Act “holds insurance companies accountable by keeping premiums down and preventing many types of insurance industry abuses and denials of care, and ending discrimination against Americans with pre-existing conditions”).

165. *Insurance Protections for Children in the Affordable Care Act*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/provisions/ChildrensPCIP/childrenspcip.html>.

166. See *Eliminating Lifetime and Annual Limits on Your Benefits*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/provisions/limits/limits.html> (explaining that the Act not only prohibits lifetime limits on most benefits, but also begins to eliminate annual dollar limits, which will be completely phased out by 2014).

167. See *Background: The Affordable Care Act’s New Rules on Preventive Care*, HEALTHCARE.GOV (July 14, 2010), <http://www.healthcare.gov/law/about/provisions/services/background.html> (detailing new requirements for private healthcare plans, including a regulation mandating coverage of preventive services that are “evidence-based”). Evidence-based preventive services are ranked by an independent panel of experts who assess the amount of evidence that indicates each service is beneficial. *Id.* The preventive services with the highest rank, such as screening for cancer or diabetes, are covered under the Act. *Id.*

168. *Preserving Doctor Choice and Ensuring Emergency Care*, HEALTHCARE.GOV (Sept. 23, 2010), http://www.healthcare.gov/law/provisions/choice_access/index.html.

169. *Young Adult Coverage Until Age 26*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/provisions/youngadult/index.html>.

170. See *Health Insurance Exchanges: State Planning and Establishment Grants*, HEALTHCARE.GOV (Mar. 22, 2011), <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html> (describing the health insurance Exchanges that will be created under the Act). These Exchanges will be run by each state and are required to not only be established, but also operational by 2014. *Id.* The goal of each Exchange is to make shopping for health insurance more convenient and beneficial for consumers. *Id.* Each Exchange is a public marketplace that offers consumers a variety of health care plans from different insurance providers. *Id.*

Third, the Affordable Care Act impacts the essential health benefits for which individuals are eligible.¹⁷¹ The Act provides us with a list of general health care services that qualify as essential health benefits, and requires insurance companies that would like to participate in Exchanges to cover the benefits by 2014.¹⁷²

Fourth, the Affordable Care Act includes tax changes and sets various workplace requirements. Under the law, employers will need to compute and report the value of the health insurance provided to their employees on employees' W-2 forms.¹⁷³ Moreover, large employers offering health coverage will be required to automatically enroll new full time employees in the plan, and, above certain thresholds, a new excise tax will be placed on the value of employer provided coverage.¹⁷⁴ In addition, as will further be discussed below, flexible spending account contributions (FSA) will be capped at \$2,500, and the threshold for itemized deductions for unreimbursed medical expenses will be increased.¹⁷⁵ Moreover, a Medicare tax and a tax on net investment income will be imposed on households with incomes exceeding \$250,000 for joint filers and \$200,000 for individuals.¹⁷⁶ Additionally, employers employing fifty individuals or more will be required to provide break time and stations for nursing mothers.¹⁷⁷

Fifth, the Affordable Care Act provides increased funds for research. It establishes new grants to fund essential projects,¹⁷⁸ authorizes disease

171. See Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 1302(b), 124 Stat. 119, 163 (2010) (to be codified at 42 U.S.C. § 18022).

172. *Glossary: Essential Health Benefits*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/e/essential.html> (last visited June 25, 2011). See also Patient Protection & Affordable Care Act, § 1302 (specifying the essential requirements for healthcare plan packages).

173. See Patient Protection & Affordable Care Act § 9002 (to be codified in scattered sections of the USC) (amending Section 6051(a) of the Internal Revenue Code to include the "cost of employer-sponsored health coverage on W-2").

174. See Patient Protection & Affordable Care Act §§ 9001, 4980I.

175. Walecia Konrad, *Flexible Spending, a Little Less So*, N.Y. TIMES, Apr. 16, 2010, <http://www.nytimes.com/2010/04/17/health/17patient.html>; Alistair M. Nevius, *Health Care Reform Reshapes Tax Code*, J. ACCT., Apr. 1, 2010, <http://www.journalofaccountancy.com/issues/2010/may/20102731.htm>.

176. George G. Jones & Mark A. Luscombe, *Tax Strategy: Planning for the Medicare Tax on Investment Income*, ACCOUNTING TODAY, June 21, 2010, http://www.accountingtoday.com/ato_issues/24_8/tax-strategy-planning-for-the-medicare-tax-on-investment-income-54489-1.html (explaining that preparation will be necessary to help make these taxes more cost-effective when they are combined with other rate increases for dividends and capital gains in 2013).

177. Patient Protection & Affordable Care Act § 4207.

178. See *Implementation Center: Grants*, HEALTHCARE.GOV, <http://www.healthcare.gov/center/grants/> (last visited June 25, 2011), for a list of state-specific grant opportunities or to learn how each state will be spending the grant money.

specific research,¹⁷⁹ and supports state education programs aimed at adolescent and non-marital abstinence.¹⁸⁰ Moreover, it allows businesses with less than 250 employees to receive tax credits for investing in chronic disease research.¹⁸¹

Finally, the Affordable Care Act considerably amends the college lending program.¹⁸² Federal money will be used to enhance the Pell Grant program for low-income students instead of paying private organizations to underwrite loans, thereby increasing the amount of grant money that will be available to each student.¹⁸³ Furthermore, students who enter into teaching, nursing, or other public service careers will be allowed to cap the repayment of their student loans at a lower income percentage, and have their remaining debt forgiven after twenty years.¹⁸⁴ In addition, health care professionals will be entitled to exclude amounts received from loan forgiveness or state loan repayment programs from their taxable income, if the loan was intended to support the professional in increasing the availability of medical services in areas where medical services are inadequate.¹⁸⁵

B. *The Negative Implications of the Affordable Care Act*

Unfortunately, the Affordable Care Act also includes some provisions that will have a negative effect on infertility patients. For example, the changes in the ability to pay for medical treatments using tax-free benefits, such as capping the FSA's contributions at \$2,500 starting 2013, will limit the ability of individuals with infertility problems to finance their medical treatments.¹⁸⁶ In addition, the Act will increase the 7.5 percent "threshold for itemized deductions for unreimbursed medical expenses"

179. ASRM Off. of Pub. Aff., *supra* note 5.

180. *See id.* (indicating that the Act specifically provides states with \$75 million in grants each year to fund pregnancy and STD prevention programs, as well as \$50 million to promote non-marital abstinence). See Patient Protection & Affordable Care Act §§ 2953, 2954 for the specific statutory language regarding these grants.

181. ASRM Off. of Pub. Aff., *supra* note 5.

182. *Id.*

183. *Id.*; see also *Student-Loan Reform Slid into Health Law*, WASH. TIMES, Mar. 29, 2010, <http://www.washingtontimes.com/news/2010/mar/29/student-loan-takeover-slips-through-with-health-ca/> (specifying that the Pell Grant program will be increased by \$36 billion under the Act).

184. ASRM Off. of Pub. Aff., *supra* note 5.

185. *Id.*

186. *See* Konrad, *supra* note 175 (explaining that individuals who use flex-spend accounts aggressively will be financially burdened by the lower maximum); *see also* Nevius, *supra* note 175 (detailing the new flexible spending arrangement and emphasizing that the maximum amount applies to the medical expenses of not only the employee, but to the employee's dependents, and any other beneficiaries of the employee as well).

to ten percent of adjusted gross income.¹⁸⁷ This will also impact individuals' ability to finance their medical treatments. This difficulty was acknowledged by the legislature immediately after the enactment of the Affordable Care Act at a Congressional hearing on April 15, 2010, where it was argued that:

Beginning January 1, 2012, according to the Joint Committee on Taxation, ObamaCare will limit the medical expense deduction, which will raise taxes by \$15 billion over 10 years. Under current law, if out-of-pocket medical expenses, including health insurance premiums and medical procedures, are not covered by health insurance and if they exceed [7.5] percent of adjusted gross income, these expenses are fully deductible, but it will increase to 10 percent under the bill that we passed. Some of the most expensive and comprehensive health insurance plans don't cover some high-cost medical procedures, such as in vitro fertilization where the cost for the procedure and for the prescription drugs can run as high as \$20,000 per treatment cycle, and some families can have multiple cycles within a year. Those are the people who are going to be hit by this change from [7.5] percent of adjusted gross income to 10 percent on most Americans. The Joint Committee on Taxation estimates this new limit will affect 14 million taxpayers-or 14.8 million taxpayers, 14.7 of whom will earn less than \$200,000 a year at the time that it is put into effect.¹⁸⁸

C. *Positive Aspects of the Reform for Fertility Care*

The Affordable Care Act does not include any provisions specific to infertility care.¹⁸⁹ But the lack of any specific fertility care provision does not prevent the new law from impacting infertile patients and their healthcare. While most of the implications on reproductive rights and infertility treatment resulting from the Affordable Care Act are negative, as discussed below, there are some positives too. The Affordable Care Act's most positive change for infertile patients is the elimination of the pre-existing conditions exclusion. This elimination resulted from the long campaign that was launched by the American Society for Reproductive Medicine (ASRM) and the National Women's Law Center titled "Being a

187. Nevius, *supra* note 175.

188. 156 CONG. REC. H2627-02, (daily ed. Apr. 15, 2010) (statement of Rep. Burgess), 2010 WL 1507386, at *H2629.

189. Sue Jasulaitis, *Fertility Care in the Midst of Healthcare Reform: An Uncertain Future*, INFERTILITY AND REPRODUCTIVE NEWS, <http://infertilityrepronews.com/content/fertility-care-midst-healthcare-reform-uncertain-future> (last visited June 25, 2011).

Woman Is Not a Pre-Existing Condition.”¹⁹⁰ As explained at several Congressional hearings (including hearings on November 6, 2009, November 16, 2009, and December 2, 2009) infertility has in many cases been viewed as a “pre-existing condition.”¹⁹¹ Consequently, women have been denied any type of health insurance coverage due to their previous infertility diagnosis. Moreover, as was shown at a number of Congressional hearings, even those women’s husbands were denied coverage because of “spousal infertility.”¹⁹² While presenting this problem to Congress, a number of couples, such as Jodie and Greg Miller of Potomac, Maryland, shared their personal experiences and the hurdles they encountered.¹⁹³ The Millers explained how women who received infertility treatments several years earlier and were done with their family planning were denied health insurance because of their pre-existing condition of infertility.¹⁹⁴ Under the Affordable Care Act, insurance companies are no longer able to deny coverage based on a pre-existing condition.¹⁹⁵ Additionally, the elimination of lifetime caps under the Affordable Care Act is a good thing for infertile patients. In particular, patients who may go through a premature birth, or need specific pre-natal or neo-natal care especially benefit from this change, as this type of care can reach or exceed the lifetime caps set by insurance companies.

