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It's an ART not a Science: State-Mandated Insurance Coverage of Assisted Reproductive Technologies and Legal Implications for Gay and Unmarried Persons

Valarie Blake*

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I. INTRODUCTION

The last several decades have witnessed a dramatic change in how our society conceives of family, parenthood, pregnancy, childbirth, and gender roles. One issue at the heart of this change was the successful uncoupling of intercourse from reproduction via assisted reproductive technology (ART).¹ ART has made it possible for a wealth of individuals, who would otherwise be unable, to create families and become parents.² Traditionally, most people think of infertile couples as the beneficiaries of such technology, but ART has special and important implications for gay and/or unmarried persons as well.³ Dubbed the “structurally infertile,” this latter group, if desirous of reproducing, “must do so through means other than sexual intercourse because of the social structure in which they self-identify.”⁴

Despite the growth in popularity of ART for both the medically and structurally infertile, ART continues to be a mainly private-payer enterprise, reserved for those individuals who have the expendable income to pay for these expensive technologies.⁵ Given both the high demand for ART as well as the astronomically high cost for some ART procedures, some states have begun mandating insurance coverage as a means of ensuring that a wider range of people are able to access reproductive technologies.⁶ While much focus has been on whether insurance should be mandated for such procedures, little attention has been paid to the unusual consequences of mandated insurance for consumers of ART, particularly gay and unmarried persons. Of the fourteen states with some form of insurance mandate, none explicitly excludes gay or

1. Marjorie Maguire Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297, 333.

2. *Id.* at 311–12.

3. *Id.* at 314–15.

4. Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 24 (2008).

5. Debora Spar & Anna M. Harrington, *Building a Better Baby Business*, 10 MINN. J.L. SCI. & TECH. 41, 49–50 (2009).

6. Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 HARV. L. REV. 2092, 2095–96 (1996) [hereinafter *In Vitro Fertilization*].

unmarried persons from coverage, but many serve to indirectly exclude these groups, raising distinct ethical and legal issues around what a state owes its citizens with respect to insurance coverage of ART.⁷ Even more legally problematic is the implicit exclusion of persons who are not only structurally infertile, but also have a medical cause for their infertility. For purposes of this Article, I will call this group the “medico-structurally infertile.” Taken both individually and as a whole, these regulations raise significant questions as to the purpose of state mandates for ART. Further questions relate to the intentions of such laws with respect to unmarried and gay persons and the political, religious, and health justice issues related to marital status, reproduction, sexual orientation, resource allocation, and health.

This Article explores the legal and ethical tensions between the purpose of health insurance, the desire to improve access to ART for everyone, and the unique legal and ethical implications of state-mandated insurance for structurally infertile and medico-structurally infertile persons. Part II provides an overview of the types of technologies that qualify as ART, as well as statistics on the types of groups accessing or interested in accessing ART. In this section, the high cost of ART, methods of payment, and the role of cost as a barrier to access are also explored. State mandates for insurance coverage are set forth in Part III, and statutory language of individual mandates is used to demonstrate two types of limits on state mandates: external limits, such as limits on dollar amounts or numbers of procedures, and internal limits, which limit treatments based on the social status of the individual. The various implicit exclusions of gay and unmarried persons are also explored. Part IV sets forth some of the legal challenges raised by implicit exclusion of insurance coverage for these groups. Due Process, Equal Protection, and Americans with Disabilities Act (ADA) challenges are each discussed. In Part V, the context of state-mandated insurance coverage for ART is explored in the broader framework of health justice, resource allocation, religious and political considerations with respect to sexual orientation, marital status, and the purposes of health

7. Nicole Rank, Comment, *Barriers for Access to Assisted Reproductive Technologies by Lesbian Women: The Search for Parity Within the Healthcare System*, 10 HOUS. J. HEALTH L. & POL’Y 115, 136–41 (2009).

insurance. Health justice is used as the main rationale for arguing that gay and unmarried persons should be granted insurance coverage for ART under state mandates. Lastly, in Part VI, the advantages and disadvantages of state-mandated insurance versus an alternative mechanism of tax deductions are explored with particular attention paid to the implications of these mechanisms for gay and unmarried persons. Concluding that state mandates are currently the best solution for ensuring wider access to ART for everyone, the Article encourages legislatures to consider a number of important ethical, legal, and social factors in drafting state mandates for insurance coverage of ART and in ensuring fair access for gay and unmarried persons.