Except for the elimination of the pre-existing condition and the lifetime caps, most of the Affordable Care Act provisions do not offer any particular help to infertility patients, nor do they make infertility treatments more accessible. Nevertheless, as explained above, in 2014, an essential health benefits package will be created that will provide a comprehensive set of services and essential coverage requirements for the individual and small group market. At that time, there will be additional regulations created and public comment will be allowed as part of the

190. Denise Grady, *Overhaul Will Lower the Costs of Being a Woman*, N.Y. TIMES, Mar. 29, 2010, <http://www.nytimes.com/2010/03/30/health/30women.html>; *Being a Woman is Not a Pre-Existing Condition*, NAT’L WOMEN’S LAW CTR., <http://www.awomanisnotapreexistingcondition.com/> (last visited June, 25, 2011).

191. See 155 CONG. REC. H13454-01 (daily ed. Dec. 2, 2009) (statement of Rep. Ryan), 2009 WL 4339967, at *H13455; 155 CONG. REC. H12986-04 (daily ed. Nov. 16, 2009) (statement of Rep. Fudge), 2009 WL 3817729, at *H12989; 155 CONG. REC. H12563-07 (daily ed. Nov. 6, 2009) (statement of Rep. Ryan), 2009 WL 3698249, at *H12564.

192. 155 CONG. REC. H13454-01 *supra* note 191; 155 CONG. REC. H12986-04 *supra* note 191; 155 CONG. REC. H12563-07 *supra* note 191.

193. 155 Cong. Reg. H12986-04; *See also* Donaldson James, *supra* note 105 (detailing the Miller’s experience). After spending \$22,000 and conceiving triplets through in vitro fertilization, the Miller’s were subsequently denied health care coverage because their insurance company determined they had pre-existing conditions. *Id.* Mrs. Miller was denied because of her infertility, and Mr. Miller was denied because of “spousal infertility.” *Id.*

194. 155 CONG. REC. H12986-04, *supra* note 191.

195. *Id.*

drafting of those regulations.¹⁹⁶ Therefore, although this package cannot be more extensive than a typical employer plan, and will only be available for infertility patients covered under the individual and small group market, if properly regulated, some infertility treatments can be covered. Indeed, although infertility treatments are not included in the Affordable Care Act, the Affordable Care Act does not list which specific diseases will or will not be covered under the new legislation.¹⁹⁷ Thus, the broadness of some of the terms included in Section 1302 of the Affordable Care Act's essential health benefits package, and the fact that such terms are not defined under the Affordable Care Act, indicate that these terms can be interpreted to include fertility care. For example, "ambulatory patient services" is the first item in the list of essential benefits.¹⁹⁸ This term is not defined anywhere under the Affordable Care Act, and there is no uniform definition for it elsewhere. In general, ambulatory services refer to medical care delivered on an *outpatient* basis that does not require hospital admission and can be managed without such admission.¹⁹⁹ Hence, any medical service that can be performed at a physician's office can be ambulatory medical care, and therefore regulators can and should interpret this term to include at least partial fertility care. Although this is not a comprehensive or official legal solution—especially because these essential benefits are only offered to the individuals and small group market—such interpretation can assist in providing coverage to many of the individuals suffering from infertility.

V. OLD HABITS ARE HARD TO CHANGE: OBJECTIONS TO PROVIDING COVERAGE FOR INFERTILITY TREATMENTS

The lack of any provisions relating to reproductive care in the Affordable Care Act is not surprising. Throughout the years, many objections were made to the notion of instituting mandatory coverage for infertility treatments. Indeed, this is a controversial issue because critics from a wide range of social, political, and religious groups have opposed infertil-

196. *Glossary: Essential Health Benefits*, *supra* note 172.

197. *See* Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 1302(b), 124 Stat. 119, 163 (2010) (to be codified at 42 U.S.C. § 18022) (defining essential health benefits as including certain general categories, such as "ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care").

198. *Id.*

199. *Ambulatory Care Law & Legal Definition*, U.S. LEGAL, <http://definitions.uslegal.com/a/ambulatory-care/> (last visited July 1, 2011) (emphasis added).

ity treatment coverage.²⁰⁰ As further described below, well-founded counterarguments exist to these objections, which can be categorized into seven primary arguments. Even if some of the criticism is legitimate, when balanced against different normative policies, as detailed below, there are strong reasons to favor mandated coverage of reproductive treatments.

The first opposition argument is related to the traditional argument that fertility treatment coverage is a hard sell when so many individuals do not have any health insurance at all.²⁰¹ Nevertheless, as described above, the Affordable Care Act is expected to extend health insurance coverage to thirty-two million more Americans, in order to cover ninety-five percent of the U.S. population under health care programs.²⁰²

The second argument that critics make is that adding a requirement mandating coverage for infertility treatments would be an unjustified costly addition to the premiums costs.²⁰³ Pursuant to this argument, requiring the coverage of infertility treatments under state insurance mandates would overly burden the health insurance markets as well as the overall economy. However, despite the common assumption that mandating coverage for infertility treatments greatly increases individuals' insurance costs, in reality, this would not be the case. In fact, information based on insurance coverage in Massachusetts reveals that IVF is an affordable component in health care insurance plans.²⁰⁴ Indeed, scholars who researched the effect of the mandate on insurance premiums through the early 1990s found that costs associated with infertility treat-

200. BARTHOLET, *supra* note 33, at 212.

201. See Strong, *supra* note 32 (explaining the argument that “the fact that millions of people in the United States lack health insurance and do not qualify for Medicaid or Medicare” is particularly relevant).

202. Cammie Croft, *Health Reform by the Numbers*, WHITEHOUSE.GOV (Mar. 19, 2010, 10:48 AM), <http://www.whitehouse.gov/health-care-meeting/by-the-numbers>.

203. See 146 CONG. REC. S1122-01 (daily ed. Mar. 2, 2000) (statement of Mr. Torricelli), 2000 WL 279976, at *S1122 (discussing fair access to infertility). Former Senator Robert Torricelli stated:

One reason often cited by health insurers for their continued refusal to provide infertility treatment is the negative impact that this coverage would have on monthly premiums. However, recent studies demonstrate that FAITH [Fair Access to Infertility Treatment and Hope] would raise the costs of health coverage by as little as \$.21 cents per month per person, an insignificant amount compared to the enormous premium increases we have recently seen from HMOs.

Id.

204. SARAH S. BACHMAN ET AL., COMPREHENSIVE REVIEW OF MANDATED BENEFITS IN MASSACHUSETTS REPORT TO THE LEGISLATURE 16 (2008), *available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf (stating that the infertility treatment mandate in Massachusetts accounts for .89% of total premium costs).

ments accounted for no more than four-tenths of a percent of the total costs of health care by insurers in Massachusetts.²⁰⁵ In addition, other studies have estimated that IVF presents a “small fraction of health costs—[approximately] three-hundredths of one percent of total health care costs.”²⁰⁶ The study also showed that “adding IVF to a representative employer’s health plan in 1995 would add only \$3.14 per year to an employee’s yearly premium.”²⁰⁷ Earlier studies have also argued that the inclusion of IVF in insurance programs would only increase annual premiums by a limited amount—an amount much lower than coverage of chiropractic services or alcohol abuse treatment, and psychiatric services.²⁰⁸ While alcohol treatment programs and psychiatric services, much like infertility treatments, are services that some individuals will never use, they are so socially acceptable such that the entire population pays for the risk of non-use, even though the inclusion of such services increases the yearly premiums.

The third argument that critics make is that the introduction of insurance mandates covering IVF, will result in negative effects on adoption,²⁰⁹ and that providing insurance for costly fertility treatments rather than sponsoring adoptions “ironically makes these technologies the only alternative some people can afford.”²¹⁰ This criticism, however, should be discounted because a recent empirical study has shown that contrary to the assumption of the substitution theory, there is no strong evidence that state support of IVF through mandates crowds out either domestic or international adoption.²¹¹

Professors Glenn Cohen and Daniel Chen exposed some of the controversial fundamental normative premises on which this criticism depends.

205. Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 *FERTILITY & STERILITY* 22, 27 (1998).

206. Neumann, *supra* note 15, at 1219.

207. *Id.* Pursuant to the 1995 study, even if IVF utilization continued to increase and rose 300 percent in comparison to its 1995 levels, consequently adding IVF services to the typical employers’ insurance plan, the “average premiums per employee would only rise about \$9 dollars per year.” *Id.* at 1221.

208. *Id.*

209. See BARTHOLET, *supra* note 33, at 213–14 (arguing that protective regulation should be developed well before IVF insurance coverage is mandated across the United States and that such mandates will discourage people from adoption). Cohen & Chen, *supra* note 108, at 500 (calling the claim that there is such an effect the “substitution theory”).

210. ROBERTS, *supra* note 34; see also BARTHOLET, *supra* note 33, at 34–35 (describing how society gives “preferred treatment to those who choose child production over child adoption”); Neumann, *supra* note 15, at 1232 (asserting that “[a]ny decision by health insurers regarding IVF has implications for adoption”).

211. Cohen & Chen, *supra* note 108, at 554.

These premises include: the comparative size of the interests of to-be-adopted children and would-be biological parents—as well as how many people each side includes; the distributive justice standard by which these interests are to be traded off; the fairness of placing the burden of adoption chiefly on infertility patients instead of on the entire society; the effect that recognizing infertility as a health need has on the argument to adopt instead of to biologically conceive; and how America's obligations to children living abroad differ from its obligations to children living domestically.²¹² Therefore, even if a policy that supports promoting adoption is desired, it should not substitute instituting infertility treatment coverage. In fact, incentives to promote adoptions are included under the Affordable Care Act.

The Adoption Tax Credit, included in the Affordable Care Act, increased the existing adoption deduction from \$12,150 to \$13,170 for tax years starting after December 31, 2009.²¹³ The Tax Credit is retroactive, applying to all child-adoptions since January 1, 2010, and it is scheduled to expire on December 31, 2010; however, the Affordable Care Act also moved the expiration date to December 31, 2011.²¹⁴ And, as with the previous Adoption Tax Credit, this credit applies to both domestic and international adoptions and to both special needs and non-special needs adoptions.²¹⁵

The fourth argument is mainly advocated by religious organizations.²¹⁶ Among these arguments is the claim that new technologies will be used by patients to select children with specific special traits.²¹⁷ Therefore, these organizations want to minimize ART usage all together. However,

212. *Id.* at 574–77.

213. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, sec. 10909(a)(1)(A), § 23(b), 124 Stat. 119, 1021 (2010) (to be codified at 26 U.S.C. § 23); Pam Connell, *A Big Difference for Adopting Parents: The Adoption Tax Credit Renewed and Expanded*, FAMILIES.COM (June 8, 2010), <http://adoption.families.com/blog/a-big-difference-for-adopting-parents-the-adoption-tax-credit-renewed-and-expanded>; Nagarsheth, *supra* note 33 (stating that in 2002 the amount of the Adoption Tax Credit was \$10,000).

214. Patient Protection & Affordable Care Act § 36(c); Connell, *supra* note 213.

215. Patient Protection & Affordable Care Act § 23(a) (increasing the dollar amount for special needs adoptions to \$13,170); Connell, *supra* note 213 (listing the income limit, based on a couples' modified adjusted gross income (MAGI), that exists for this tax credit). If your MAGI is greater than \$222,520 the tax credit will be completely eliminated. *Id.* The credit will be reduced for those whose MAGI is \$182,520 to \$222,520, and the tax credit will not affect the credit at all for those whose MAGI is \$182,520 or less. *Id.*

216. Moses, *supra* note 35. Some of the controversy relates to the use of extra fertilized eggs. See Goldberg, *supra* note 31 (explaining that “[t]o many Americans, a ‘spare embryo’ is a human life . . . [a]s a result, discarding an embryo is entirely unacceptable”).

217. See Crossley, *supra* note 37, at 284–85 (focusing on current trait selection practices, such as prenatal genetic screening, and how they may create inequality in our society).

these technologies can also be viewed as a godsend to couples with problematic family histories of genetic disorders and chromosomal mutations causing infertility. Moreover, proper regulation can ensure that patient and physician usage of ART methods is limited to assist with the production of healthy children, rather than genetic selection or manipulation.

The fifth argument is that the availability of IVF has a harmful impact on people because it pressures individuals who are fine with being child-free, to become parents. Indeed, the disapproving attitude that such individuals receive from society sends them into a form of hiding.²¹⁸ It has been argued that fertility care has an especially negative impact on women,²¹⁹ because women suffer from “the addiction to high tech promise.”²²⁰ While in the process of being treated with IVF, women believe that they can “make it happen” and that they are in control of the proceeding. This can result in women only focusing on the treatment, and living from one treatment to the next, and in between treatments feeling nothing but loneliness and emptiness.²²¹ The argument is that women are better-off without these infertility treatments, which often result in nothing but false hope, great disappointment, and severe mental tolls.²²² The availability of these treatments makes it much more difficult for women to view themselves as child-free, instead of lonely and childless.²²³ However, while these arguments do have some merit, they are in many ways over-paternalistic and suggest that it is better to deprive women from having a choice, in order to protect them from potential mental or physical distress. Although it is true that not all infertility treatments will be

218. See CHILDFREE.NET, <http://www.childfree.net/> (last visited June 25, 2011), a website that was created for individuals who wish to remain childfree and not be pressured by society to procreate, for information about the childfree lifestyle. See also JANE BARTLETT, *WILL YOU BE MOTHER? WOMEN WHO CHOOSE TO SAY NO* (1995) (exploring the personal implications of the pressure society places on women who, for various reasons, have decided not to have children).

219. Cf. PEGGY ORENSTEIN, *WAITING FOR DAISY: A TALE OF TWO CONTINENTS, THREE RELIGIONS, FIVE INFERTILITY DOCTORS, AN OSCAR, AN ATOMIC BOMB, A ROMANTIC NIGHT AND ONE WOMAN'S QUEST TO BECOME A MOTHER* (2007) (describing the transition from an initial complete lack of interest in being a mother to extreme efforts to have a child).

220. Linda S. Williams, *No Relief Until the End: The Physical and Emotional Costs of In Vitro Fertilization*, in *THE FUTURE OF HUMAN REPRODUCTION* 120, 134 (Christine Overall ed., 1989).

221. *Id.*

222. See *id.* at 123-37 (detailing “the immense emotional and physical stress” women experience during IVF).

223. See *id.* at 134 (describing the difficulty many women experience when trying to remain both optimistic about becoming pregnant, and realistic about the low success rate when undergoing IVF).

successful, women should have the right to decide whether or not to pursue such treatments.

The sixth argument is not an objection to ART, but to providing it without discrimination; some critics have argued that ART should only be offered to patients who will be fit parents, in order to prevent harm to their offspring and society.²²⁴ Professor Judith Daar disagrees with these critics because they fail to understand that it is “essential to evaluate these actions by the same standards . . . [society uses to] evaluate barriers to natural conception.”²²⁵ Indeed, since the right to procreate “is widely acknowledged when reproduction occurs *au naturel*,” Professor John Robertson also argues that “it should be equally honored when reproduction requires technological assistance.”²²⁶ For example, currently in the United States, single-motherhood appears to be steadily increasing and single women now head close to a third of U.S. households.²²⁷ Nevertheless, the marital status of women desiring fertility treatments still plays a role in receiving or being denied treatment.²²⁸ Hence, applying different standards to patients with infertility problems would cause great inequality.

Finally, some critics argue that infertility is not an illness, while others argue that an infertility treatment is not a medical necessity and therefore need not be covered.²²⁹ However, some courts have determined that infertility resulting from a medical condition is indeed an illness. One such court is the U.S. Courts of Appeals for the Second Circuit, which recently expressed the view that infertility is a medical condition.²³⁰ This result is

224. Darr, *supra* note 19, at 82.

225. *Id.*

226. ROBERTSON, *supra* note 52.

227. Jennifer Egan, *Wanted: A Few Good Sperm*, N.Y. TIMES, Mar. 19, 2006, (Magazine), <http://www.nytimes.com/2006/03/19/magazine/319dad.html>.

228. See Richard F. Storrow, *The Bioethics of Prospective Parenthood: In Pursuit of the Proper Standard for Gatekeeping in Infertility Clinics*, 28 CARDOZO L. REV. 2283, 2289 (2007).

229. Leon R. Kass, *Regarding the End of Medicine and the Pursuit of Health*, in CONCEPTS OF HEALTH AND DISEASE: INTERDISCIPLINARY PERSPECTIVES 3, 5 (Arthur L. Caplan et al. eds., 1981).

230. See *Saks v. Franklin Covey*, 117 F. Supp. 2d 318, 324 (S.D.N.Y. 2000), *aff'd*, 316 F.3d 337 (2d Cir. 2003) (stating that failure to provide coverage for infertility treatment does not violate the law). In *Saks*, the court dismissed an action by a woman whose employer's self-insured health plan did not include coverage for a number of medical services she had undergone, including IVF. *Id.* The female employee argued that refusal to cover the infertility treatment violated federal law prohibiting sex, disability, and pregnancy discrimination. *Id.* at 320. Nevertheless, although the court agreed that infertility was an illness, the court held that the employer's exclusion of specific costly treatments was permissible, as the denial was gender-neutral. *Id.* at 324, 329. In another case, the defendant insurance company denied coverage for infertility treatments aimed at improving the pa-

also consistent with illness determinations in other contexts. The malfunction of the reproductive system's body organs should not be treated any differently than the malfunction of any other body organ.²³¹ Moreover, if one adopts Norman Daniels' view regarding medical care that repairs "normal species functioning," infertility should undoubtedly be covered because reproduction is part of a basic species' functioning²³² and a "major life activity."²³³

In addition, as described above, the physical, medical reasons for using infertility treatments include, inter alia, women's failure to ovulate, refractory endometriosis, absent or nonpatent fallopian tubes, and advanced age in which the woman tries to conceive.²³⁴ Therefore, infertility resulting from the inability to conceive or carry a pregnancy to term after twelve months of trying to conceive, and six months for individuals above the age of thirty-five, should be viewed as a disease. Moreover, this type of infertility is undoubtedly a medical condition that requires medical treatment. And, there are medical solutions available to treat this medical problem.

However, despite the existence of the technologically available medical treatments and their great success rates, some opponents to infertility treatment coverage argue that infertility treatments should not be covered because infertility is not a disease and the treatment of infertility bypasses the problem rather than correcting it.²³⁵ Therefore, according

tient's sperm motility, based on the argument that infertility is not an illness. *Witcraft v. Sunstrand Health & Disability Grp. Benefit Plan*, 420 N.W.2d 785, 786–87 (Iowa 1988). This argument was rejected by the court, which held that infertility is an illness as it includes the improper functioning of bodily organs because the reproductive organs fail to perform their natural function. *Id.* at 789–90. A number of other courts have made similar determinations. *See, e.g., Egert v. Conn. Gen. Life Ins. Co.*, 900 F.2d 1032, 1038 (7th Cir. 1990) (denying the insurance companies claim that it does not consider fertility problems to be an illness, because internal company memoranda specifically mentioned the "illness of infertility" and holding that the insurance company would be required to reimburse insured for infertility treatments); *Kinzie v. Physician's Liab. Ins. Co.*, 750 P.2d 1140, 1141 (Okla. Civ. App. 1987) (explaining that the claim holder had infertility problems, which were considered to be a medical condition). The court in *Kinzie*, however, ended up denying insurance coverage for treatment, holding that conceiving a baby was not considered a medical necessity. *Id.* at 1143.

231. *See* William C. Cole, Comment, *Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage*, 27 SAN DIEGO L. REV. 715, 733 n.149 (1990).

232. NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* 34, 34 n.9 (2008).

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

234. *See* David S. Guzick, *Human Infertility: An Introduction*, in 2 REPRODUCTIVE ENDOCRINOLOGY, SURGERY, AND TECHNOLOGY 1897, 1899–1902, 1905–1909 (Eli Y. Adashi et al. eds., 1996).

235. Orentlicher, *supra* note 49, at 168.

to this logic, only medical treatments such as antibiotics, which treat and eliminate the underlying problems, should be covered and approved.²³⁶ Yet, medical solutions, such as hearing aids, prosthetics, and wheelchairs also bypass the reason for which individuals cannot hear or walk.²³⁷ Those treatments enable patients to hear or be mobile, without attempting to correct the underlying impairments. And since society does recognize the need to cover other treatments that bypass medical problems, which are often as expensive as or even pricier than certain infertility treatments, such as wheelchairs, this argument cannot be used against infertility treatment coverage.²³⁸

As explained above, infertility causes various psychological problems, including depression, low self-esteem, and anger.²³⁹ Although infertility treatments bypass the medical problem of infertility without correcting the underlying impairment, infertility treatments can correct the underlying impairment causing depression and other psychological effects—the problem of infertility. Treating the medical problem of infertility, which takes a toll on the patients’ mental state and often causes depression, also promotes economic efficiency, as it relates to amounts spent to treat depression. Indeed, studies have shown that untreated clinical depression costs the U.S. economy an annual amount of \$43.7 billion.²⁴⁰ Of this figure, workplace lost productivity totals at \$23.8 billion, and treatment and rehabilitation costs amount to \$12.4 billion.²⁴¹

Other opponents to providing coverage for infertility treatment have argued that infertility is not a disease or a medical problem, but a “lifestyle choice,”²⁴² and that infertility does “not involve the sort of catastrophic losses that justify a medical expense deduction.”²⁴³ This argument, however, contradicts the findings of the legislators and policy makers, which have determined that “[i]nfertility is a disease affecting more than 6,000,000 American women and men, about ten percent of the reproductive age population.”²⁴⁴ This argument also ignores the large percentage of medical infertility patients that have no choice at all in deciding if and when to conceive. Indeed, for many infertility patients, not

236. *Id.*

237. *Id.*

238. *Id.*

239. ZOLDBROD, *supra* note 56.

240. Dana L. Kaplan, *Can Legislation Alone Solve America’s Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 332 (2005).

241. *Id.*

242. Pratt, *supra* note 53, at 1124.

243. *Id.* at 1125.

244. See Family Building Act of 2009, H.R. 697, 111th Cong. § 1(b)(1) (2009).

having children is not a lifestyle choice, but a medical reality. Some patients suffer from a disabling medical condition that existed from birth, while others might have lost their reproductive ability because of illness or injury.²⁴⁵ Similarly, the argument that infertility does “not involve the sort of catastrophic losses that justify a medical expense deduction” is also flawed.²⁴⁶ Currently, the costs of medication such as prescription drugs for high blood pressure and diabetes are deductible despite the fact that no “catastrophic losses” are involved.²⁴⁷

Some critics claim that society as a whole should not be paying for the infertility treatments of individuals who delayed having children until a later age and as a result of that delay suffer from infertility. Their argument is that such patients who knowingly choose to delay becoming pregnant do not have a medically disabling problem but experience a natural state that inevitably results from aging.²⁴⁸ But many well-recognized medical disabilities are the typical result of aging.²⁴⁹ Such aging-related disabilities include, for example, osteoporosis and hearing loss.²⁵⁰ Therefore, if society as a whole is willing to provide medical treatments such as hearing aids and hip replacements for the elderly in order to assist individuals to overcome age-related disabilities, society should also treat the disabling medical condition of infertility, even if it is the result of aging.²⁵¹ Moreover, even if infertility patients knowingly choose to delay childbearing, they still deserve to receive a medical treatment for their medical problem, just like people who choose to smoke and consequently become ill with cancer are still entitled to get medical treatment. Similarly, medical treatment is also provided to people who chronically consume alcohol and as a result develop cirrhosis of the liver, as well as to individuals who frequently sunbathe as young adults and end up with melanoma at a later age. Indeed, no one would decline medical treatment coverage for a former sunbather simply because such an individual has higher chances of developing melanoma.

Therefore, despite the arguments against conceptualizing infertility as a disease, it should uniformly be viewed as a disabling impairment of the

245. See Orentlicher, *supra* note 49, at 157; see also Pendo, *supra* note 1, at 338–40 (discussing and criticizing the argument that reproduction is a lifestyle option).

246. Pratt, *supra* note 53, at 1125.

247. See *id.* at 1125, 1140–41 (2004) (examining whether fertility costs are and/or should be deductible under the current tax laws).

248. *Id.* at 1154–55.

249. *Id.* at 1155; Jack M. Guralnik et al., *Disability as a Public Health Outcome in the Aging Population*, 17 ANN. REV. PUB. HEALTH 25, 32 (1996).

250. Pratt, *supra* note 53, at 1155; Guralnik et al., *supra* note 249.

251. Orentlicher, *supra* note 49, at 157. This is not to suggest, of course, that there should be no age limits on infertility treatments. Age limits should be set based on health, social, and ethical considerations that are beyond the scope of this Article.

reproductive system. As explained above, infertility is a disease by all standards under which other illnesses are measured and for which society does provide treatment coverage. Accordingly, treatment for infertility should be regarded in the same way as other diseases' treatments, even if the chances to develop infertility increase with age, or through individuals' choices, and regardless of whether the treatment bypasses the medical condition or solves it. Treating infertility will assist in resolving various psychological problems, which take a financial toll on society and result from infertility. Conceptualizing infertility as a disease is also consistent with the legal reality in most of the European Union Member States, which also provide for full or at least partial coverage for infertility treatment.²⁵²

VI. THE STORY OF A MISSED OPPORTUNITY OR THE POLICY REASONS TO MANDATE COVERAGE FOR INFERTILITY TREATMENTS

While arguments and propositions in opposition of expanding coverage for infertility treatments exist, regulators and policy-makers should focus their attention on the promotion of desired theories, which present strong reasons to favor making ART methods more accessible. Such desired policies include a gender and economic equalities related policy, a social justice related policy, a medical related policy, and a health related policy.

A. *A Gender and Economic Equalities Related Policy*

The average age of first birth deliveries is constantly increasing in the United States. In fact, studies have shown that the average age of first time mothers has increased to twenty-five, several years higher than it was almost forty years ago.²⁵³ However, an individual's chance of a successful pregnancy starts to decline after the age of twenty-five. Accordingly, women are twice as likely to conceive at twenty-five as they are at thirty-five.²⁵⁴ Therefore, while many couples postpone their efforts to have children until their thirties, or even after, the chance of becoming pregnant is much lower than what it would have been had they tried to

252. See Corinna Sorenson, *ART in the European Union*, EURO OBSERVER, Autumn 2006, at 2, available at http://www.euro.who.int/__data/assets/pdf_file/0019/80371/EuroObserver8_4.pdf.

253. T.J. MATHEWS & BRADY E. HAMILTON, DELAYED CHILDBEARING: MORE WOMEN ARE HAVING THEIR FIRST CHILD LATER IN LIFE, NAT'L CTR. FOR HEALTH STAT. 1 (2009), available at <http://www.cdc.gov/nchs/data/databriefs/db21.pdf> (reporting that the average age of first time mothers has increased from 21.4 years old in 1970 to twenty-five years old in 2006).

254. Adam H. Balen & Anthony J. Rutherford, *Management of Infertility*, 335 BRIT. MED. J. 608, 608 (2007).

become pregnant in their early twenties.²⁵⁵ In addition, the age of a woman during her first birth influences the total number of births that she might have in her life.²⁵⁶

Infertility, framed in medical or social terms, is a severe problem for which not only individual women should be responsible. Indeed, reproduction is tightly related to the shift in society toward a greater equality between the sexes and a reassessment of the historical gender roles.²⁵⁷ Pursuant to the contemporary social norms, women are encouraged to study and work outside the home, just like men. This encouragement was further advanced by the enactment of various anti-discrimination laws designed to fight workplace discrimination against women and resulted in an increase of the number of women who are actively contributing to the American workforce.²⁵⁸ It is also important to note that this encouragement is also demonstrated in other health care related laws, such as maternity leave, which was recently expanded under the Affordable Care

255. See Orentlicher, *supra* note 49, at 154 (citing Kristin P. Wright & Julia V. Johnson, *Infertility*, in DANFORTH'S OBSTETRICS AND GYNECOLOGY 705, 713 (Ronald S. Gibbs et al. eds., 10th ed. 2008)).

256. MATHEWS & HAMILTON, *supra* note 253.

257. Herbert S. Klein, *The U.S. Baby Bust in Historical Perspective*, in THE BABY BUST: WHO WILL DO THE WORK? WHO WILL PAY THE TAXES? 115, 132 (Fred R. Harris ed., 2006).

258. See, e.g., Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k) (2006) (stating that pregnant women must be treated equally in the workplace); 42 U.S.C. § 2000e-2(a) (2006) (outlawing the practice of discrimination by employers based on sex and other immutable characteristics). The Pregnancy Discrimination Act (PDA) was passed in 1978 as an amendment to Title VII of the Civil Rights Act of 1964. *Hall v. Nalco Co.*, 534 F.3d 644, 647 (7th Cir. 2008). Note that infertility is covered by the PDA, because pursuant to the PDA, an employee who suffers an adverse employment action for taking leave of absence from work to receive infertility treatments has stated a cognizable claim. *Id.* at 649. In *Hall v. Nalco*, the plaintiff, a secretary at Nalco Company requested two leaves of absence, one after the other, in order to receive infertility treatments. *Id.* at 646. Nalco decided to terminate Hall as it was reorganizing and planned to let go one secretary. *Id.* When she was terminated, Hall was told that it "was in [her] best interest due to [her] health condition," because it was known that she missed work for infertility treatments. *Id.* Hall filed suit, arguing that she was terminated in violation of the PDA. *Id.* The district court concluded that infertility, because it is gender neutral, is not covered under the PDA, however, the Seventh Circuit rejected this conclusion. *Id.* at 647-49. The Seventh Circuit held that the employer's conduct must still be gender-neutral. *Id.* at 649. Thus, when employers categorize employees based on gender-specific traits, such as the potential for pregnancy, such a classification is discrimination under the PDA. *Id.* Therefore, the Seventh Circuit held that if an employer terminates an employee for taking time off to undergo IVF, it is obvious that such an employee will necessarily be a woman, just as it is always women who give birth and therefore take time off to do so. *Id.* at 648-49. The court concluded that Hall was not let go because of her infertility, but instead because of her gender-specific capability to conceive. *Id.* at 649.

Act.²⁵⁹ However, once women started studying and working, they experienced greater opportunities and found that self-fulfillment was very rewarding. Consequently, many women started delaying marriage and procreation and started spacing their children further apart, which resulted in a shortened procreation period.²⁶⁰ Indeed, studies have shown that increasing equality between the sexes and enabling women to study and work outside the home has caused an increase in childlessness rates.²⁶¹ In the United States, women with graduate degrees have fertility rates that are two thirds lower than women who did not graduate high school.²⁶² Thus, while there are other factors that impact women's decisions regarding procreation—the availability of affordable childcare and more flexibility of workplace hours²⁶³—these factors directly result from the already existing phenomenon of women's encouraged participation in the workplace, which lead to declining fertility rates and the growing age of first deliveries.