II. BACKGROUND: USAGE, ACCESS, AND COST IN ASSISTED REPRODUCTIVE TECHNOLOGY

A. DEFINITIONS AND TECHNOLOGY

The Centers for Disease Control and Prevention (CDC) defines ART, widely known as ART, as “all fertility treatments in which both eggs and sperm are handled.”⁸ In this way, ART is “designed to enable conception . . . when coital reproduction is either not possible or not desirable.”⁹ ART encompasses a number of specific techniques and procedures including: gamete intrafallopian transfer (GIFT), which is the placing of eggs and sperm into the fallopian tubes; zygote intrafallopian transfer (ZIFT), which is the placing of a zygote in the fallopian tubes; and intracytoplasmic sperm injection (ICSI), which is “the direct insertion of an individual sperm into the ovum,” a technique often used to remedy male-factor infertilities.¹⁰ In vitro fertilization (IVF) is the most complex, invasive, and expensive of all the ARTs.¹¹ IVF begins with hormone therapy given to the woman to induce ovulation, followed by egg

8. *Assisted Reproductive Technology*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/art> (last updated Oct. 21, 2010).

9. Justyn Lezin, *(Mis)conceptions: Unjust Limitations on Legally Unmarried Women's Access to Reproductive Technology and their Use of Known Donors*, 14 HASTINGS WOMEN'S L.J. 185, 190 (2003).

10. Spar & Harrington, *supra* note 5, at 45–46.

11. See Daar, *supra* note 4, at 20 n.3 (describing the procedural steps necessary for IVF); Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 300 (2005) (suggesting that IVF is more complex than another form of artificial insemination); Schultz, *supra* note 1, at 339 n.125.

retrieval and fertilization of the eggs with semen, incubation of the fertilized egg(s) in a laboratory dish for several days until an embryo is formed, and, lastly, the transplant of the embryo directly into the uterus.¹² All of the above technologies may or may not involve the use of gamete donors (third parties that donate eggs and sperm),¹³ cryopreservation and storage of gametes,¹⁴ and/or gestational surrogates (third parties that gestate and birth the fetus), all of which are factors particularly relevant for gay and unmarried persons considering ART.¹⁵ Though not considered an ART, artificial insemination, where sperm is transferred into a female's reproductive tract to produce pregnancy,¹⁶ implicates ethical and legal challenges similar to that of ART,¹⁷ and is also a popular method of pregnancy for lesbians and single women because it enables pregnancy without sexual intercourse with a male.¹⁸

Different medical and structural needs, as well as gender issues, determine the type of ART one uses to become pregnant. Lesbian couples and single women may often achieve pregnancy through the simpler method of artificial insemination, if there are no medically-related problems.¹⁹ Using a known or anonymous sperm donor, the single woman or lesbian woman can become pregnant with the use of her own eggs and can gestate the pregnancy, barring any medical barriers.²⁰ Gay or single men who wish to reproduce require the use of a gestational surrogate, who is impregnated by any of the techniques above using the sperm of the single man, one of the couple members, or a donor.²¹ For structurally infertile

12. Pendo, *supra* note 11, at 300.

13. Shultz, *supra* note 1, at 312.

14. Daar, *supra* note 4, at 20 n.4.

15. *Id.* at 33.

16. James Ringo ed., *Tenth Annual Review of Gender and Sexuality Law: Health Care Law Chapter: Assisted Reproductive Technologies*, 10 GEO. J. GENDER & L. 859, 860–61 (2009).

17. Rank, *supra* note 7, at 127.

18. *See id.* at 130 (suggesting that many women find greater success with physician-assisted insemination than with self-insemination).