If today's women are encouraged and expected to study, work, and fulfill themselves mentally, socially, and economically as men's equals, society should not let women pay the price for doing so on their own. Society should, therefore, promote such gender equality by mandating infertility treatment coverage. Such coverage would enable women to fulfill themselves by obtaining an education and pursuing a career knowing that it would not come at the cost of having a family.

259. Maternity and new born care are actually included in the categories of health services that are now required to be covered as “essential health benefits” in health programs, which will be sold via small business with up to 100 employees and individuals, starting in 2014. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, § 1302(b), 124 Stat. 119, 163 (2010) (to be codified at 42 U.S.C. § 18022).

260. See Klein, *supra* note 257, at 143; Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER, RACE & JUST. 1, 2 (2005) (arguing that pregnancy discrimination is largely ignored in the workplace).

261. See JANE LAWLER DYE, U.S. CENSUS BUREAU, FERTILITY OF AMERICAN WOMEN: 2006, at 1 (2008), available at <http://www.census.gov/prod/2008pubs/p20-558.pdf> (reporting that among American women ranging between forty to forty-four years old in 2006, twenty percent were childless). That number is twice as much as the percentage of childless women age forty to forty-four in 1976. *Id.*

262. *Id.* at 4. In addition, the fertility rates in more politically conservative states, where traditional gender roles are more present, tend to be higher than fertility rates in more liberal states. Naomi Cahn & June Carbone, *Red Families v. Blue Families* 26 (George Washington Univ. Sch. of Law, Pub. Law & Legal Theory Working Paper Group, Working Paper No. 343, 2007), available at <http://ssrn.com/abstract=102589>.

263. See Ronald R. Rindfuss et al., *The Changing Institutional Context of Low Fertility*, 22 POPULATION RES. & POL'Y REV. 411, 416–17 (2003) (discussing the importance of the consideration of child care when deciding on whether to have children).

B. *A Health Related Policy*

Recently, scholars have taken notice of the various risks associated with multiple births, which are common in the case of assisted reproduction. In fact, about thirty-three percent of the births resulting from assisted reproduction treatments are multiples.²⁶⁴ This high percentage imposes considerable health risks on both mothers and their children.²⁶⁵ These risks include: miscarriages, increased need for caesarean delivery, premature births,²⁶⁶ low-weight babies, mental retardation, short- and long-term health-problems for the child, prenatal mortality,²⁶⁷ learning disabilities, and different behavioral complications.²⁶⁸ Therefore, the public health community considers the significant increase in multiple births—at least those that occur in a single pregnancy *and* are related to assisted reproduction—as an avoidable epidemic.²⁶⁹ In the United States, more public focus was given to this phenomenon following the recent resolution of Nadya Suleman, later known as Octomom, to transfer six embryos—two of which twinned—using in vitro fertilization (IVF).²⁷⁰ On account of the media's and public's focus, a number of state

264. U.S. DEP'T OF HEALTH & HUM. SERVS., ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: 2007 NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 24 (2009), available at http://www.cdc.gov/art/ART2007/PDF/COMPLETE_2007_ART.pdf.

265. See Sheree L. Boulet et al., *Perinatal Outcomes of Twin Births Conceived Using Assisted Reproduction Technology: A Population-Based Study*, 23 HUM. REPROD. 1941, 1941–42 (2008), available at <http://humrep.oxfordjournals.org/cgi/reprint/23/8/194> (describing the significant health risks for twin deliveries related to IVF treatments); SASWATI SUNDERAM ET AL., CTR. FOR DISEASE CONTROL AND PREVENTION, ASSISTED REPRODUCTIVE TECHNOLOGY SURVEILLANCE — UNITED STATES, 2006, at 1 (2009), available at <http://www.cdc.gov/mmwr/pdf/ss/ss5805.pdf> (describing the significant health risks for women with multiple-gestation pregnancies and for the infants born in multiple-birth deliveries); Velikonja, *supra* note 40, at 472–74 (discussing the risks to the mother and the children).

266. Strong, *supra* note 32, at 273–74. Fourteen percent of twins and forty-one percent of triplets are born premature prior to thirty-three weeks, but only two percent of single fetus pregnancies end in a delivery that is prior to thirty-three weeks gestational age. *Id.* at 273.

267. The death rate per 1000 births is 8.8 for singleton pregnancies, but is 46.8 for twins and 82.6 for triplets. *Id.*

268. Sorenson, *supra* note 252, at 3.

269. See Maurizio Macaluso et al., *A Public Health Focus on Infertility Prevention, Detection, and Management*, 2008, at 5.e5–5.e7, available at <http://www.cdc.gov/reproductivehealth/Infertility/PDF/WhitePaper.pdf> (encouraging the development of a national plan to address the risks associated with fertility treatments).

270. See *Octuplets' Mom: 'All I Ever Wanted,'* CNN.COM (Feb. 6, 2009, 11:14 AM), <http://www.cnn.com/2009/US/02/06/octuplets.mom/index.html> (describing the public's lack of belief that Suleman can offer adequate care for her fourteen children); Jennie Eng, *Eight's a Crowd for Some in Debate Over In-Vitro Fertilization*, DAILY FREE PRESS, Feb. 17, 2009, <http://www.dailyfreepress.com/eight-s-a-crowd-for-some-in-debate-over-in-vitro-fertilization-1.1481683> (emphasizing criticisms of Suleman's use of assisted reproduction);

legislatures considered legislation to cap the number of embryos transferred in IVF.²⁷¹ This type of legislation is similar to the laws in many of the member countries of the International Federation of Fertility Societies, which have legislation and guidelines regulating the number of the transferred embryos in order to avoid multiple birth pregnancies.²⁷² Mandatory IVF coverage can reduce the number of multiple births resulting from assisted reproduction in the United States.

In the attempt to suggest a solution to the problem, at least one scholar has argued that it is possible to address the decision-making factors and incentives that pull patients towards choices that lead to high risks of multiple gestations, while still allowing them to accomplish their dreams of having children.²⁷³ Health care coverage for fertility treatment would encourage approaches that promote single-embryo transfer, instead of implanting multiple embryos, which often leads to multiple gestations.²⁷⁴ As demonstrated in many European countries,²⁷⁵ coverage of infertility

see also Kimi Yoshino, *Doctor Who Treated Octuplets Mom Ejected from Society of Reproductive Medicine*, L.A. TIMES, Oct. 20, 2009, <http://www.latimes.com/news/local/la-me-octuplets-doctor20-2009oct20,0,4363432.story> (concerning the disciplinary action that was commenced against doctor, who was expelled from the American Society for Reproductive Medicine). The Medical Board of California has also initiated a legal action against Dr. Kamrava for multiple counts of gross negligence, acts of repeated negligence, and inadequate record keeping; convictions on these charges could result in suspension or revocation of his medical license. Joel Zand, *Octomom's Doctor Michael Kamrava Sued by CA Medical Board*, FINDLAW (Jan. 5, 2010, 5:10 PM), <http://blogs.findlaw.com/courtside/2010/01/octomoms-doctor-michael-kamrava-sued-by-ca-medical-board.html>.

271. See Kimi Yoshino & Jessica Garrison, *Stricter Rules on Fertility Industry Debated*, L.A. TIMES, Mar. 6, 2009, <http://articles.latimes.com/2009/mar/06/nation/na-octuplets-laws6> (concerning different states' proposed bills regarding limiting the number of embryos that can be used in in-vitro fertilization).

272. See PATRICIA KATZ ET AL., INST. FOR HEALTH POL'Y STUD., *THE ECONOMIC IMPACT OF THE ASSISTED REPRODUCTIVE TECHNOLOGIES*, at s31 (2002), available at <http://www.nature.com/fertility/content/pdf/ncb-nm-fertilys29.pdf>.

273. See generally Glennon, *supra* note 41 (discussing the factors that push parents towards high-risk infertility treatments).

274. *Id.* at 170, 201. Indeed, in several European countries, by expanding coverage for IVF and including limits on the number of embryos transferred depending on patient age, the twinning rate related to IVF and other fertility treatments was dramatically reduced. *Id.* at 201. Moreover, women normally use IVF to transfer only one embryo at a time. *Id.*

275. In Sweden, for example, where access to assisted reproduction is aided by public funding for the first three cycles of IVF, the National Board on Health and Welfare issued guidelines promoting adhering to implanting only one embryo unless the potential hazards of a twin pregnancy are insignificant. P.O. Karlström & C. Bergh, *Reducing the Number of Embryos Transferred in Sweden—Impact on Delivery and Multiple Birth Rates*, 22 HUM. REPROD. 2202, 2204 (2007). Consequently, the rate of twin pregnancies in Sweden following IVF dropped to five percent without compromising the IVF success rate, which is valued by the number of live births. *Id.* Similarly, in Belgium, the government covers certain

treatment makes a tremendous difference because many patients' decisions to maximize the chances of pregnancy on the first cycle, through multiple-embryo transfer, are based on their inability to pay for additional cycles. A patient's decision to implant multiple embryos is not based on her intention to have multiple embryos in the same pregnancy.²⁷⁶ Instead, this decision is more often than not based on the limited financial resources and on the forced economic calculations. This financially influenced reality was also demonstrated by the situation in Massachusetts, where the requirement of full coverage for IVF treatment encouraged financially struggling patients to employ a single-embryo transfer.²⁷⁷

C. A Social Justice Related Policy

Insurance, therefore, takes from all a contribution; from those who will not need its aid, as well as from those who will; for it is as certain that some will not, as that some will. But as it is uncertain who will, and who will not, it demands this tribute from all to the uncertainty of fate. And it is precisely the moneys thus given away by some, and these only, which supply the fund out of which the misfortune of those whose bad luck it is that their moneys have not been thrown away, are repaired.²⁷⁸

Mandating infertility treatment coverage would assist in making the ability to parent accessible to everyone. The ability to procreate should be viewed as a social good, to which all should be entitled because "the birth of a child is deemed a good in itself, and helping the parents achieve that goal is a morally worthwhile endeavor."²⁷⁹ Professor Amy Monahan argues that "mandated health benefit laws serve an important policy

expenses for up to six IVF cycles for women below the age of forty-three, at clinics that adhere to government's funding restrictions. Glennon, *supra* note 41, at 194–95. Women using government funded assisted reproduction, however, must begin with single-embryo transfer. *Id.* at 195. And while studies have shown that following such a policy will increase the government's costs, research has shown that these costs will probably be offset by the "cost savings related to pregnancy, delivery, and newborn care." *Id.*

276. See Richard H. Reindollar et al., *A Randomized Clinical Trial to Evaluate Optimal Treatment for Unexplained Infertility: The Fast Track and Standard Treatment (FASTT) Trial*, 94 FERTILITY & STERILITY 888, 895 (2010) (identifying average cost of conventional infertility treatments in a studied group).

277. See Glennon, *supra* note 41, at 201.

278. Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 371–72 (2003).

279. Ethics Committee of the American Society for Reproductive Medicine, *Child-Rearing Ability and the Provision of Fertility Services*, 92 FERTILITY & STERILITY 864, 865 (2009), available at <http://www.asrm.org/publications/detail.aspx?id=632>.

function by allowing certain health risks to be widely pooled, and should therefore be retained as an important health policy tool.”²⁸⁰ However, mandated benefit laws also play a prominent role in health care debates because they demonstrate a basic tension that exists between the desire to keep costs low and the desire to spread the risk of loss as extensively as possible.²⁸¹ As Professor Tom Baker, one of the nation’s leading insurance theory scholars, indicated, “[t]he debate over the government’s role in U.S. health insurance is, in significant part, a debate over the nature of health insurance: does it exist to protect me and mine, or does it serve a greater good?”²⁸²

So how should society choose between “the desire to keep costs low versus the desire to spread the risk of loss as widely as possible” to serve a greater good?²⁸³ Scholars have identified several justifications for mandating that an insurance contract cover benefits that it otherwise would not cover.²⁸⁴ These rationales include addressing market failures and suboptimal use of a medical treatment.²⁸⁵

Mandated benefits laws commonly address market failures and preserve the risk pooling function of insurance. Mandated benefit laws preserve information asymmetry at the micro-level, mandating that these micro-level risks be spread across the entire insured population, instead of on just the impacted people. Consequently, the market failure is overcome by having the entire population pay a slightly higher premium to cover the mandated benefit, which enables the few unfortunate impacted people to avoid being priced out of coverage.²⁸⁶ Scholars have argued that mandating benefits laws in order to overcome market failures is legitimate if: (1) the covered individual has a reason to know, or knows, that she will use the mandated benefit, and (2) if the knowledge of the possibility of utilization is not easily or cost-effectively discoverable by the insurance company.

280. Monahan, *supra* note 29, at 128. Deborah Stone contends that insurance also shapes larger culture and behavior. Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in *EMBRACING RISK*, *supra* note 42, at 52, 54. Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation. *Id.*

281. Monahan, *supra* note 29, at 128.

282. Baker, *supra* note 42. Tom Baker and Jonathan Simon, two of the nation’s leading experts in insurance law and theory, have written that insurance is the “paradigmatic risk spreading institution.” Baker & Simon, *supra* note 42, at 7.

283. Monahan, *supra* note 29, at 128.

284. *Id.* at 129.

285. *Id.*

286. *Id.* at 128.

This is indeed the situation with coverage of infertility treatments, where there is a clear market failure given the low coverage rates and the high costs of the treatments. A patient has much more information about her fertility levels and her desire to procreate than the insurance companies. This information asymmetry and the cost of infertility treatments result in the insurance companies excluding infertility treatment coverage. If individuals wish to add such coverage it would be considered a special request, and be priced accordingly, further emphasizing the market failure. Spreading the risk of loss across the entire population, however, would guarantee access to infertility treatments. It would also solve the adverse selection problem of individuals using their private knowledge regarding their own risk when making insurance purchasing decisions.

Often, there is no optimal use of medical treatments simply because insurance companies make purely financially-driven coverage determinations. In the context of infertility treatment, given the lack of insurance coverage, financially and emotionally distressed patients often pressure their physicians to make the treatment work as quickly as possible. This pressure often leads to riskier treatment,²⁸⁷ such as: using a higher doses of stimulation, which results in more mature eggs and an increased risk of multiple pregnancies; implanting and transferring more embryos through IVF,²⁸⁸ which leads to multiple pregnancies, despite the associated health risks; or a patient's refusal to cancel an artificial insemination procedure on which a high number of eggs are stimulated, which also leads to an increased risk of pregnancy with multiple fetuses.²⁸⁹ Therefore, mandating infertility treatment coverage and lowering the costs of treatments would reduce the pressure to make aggressive treatment decisions. As explained above, most individuals that are in need of infertility treatments do not receive coverage for the treatment and are left to deal with the financial difficulty on their own. Accordingly, infertility treatment coverage can be justified on the basis of promoting optimal utilization of the treatment.

It has been argued that for the justifications stated above to be legitimately used in the context of infertility treatment, not only must there be a feasible justice claim for providing coverage but alternatively, there

287. See Glennon, *supra* note 41, at 170.

288. Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 *NEW ENG. J. MED.* 661, 665 (2002). Studies indicate that IVF insurance coverage lowers the number of embryos transferred in each IVF cycle. *Id.* at 663–64.; Meredith A. Reynolds et al., *Does Insurance Coverage Decrease the Risk for Multiple Births Associated With Assisted Reproductive Technology?*, 80 *FERTILITY & STERILITY* 16, 22 (2003).

289. Stephanie Saul, *Grievous Choice on Risky Path to Parenthood*, *N.Y. TIMES*, Oct. 11, 2009, <http://www.nytimes.com/2009/10/12/health/12fertility.html>.

must be a “cost-efficiency or cost-benefit analysis compared to non-coverage.”²⁹⁰ Such feasible justice claim, as well as an economic incentive for providing coverage for infertility treatments exists as further explained below. Indeed, “value-based mandates can improve health outcomes and help to ensure that [the] medical dollars are spent effectively.”²⁹¹

i. Justice Claims Support Using Mandates to Address the Health Insurance Market

All individuals, including those that are unaffected by infertility, will be required to pay slightly higher insurance premiums if infertility treatment coverage is mandated.²⁹² This increase of premiums can be argued to cause certain individuals to lose the ability to pay for insurance coverage. However, studies have shown that while insurance costs do impact health insurance take-up rates, only a substantial change of price actually affects insurance enrollment.²⁹³ As a result, the number of individuals affected, if at all, will be very small. Therefore, this argument against mandating coverage is not a critical one. Especially, as the infertile individuals have a legitimate and appealing justice claim to mandate infertility treatment coverage, and fulfill their basic need to parent.

ii. Mandating Coverage for Infertility Treatments Promotes Cost-Efficiency²⁹⁴

As argued above, given the lack of coverage for infertility treatments, most couples facing infertility problems choose to save money on addi-

290. Monahan, *supra* note 29, at 129.

291. *Id.* at 130.

292. *Id.* at 174 (referencing different cost studies, reporting premium increases ranging from \$2.49 per member per year to an increased cost of \$70 per year).

293. See, e.g., Anne Beeson Royalty & John Hagens, *The Effect of Premiums on the Decision to Participate in Health Insurance and Other Fringe Benefits Offered by the Employer: Evidence from a Real World Experiment*, 24 J. HEALTH ECON. 95, 110–11(2005) (showing that take up rates were not lower than the baseline rate when baseline premiums of 125 percent were charged). Similarly, when the baseline premium was lowered to seventy-five percent, take up rates only increased one percent. *Id.* at 109–10; Michael Chernew et al., *The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?*, 32 HEALTH SERVS. RES. 453, 464 (1997) (demonstrating that reducing premium rates by fifty percent only resulted in a three percent increase of take up rates); IRENA DUSHI & MARJORIE HONIG, PRICE AND SPOUSE’S COVERAGE IN EMPLOYEE DEMAND FOR HEALTH INSURANCE 4 (n.d.) (“A change from paying nothing to paying part or all of the costs results in a 5.2[%] decline in take-up among women and a 1.8[%] decline among men.”).

294. Despite the long list of costs associated with infertility treatments, mandated coverage will spread the costs across the population and make fertility a cost-effective

tional IVF cycles, by implanting multiple embryos, which commonly leads to multiple gestations. However, more often than not, the greater expenses resulting from IVF related multiple gestations' births, and the long-term care costs that result from the affiliated risks are ignored. These great costs are not imposed on the infertility clinics, but on public hospitals, schools, insurance companies, and, of course, the infertility patients themselves.²⁹⁵

Although it is notoriously difficult to estimate the costs resulting from multiple births, as those can include anything from medical care at birth to special education programs required for the high order pregnancies children, some studies have shown that these costs are significantly higher than those associated with singleton birth. Pursuant to certain U.K. reports, "a twin birth is sixteen times more expensive than a singleton delivery, and a triplet or higher-order multiple births can easily cost several hundred thousand dollars."²⁹⁶ Similarly, recent research done by the Infertility Awareness Association of Canada shows that reducing the multi-

option for all who need it. Corrinna Sorenson lists a comprehensive number of implications credited with these increased costs. Sorenson, *supra* note 252, at 3.

Multiple pregnancies generate higher costs than single births, as a result of increased antenatal, obstetrical, and neonatal treatment, long-term disability services, and increased demands on family resources. It has been reported that average hospital charges for twin deliveries were four times higher than for a singleton, with charges increasing exponentially for triplet and quadruplet deliveries. Moreover, women with higher order pregnancies frequently require hospitalization, Caesarean delivery, and many give birth to premature, low-weight babies or suffer miscarriage. Short- and long-term complications for the child include increased risk for perinatal mortality, mental retardation, learning disabilities, and behavioural problems. Moreover, multiple births also affect families by introducing financial hardship and a higher incidence of maternal depression and marital problems.

Id.

295. Velikonja, *supra* note 40, at 466.

American ART parents may pay a high price to conceive children, but they do not pay out-of-pocket for the medical expenses of multiple gestation pregnancies. U.S. consumers do, through higher insurance premiums, hospital fees, and higher taxes, which are used to treat, educate, and care for children with medical problems.

Id. See also Stephanie Saul, *Grievous Choice on Risky Path to Parenthood*, N.Y. TIMES, Oct. 11, 2009, <http://www.nytimes.com/2009/10/12/health/12fertility.html> (stating that Dr. Brian Kirshon finds that many couples do not completely appreciate the health risks resulting from multiple gestation and premature birth).