19. *See* Bebe J. Anderson, *Lesbians, Gays, and People Living with HIV: Facing and Fighting Barriers to Assisted Reproduction*, 15 CARDOZO J.L. & GENDER 451, 453–454 (2009) (suggesting that artificial insemination is particularly relevant to lesbians, and that it can be ceased if the donor is found to be HIV positive).

20. *Id.*

21. *Id.* at 453.

individuals or couples who also have medical infertility, the type of ART used depends on both the structural infertility as well as the type of medical infertility.²² In these instances, the more expensive IVF and gestational surrogacy may be necessary. For example, a single woman with blocked fallopian tubes would require sperm donation because of her structural infertility, but would also require in-vitro fertilization because of her medical infertility.²³

B. POPULARITY OF ART

The business of treating infertility is booming, with more than one million individuals seeking infertility treatment on an annual basis.²⁴ ART usage has rapidly increased over the last decade, with the number of ART cycles and babies born from ART doubling between 1996 and 2005.²⁵ More than 54,000 babies were born in the United States with the help of assisted reproduction in 2006 alone, which accounts for more than one percent of U.S. births that year.²⁶ Scholars estimate that the business of assisted reproduction in the United States is “at least a \$1.7 billion market before even considering sperm sales, high-end eggs, legal fees, surrogacy, or adoption.”²⁷

The ten percent of the population that suffers from medically-related infertility accounts for a significant portion of ART use.²⁸ Medical infertility affects both genders and occurs across all races, ethnic backgrounds, and socioeconomic levels.²⁹ “The incidence of structural infertility. . . [however] is largely unknown, as no government surveys report such figures.”³⁰ Data suggests, however, that structurally infertile persons are also finding ways, whether by ART or otherwise, to

22. *Id.* at 454–55 (explaining differences in ART methods when a donor or surrogate is infected with HIV).

23. Rank, *supra* note 7, at 119.

24. Pendo, *supra* note 11, at 298.

25. Spar & Harrington, *supra* note 5, at 46.

26. *Assisted Reproductive Technology Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://cdc.gov/Reproductivehealth/DRH/activities/ART.htm> (last updated July 31, 2009).

27. Spar & Harrington, *supra* note 5 at 47.

28. *See* Daar, *supra* note 4, at 24, 34 (stating that 1.2 million medically infertile women sought ART in 2005, and that the majority of ART patients are heterosexual, married women).

29. Pendo, *supra* note 11, at 298.

30. Daar, *supra* note 4, at 25.

have families.³¹

The rates of reproduction outside of heterosexual married relationships have been increasing in recent years. Approximately forty percent of births in the United States are now to single, unmarried women.³² Additionally, the 1980s saw an increase in children born to lesbian women. The same increase occurred with gay men in the 1990s, causing the media to coin the term the “gay baby boom.”³³ “Currently in the United States, there are an estimated six to fourteen million children being raised by at least one gay or lesbian parent, usually as a result of a heterosexual relationship.”³⁴ “[T]he 2000 Census Report documented a total of 594,000 households headed by same-sex couples; thirty-three percent of female same-sex households and twenty-two percent of male couples had children.”³⁵ However, it is difficult to estimate the extent to which this trend in families raised by single or gay persons is due to ART versus other factors.³⁶ Newspaper accounts “suggest that one-third of all [artificial insemination] consumers in the U.S. are unmarried women,” indicating that there is a strong current of structurally infertile groups making use of ART.³⁷

The burgeoning market of ART is appealing to both medically infertile and structurally infertile groups as a means of creating genetic offspring. The next section will discuss some of the financial and access issues raised by ART for these groups.

31. *Id.* at 28.

32. The Ethics Comm. of the Am. Soc’y for Reprod. Med., *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 92 FERTILITY & STERILITY 1190, 1190 (2009) [hereinafter *ASRM*].

33. Catherine DeLair, *Ethical, Moral, Economic and Legal Barriers to Assisted Reproductive Technologies Employed by Gay Men and Lesbian Women*, 4 DEPAUL J. HEALTH CARE L. 147, 147–48 (2000).