296. Velikonja, *supra* note 40, at 466. Pursuant to a 1999 U.S. study, "a twin delivery costs \$43,300 more than a singleton delivery, a triplet delivery \$120,000 more, and a quadruplet delivery \$174,000 more . . . health care costs have been rising faster than inflation, the figures today are likely to be at least [fifty-percent] higher." *Id.* at 480. Finally, "since twins and higher-order multiples are more likely to require special education and other programs financed by the local, state, and federal governments, all American taxpayers—and not just the parents—pay to raise and educate them." *Id.* at 479.

ple births to ten-percent in Ontario, results in a net savings of \$100–\$111 million per year.²⁹⁷

The costly price of infertility treatments distorts many patients' decision-making considerations even though the consequences can heavily impact the patients' health and the health of their hoped-for children.²⁹⁸ Moreover, the multiple pregnancies and births are much more expensive and often lead to additional costs that do not occur in the case of a singleton pregnancy and delivery. The additional costs make it economically efficient to promote single embryo transfers and singleton pregnancies and births. Providing for coverage for infertility treatment is a useful tool that should be used to promote this policy.

D. A Medical Related Policy

Infertility, which results from the inability to conceive or carry a pregnancy to term, should be viewed as a legitimate medical problem that requires medical treatment. In addition to the medical arguments detailed above, because of the severe mental, physical, and social hurdles

297. Mathias Gysler, *Why Ontario Must Fund IVF Now*, INFERTILITY AWARENESS ASS'N. OF CANADA, <http://www.iaac.ca/content/why-ontario-must-fund-ivf-now-dr-mathias-gysler-summer-2010> (last visited Sept. 10, 2011). Pursuant to the calculation, the cost of IVF coverage in the first year in Ontario, Canada is \$72 million. *Id.* This coverage would provide the following benefits over the course of five years: (i) assisting additional 1,870 couples to have a birth of a child; (ii) to lower the percentage of multiple birth pregnancies to sixty-four percent fewer (this includes twins and triplets); (iii) lowering the number of low birth weight multiples by 2831. *Id.* The cost savings is estimated in the following way:

- Annual savings of at least \$51–\$70 million in prenatal hospitalization costs related to the birth of premature multiples.
- Annual savings of about \$30–\$40 million in post natal health costs for the first year of care of surviving low birth weight multiples.
- Annual savings of \$91 - \$131 million in long-term health and social services costs of caring for children with permanent disabilities as a result of pre-term birth.
- Net savings = \$100–\$111 million each year.

Id.

298. Glennon, *supra* note 41, at 147. While the patients participating in the study did not describe financial stress as the main factor in their decision-making, many patients encounter financial difficulties. *Id.* at 184. Additionally, even if such patients are fortunate enough to have a health insurance plan that does cover IVF, many plans restrict the number of cycles covered, which creates additional incentive for such patients to reduce the number of cycles used. *Id.* at 184–85. It should also be noted that pursuant to a study done at the University of Iowa, most patients were willing to try single-embryo transfer if the pregnancy rates were equivalent; however, the findings of this study clearly showed that patients were not tolerant of a single percentage drop in success rate. See Ginny L. Ryan et al., *A Mandatory Single Blastocyst Transfer Policy with Educational Campaign in a United States IVF Program Reduces Multiple Gestation Rates Without Sacrificing Pregnancy Rates*, 88 FERTILITY & STERILITY 354, 356 (2007).

that infertility patients are forced to encounter and deal with—if infertility is recognized as a disease it should be also recognized as a disabling impairment.

Mandating infertility treatment coverage and defining infertility that results from the inability to conceive or carry a pregnancy to term as a disease, guarantees that discrimination of infertility patients resulting from society's lack of understanding of their condition will not be tolerated. Infertility patients will be entitled to receive medical treatment, as do all other patients with a disabling medical condition. Additionally, infertility patients would have a legal tool to assist them if they do encounter any un-called for discrimination associated with their medical condition.

The best basis for such protection is Title I of the ADA. The ADA is intended to protect eligible individuals with disabilities²⁹⁹ from disability-based prejudice in employment,³⁰⁰ and in the provision of services.³⁰¹ The employment provision, found in Title I of the ADA, protects individuals with disabilities in the contents and terms of their employment.³⁰² However, while the ADA is intended to address discrimination that is customary in employment circumstances in the United States,³⁰³ the ADA includes inadequately defined terms, which make the ADA somewhat inefficient as its reach and effect are left to be defined and inter-

299. Americans with Disabilities Act, § 1201(b) (2006). In order to have a claim under the ADA, a plaintiff must be a “qualified individual with a disability.” 42 U.S.C. § 12111(8) (2006). The ADA defines a qualified person as a disabled individual who can perform the “essential functions of the . . . [job he or she] holds or desires,” with or without reasonable accommodation from the employer. *Id.* Thus, job applicants or current employees can be eligible individuals; however, this definition is somewhat elusive as defining disability under the ADA, especially regarding whether former employees may sue their prior employers for discrimination that took place while they were still employed. *Compare* Ford v. Schering-Plough Corp., 145 F.3d 601, 607 (3d Cir. 1998) (interpreting the ADA to include former employees who are disabled and permitting them to sue prior employers), *with* Gonzales v. Garner Food Servs., Inc., 89 F.3d 1523, 1526–31 (11th Cir. 1996) (determining that for purposes of the ADA former employees are not qualified individuals with a disability).

300. Americans with Disabilities Act, § 1201(b). Title I governs employment discrimination. *See* 42 U.S.C. §§ 12111–17 (2006).

301. *See* 42 U.S.C. §§ 12131–65 (2006) (mandating certain regulations to make public services accessible to those with disabilities).

302. *See* 42 U.S.C. § 12112 (2006) (prohibiting any kind of discrimination against those with disabilities in the work place).

303. *See* 42 U.S.C. § 12101 (2006) (setting forth the purpose of the ADA and the discriminatory reality, which it was intended to resolve; when enacted, the Congress found an astounding 43,000,000 people in America to have some form of mental or physical impairment).

preted by courts.³⁰⁴ One such term is “disability.” Under the ADA, a disability is defined as “a physical or mental impairment that substantially limit[s] one or more . . . major life activities.”³⁰⁵

Analyzing the rationale behind the definition of “disability,” a court has found that pursuant to the ADA, infertility is a physical impairment of the reproductive system.³⁰⁶ Similarly, another court has found that infertility is impairment to reproduction under the standards of the ADA.³⁰⁷ However, two other courts have held that the inability to reproduce is not a major life activity because it is not specifically listed in the Act.³⁰⁸ But there are no indications that the list of activities was intended to be exhaustive.³⁰⁹ Indeed, it has been held that activities that are not listed can be considered major life activities under the ADA.³¹⁰

For so many individuals, bearing and raising children are the most important activities of their lives—much more important than working for example—the Supreme Court has recognized that reproduction is a ma-

304. *See generally* Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) (providing the Supreme Court’s interpretation of the ADA provisions and the definition of “disability”).

305. Americans with Disabilities Act, § 12102(2)(A).

306. Pacourek v. Inland Steel Co., 858 F. Supp. 1393, 1404 (N.D. Ill. 1994). The court found infertility to be a physical impairment of the reproductive system and that reproduction to be a major life activity. *Id.* at 1404–05. Because the claimant’s infertility substantially limited the major life activity of reproduction, she had described a disability under the ADA. *Id.* at 1405.

307. *See* Erickson v. Bd. of Governors, 911 F. Supp. 316, 323 (N.D. Ill. 1995) (noting infertility “substantially limits the major life activity of reproduction”). The court relied upon two Rehabilitation Act cases for the proposition that reproduction is a major life activity under the ADA: *Sch. Bd. of Nassau Cnty. v. Airline*, 480 U.S. 273 (1987), and *McWright v. Alexander*, 982 F.2d 222 (7th Cir 1992). The *Erickson* court also relied on the propositions that Congress and the EEOC designed the definition of “major life activity” with the intention that it will have a “broad definition, one not limited to so-called ‘traditional handicaps,’ is inherent in the statutory definition.” *Id.* at 322.

308. Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996) (holding that reproduction does not meet the definition of a major life activity under the ADA because it does not rise to the level of the listed activities provided by the Equal Opportunity Employment Commission (EEOC)); *Zatarain v. WDSU-Television, Inc.*, 881 F. Supp. 240, 243–44 (E.D. La. 1995). Nevertheless, the *Zatarain* court refused to rule that infertility was not a physical impairment of the reproductive system. *Id.* at 244.

309. The EEOC, the federal agency charged with promulgating regulations to enforce Title I of the ADA, provided that major life activities are functions such as “caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.” 29 C.F.R. § 1630.2(i) (2010). However, the use of the words “such as,” indicates that this list was not intended to be exhaustive, as also demonstrated in the EEOC’s Interpretive Guidance. *See id.* “This list is not exhaustive. For example, other major life activities include, but are not limited to, sitting, standing, lifting, reaching.” *Id.*

310. *Lowe v. Angelo’s Italian Foods, Inc.*, 87 F.3d 1170, 1172 (10th Cir. 1996) (holding that lifting is a major life activity under the ADA).

major life activity.³¹¹ The Supreme Court's *Bragdon v. Abbott*³¹² decision put an end to a split among the circuits regarding whether reproduction should be interpreted to be a major life activity.³¹³ Specifically, the Supreme Court held that HIV infection is a "disability" even when the infection has not yet advanced to the symptomatic phase, because it impairs, impacts, and limits reproduction, which is a major life activity.³¹⁴ The Supreme Court stated that, at least in the context of that case, "[r]eproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself."³¹⁵

The *Bragdon* decision was rendered more than half a century after the Supreme Court first recognized that procreation is a basic human right by holding that "[m]arriage and procreation are fundamental to the very existence and survival of the race."³¹⁶ Similarly, following this logic, an appellate court has recently stated that sterility is a disability under the ADA.³¹⁷ Therefore, the Supreme Court's recognition of reproduction as a major life activity can and should open the door to officially recognizing that infertility is also a disability. Given the importance of the right to procreate, it seems logical that the Supreme Court's reasoning should be extended to permit other diseases or physical impairments, such as infertility, to be "disabilities" for purposes of the ADA.³¹⁸

Infertile individuals have an impairment of their reproductive tracts and should be considered disabled due to this physical impairment. Based on society's views on infertility and the stigma associated with it, it is plausible to argue that infertile individuals are also disabled due to the effect of this social stigma.³¹⁹ Moreover, based on the severe effect, which infertility has on infertile individuals' mental condition—including the grief, depression, anger, and isolation—it is also plausible to argue that such individuals are seen by society, as well as by themselves, as dis-

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

312. 524 U.S. 624 (1998).

313. *Id.* at 638.

314. *Id.* at 641–42.

315. *Id.* at 638.

316. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

317. *Yindee v. CCH, Inc.*, 458 F.3d 599, 601 (7th Cir. 2006).

318. *Cehrs v. Ne. Ohio Alzheimer's Research Ctr.*, 155 F.3d 775, 780 (6th Cir. 1998) (relying on *Bragdon* to find that under the ADA, plaintiff's psoriasis was indeed a disability).

319. See ANITA SILVERS ET AL., *DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY* 9–10 (1998) (explaining that those who are "disabled" are people who are unable to function equally in society, an analysis which focuses more on the treatment of the "disabled" person, and less on the person's specific "disability").

abled. Indeed, these individuals also suffer from a physiologically and scientifically recognized impairment that is characterized as a mental anomaly. Therefore, individuals suffering from infertility are likely to meet the definition of disability.

VII. INTERNATIONAL COVERAGE OF FERTILITY TREATMENT

Many developed countries around the world have recognized the importance of focusing efforts not only on preventing the occurrences of undesired pregnancies, but also on promoting the desired conceptions of the increasing population of people suffering from infertility. More than twenty countries have provided at least partial coverage for ART methods.³²⁰ Consequently, “in developed countries such as Australia, France, Japan, and Germany, per capita use of IVF procedures is more than a few times higher than in the United States[.]” which is a result of policy differences.³²¹ For comparative purposes, information regarding other developed countries’ policies is provided below.

Austria. Under a law that came into effect in 2000, seventy-percent of the fertility treatment care, including expenses used for IVF, are reimbursable by the In Vitro Fertilization Fund for services provided by facilities under contract with the Fund for up to four cycles. This treatment can be re-started for every achieved pregnancy. The patients, however, need to be married couples or be in a stable relationship for several years and have an existing SHI coverage to qualify for the age requirements.³²²

Belgium. A reimbursement plan, which was created by the Minister of Social Affairs, went into effect on July 1, 2003. The plan provides for government funding at clinics, which must strictly comply with the government’s requirements.³²³ The plan covers laboratory expenses for women below a certain age, which provide as many as six IVF cycles for each woman.³²⁴ The government plan also partially reimburses “consultation, ultrasonography, endocrine assays, ovum pick up and embryo transfers as well as admission in the hospital and necessary drugs.”³²⁵

320. See *IFFS Surveillance 07*, 98 FERTILITY & STERILITY S1, S15 (2007), available at http://www.iffs-reproduction.org/documents/Surveillance_07.pdf (outlining how ART is covered or reimbursed in forty-seven countries).

321. Katherine E. Abel, *The Pregnancy Discrimination Act and Insurance Coverage For Infertility Treatment: An Inconceivable Union*, 37 CONN. L. REV. 819, 822 (2005).

322. Sorenson, *supra* note 252, at 7.

323. Glennon, *supra* note 41, at 194–95.

324. *Id.*

325. *Id.* (quoting Diane de Neubourg et al., *Impact of a Restriction in the Number of Embryos Transferred on the Multiple Pregnancy Rate*, 124 EUR. J. OBSTETRICS & GYNECOLOGY & REPROD. BIOLOGY 212, 214 (2006)).

Denmark. Under the law, patients are entitled to receive funded infertility treatment and patients' first three cycles are covered if they use public clinics or hospitals. ART related drugs, however, are not fully covered, and patients that purchase related drugs can be reimbursed for up to eighty-five percent of the cost, depending on the drugs' total price.³²⁶

Finland. Under the Act on Assisted Fertility Treatments,³²⁷ which went into effect in 2007, the Finnish government funds IVF in both public and private clinics.³²⁸ Likewise, reimbursable expenses include: infertility treatment procedures, consultations with specialists, drugs, radiological inspections, and laboratory tests.³²⁹ In Finland, the National Social Insurance Institution subsidizes most of the fertility treatment's cost and the patients pay the remainder, which is estimated to be twenty-five to forty percent of the entire amount.³³⁰

France. Under a 1978 law, the Encouragement of Birth of Children was enacted by the government. In addition, pursuant to the eleventh section of the 1946 Constitution's preamble, all citizens are entitled to health care.³³¹ Therefore, citizens, who are commonly entitled to get reimbursed up to eighty percent of all medical expenditures by the government health care system, receive full coverage for infertility treatment expenses under France's national health insurance system.³³² Such couples, however, need to be married or live together for two years and if they choose to use private clinics, they will only be reimbursed for the amount that would be covered in the public clinics.³³³ If the treatments result in a live birth, the same treatment possibilities are available for additional pregnancies.³³⁴

326. Sorenson, *supra* note 252, at 7.

327. Act on Assisted Fertility Treatments, (Act No. 1237/2006), (Fin.), available at www.finlex.fi/fi/laki/kaannokset/2006/en20061237.pdf (unofficial English translation) (regulating assisted human fertilization in Finland).

328. Sari Koivurova et al., *Health Care Costs Resulting from IVF: Prenatal and Neonatal Periods*, 19 HUM. REPROD. 2798, 2803 (2004). The private clinics are responsible for approximately sixty percent of the IVF treatment cycles in Finland. Mika Gissler et al., *Monitoring of IVF Birth Outcomes in Finland: A Data Quality Study*, 4 BMC MED. INFORMATICS & DECISION MAKING 2 (2004), available at <http://www.biomedcentral.com/1472-6947/4/3>.

329. Gissler et al., *supra* note 328.

330. Glennon, *supra* note 41, at 197.

331. Noelle Lenoir, *French, European, and International Legislation on Bioethics*, 27 SUFFOLK U. L. REV. 1249, 1252 (1993).

332. Nan T. Ball, *The Reemergence of Enlightenment Ideas in the 1994 French Bioethics Debates*, 50 DUKE L.J. 545, 550 (2000).

333. Sorenson, *supra* note 252, at 7.

334. *How Does the US Compare to the Rest of the World for Infertility Coverage?*, *supra* note 39.

Germany. Under the German law, comprehensive public funding is offered for infertility treatments, which includes coverage for up to fourteen inseminations and four IVF cycles.³³⁵

Israel. Under Israel's basic health care coverage, expansive access to IVF and other infertility treatments are provided, which includes unlimited coverage for the birth of two live children. The coverage is offered to married as well as single women, even though a screening interview might be necessary for women who are interested in donor insemination. In addition, the coverage is limited to women who are above thirty but below fifty.³³⁶

Norway. Under the Act on Artificial Fertilization, which came out in 1987, different restrictions and limitations on assisted reproduction were made, including limiting assisted reproduction treatment only to married couples.³³⁷ Then in 1994, the Biotechnology Act was put in place, and its 2000 amendments stating that the infertile couples themselves pay the costs of infertility treatment, were approved. However, six months later, the government held that the national health insurance should assume part of the costs. Currently, couples pay approximately \$3,358 (U.S. Dollars) for a basic fertility treatment package that includes up to three cycles in public hospitals and all additional costs are funded by the national health insurance.³³⁸

Sweden. Under the Act on In-Vitro Fertilization, which was promulgated in 1988,³³⁹ government-licensed clinics were to provide all assisted reproduction, and many barriers to accessing IVF treatments were put in place, limiting IVF treatments only to married heterosexual couples.³⁴⁰ The Act on In-Vitro Fertilization, nevertheless, was amended to enable lesbian couples to also use IVF and to permit donor insemination in the context of IVF.³⁴¹ Currently, access to assisted reproduction is aided by Swedish public funding for three IVF cycles.³⁴² Because of the endless waiting periods for the publicly funded treatment, which can be as long as

335. *Id.*

336. Ellen Waldman, *Cultural Priorities Revealed: The Development and Regulation of Assisted Reproduction in the United States and Israel*, 16 HEALTH MATRIX 65, 85 (2006).

337. RIITTA BURRELL, ASSISTED REPRODUCTION IN THE NORDIC COUNTRIES: A COMPARATIVE STUDY OF POLICIES AND REGULATION 31 (2005), available at http://www.norden.org/en/publications/publications/2006-505/at_download/publicationfile.

338. *Id.* at 34 n.18 (stating that the cost is 18,000 Norwegian Kroner per package). U.S. Dollar cost conversion is based on the exchange rate on July 3, 2011. XE Currency Converter Widget: NOK to USD, XE.COM, <http://www.xe.com/ucc/convert/?Amount=18000&From=NOK&To=USD> (last visited July 3, 2011).

339. BURRELL, *supra* note 337, at 76.

340. *Id.* at 12.

341. *Id.*

342. Sorenson, *supra* note 252, at 6-7.

several years, many patients prefer to pay for a private treatment.³⁴³ Consequently, about half of IVF is publicly funded and the other half is funded privately, but no insurance coverage is offered to cover the costs of the individuals who chose to get private treatment.³⁴⁴

United Kingdom. The National Health Service (NHS) provides fertility services. Nevertheless, these services are limited and barriers exist as to which individuals will get these services as well as to the how expansive the fertility treatment provided will be.³⁴⁵ Individuals that are interested in obtaining the NHS's fertility services face long waiting periods, which make the services not very accessible to many individuals.³⁴⁶ These limitations have encouraged most patients to choose the private fertility market.³⁴⁷

VIII. CONCLUSION

There are well over seven million women of procreation age with an impaired ability to have children in the United States. These women and their partners have dozens of millions of family members, friends, and relatives who are also affected by the financial, emotional, and even physical difficulties that their loved ones experience when they struggle to have access to infertility treatments. Infertility affects families as a whole, not just individuals.

The recent Affordable Care Act included comprehensive modifications to the American health care system. One of its major contributions is extending coverage to individuals who otherwise would have been without assurance. The Affordable Care Act, however, fails to address the lack of coverage of infertility treatment, despite the constantly increasing infertility rates in the United States. The failure to address infertility treatment coverage is especially disappointing given the previous legislative attempts to address this issue, and to assist individuals to fulfill their basic need of parenthood and procreation. The complete failure to address infertility, except for a number of provisions that are somewhat relevant to assisted reproduction, preserves the current status-quo of great barriers that exist to having access infertility treatment. Nevertheless, creative interpretation of the essential benefits package provision of the Affordable Care Act can and should help at least certain individuals obtain fertility care coverage.

343. *Id.* at 6.

344. Glennon, *supra* note 41, at 187.

345. *NHS Fertility Treatment*, HUM. FERTILISATION & EMBRYOLOGY AUTH. (Aug. 28, 2009), <http://www.hfea.gov.uk/fertility-treatment.cust.html>.

346. Glennon, *supra* note 41.

347. *Id.*

Reproduction is a fundamental human right, and a major life activity. The right to parent should therefore be a legally protected positive right. Mandating infertility treatment coverage would promote a number of substantial gender, social, and economic equalities, as well as health related policies, which society, as a whole, should advance.