34. *ASRM*, *supra* note 32, at 1191.

35. Daar, *supra* note 4, at 32–33.

36. See DeLair, *supra* note 33, at 147 (suggesting that most children being raised by gay men and lesbian women result from previously heterosexual relationships, but that the number of children born to gay and lesbian couples utilizing ART is rising).

37. Daar, *supra* note 4, at 25.

C. PURSE STRINGS AND PARENTHOOD: COST AS A BARRIER TO ART

ART is a costly endeavor in the United States. Staniec and Webb aptly describe the situation when they say that, for many infertile couples, the question is not whether or not to have children, but rather “[h]ow will we get pregnant?” followed closely by “[h]ow will we afford it?”³⁸ The average cost of one cycle of IVF is “more than \$10,000 and it frequently takes multiple cycles to achieve pregnancy, with success rates decreasing with each try.”³⁹ Cost for a successful delivery as a result of IVF is estimated at \$66,667 if successful by the first cycle and as high as \$114,286 if it takes six cycles.⁴⁰ These costs vary by a number of patient factors, but can be even higher when egg donation or gestational surrogacy is involved.⁴¹ Other forms of ART, such as artificial insemination, are more affordable but still cost over \$1,000 and do not work for everyone.⁴²

It is important to reiterate that, in the context of structural infertility, high-tech and expensive interventions may not always be necessary, but sometimes are. Single women and lesbians without medical infertility may become successfully pregnant with sperm donation, which is fairly inexpensive or may even be gifted.⁴³ Artificial insemination can be done at home at no cost or at a physician’s office.⁴⁴ Multiple attempts

38. See J. Farley Ordozensky Staniec & Natalie J. Webb, *Utilization of Infertility Services: How Much Does Money Matter*, 42 HEALTH SERV. RES. 971, 971–72 (2007).

39. Spar & Harrington, *supra* note 5, at 49.

40. See *id.*

41. Donor eggs typically cost between \$3,000 and \$5,000 with an average IVF cycle then costing between \$15,000 and \$25,000. “Some small portion of these eggs—known colloquially as ‘Ivy League’ or ‘designer’ eggs—fetched in the range of \$25,000 to \$ 50,000.” *Id.* at 47. Gestational surrogacy is also an expensive endeavor. “Currently, the typical fee for a first time surrogate mother ranges from \$14,000 to \$18,000, with an average of \$15,000.” Jennifer Watson, *Growing a Baby for Sale or Merely Renting a Womb: Should Surrogate Mothers be Compensated for their Services?*, 6 WHITTIER J. CHILD & FAM. ADVOC. 529, 531 (2007). This payment may be significantly higher where the surrogate agrees to additional medical tests or to carry or implant multiple fetuses. See *id.* at 531–32.

42. See Melissa B. Jacoby, *Show Me the Money: Making Markets in Forbidden Exchange: The Debt Financing of Parenthood*, 72 LAW & CONTEMP. PROB. 147, 149 (2009).

43. See DeLair, *supra* note 33, at 160.

44. See *id.*

however, may cost thousands of dollars.⁴⁵ Furthermore, gay or single men must rely on gestational surrogacy and may require egg donation, both of which are very expensive practices.⁴⁶ Certainly, too, any such individuals who experience some medical infertility may also require IVF or other more invasive and costly forms of ART.

In addition, while some people advocate adoption as an alternative to ART for the medically and/or structurally infertile, adoption can also be an expensive endeavor and does not satisfy the goals of creating a genetically-related child, which is important to some individuals or couples.⁴⁷ Furthermore, some laws prohibit certain structurally infertile persons, including gay and unmarried persons, from adopting children.⁴⁸

Not surprisingly, researchers have found that “financial access . . . [has] significant effects on the probability of seeking infertility treatments.”⁴⁹ Income and insurance coverage of infertility services are two of the major predictors for seeking infertility treatment, and few individuals have fertility treatments like ART covered under their healthcare plans.⁵⁰ International surveys of foreign countries also indicate that cost plays a large role in access to ART. “Nations with national health care systems report higher rates of infertility help-seeking.”⁵¹ In the United States, where the cost of treatment is

45. *Id.*

46. “After medical and legal bills are calculated, the entire final cost of a surrogacy arrangement may be \$20,000–\$30,000 or more.” *Id.* at 161.

47. “Adoption costs vary greatly depending on the type of adoption and the characteristics of the child.” While foster-care adoptions can be relatively inexpensive, some adoptions can cost as much as \$30,000 or more. Additionally, foreign adoptions can also be time-consuming and expensive. *See* Jacoby, *supra* note 42, at 150.

48. For example, in Utah, “[i]n order to adopt, you must be an adult who is either married (and has permission from your spouse) or single (and not cohabiting with another person).” This requirement rules out individuals who are gay and individuals who are unmarried but cohabitating with a partner. *Domestic Law Handbook*, UTAH LEGAL SERVS., <http://www.utahlegalservices.org/public/self-help-webpages/domestic-law-handbook#Adoption> (last modified Aug. 10, 2009).

49. Staniec & Webb, *supra* note 38, at 985.

50. Lynn K. White et al., *Explaining Disparities in Treatment Seeking: The Case of Infertility*, 85 FERTILITY & STERILITY 853, 855 (2006). The role that insurance coverage plays in increasing access to ART will be discussed in more depth later in this paper.

51. *Id.*

paid out-of-pocket, only one-half of all infertile women seek treatment.⁵² In contrast, other developed nations which cover infertility treatment have much higher rates of access.⁵³

The high cost of ART and its impact on access have led many to challenge the system as “inherently inequit[able].”⁵⁴ One scholar claims that “only a fortunate few can afford to spend \$50,000, much less \$100,000, in order to have a chance at a baby . . . [m]any couples are forced out of the baby business from the outset.”⁵⁵ Another critiques the field of assisted reproduction as “relying on the emotional desperation of childless couples to inflate the asking price” and argues that ART “provide[s] choice for affluent middle-class couples . . . however, the same privilege is denied to the less affluent.”⁵⁶

Furthermore, worrisome practices exist among the eighty-five percent of infertile individuals who do choose to pay for these technologies out-of-pocket. “They will mortgage their houses, sell their cars, deplete the family savings” or sign up “for a host of credit cards and charg[e] up to their credit limit.”⁵⁷ Banks are now even offering fertility market loans to eligible consumers.⁵⁸

D. PROPOSED ECONOMIC SOLUTIONS TO ACCESS ISSUES IN ART

Mandated insurance coverage has been proposed as a means of reducing inequity in assisted reproduction and equalizing access across socioeconomic groups. The high demand for and costs of ART and the frequent need for multiple interventions all serve as disincentives for insurers to cover such procedures under health plans. “Only one in four employers cover some form of fertility services, and ARTs, the most expensive fertility treatments, are unlikely to be

52. A. L. Greil & J. McQuillan, *Help-Seeking Patterns among Subfecund Women*, 22 J. REPROD. & INFANT PSYCHOL. 305, 312 tbl.2 (2004).

53. See Daar, *supra* note 4, at 37 (noting that infertile women seek treatment 67% of the time in Finland, 86% of the time in the Netherlands, and 72–95% of the time in the United Kingdom.).

54. Spar & Harrington, *supra* note 5, at 50.

55. *Id.*

56. Meena Lal, *The Role of the Federal Government in Assisted Reproductive Technologies*, 13 SANTA CLARA COMPUTER & HIGH TECH. L.J. 517, 530–31 (1997).

57. Jacoby, *supra* note 42, at 150; see also Anna L. Benjamin, *The Implications of Using the Medical Expense Deduction of I.R.C. 213 to Subsidize Assisted Reproductive Technology*, 79 NOTRE DAME. L. REV. 1117, 1129 (2004).

58. See Jacoby, *supra* note 42, at 161.

included.”⁵⁹ Lobbyists in favor of mandated insurance have encouraged reform at both the state and federal level. While federal reform has not yet been successful, efforts in the House of Representatives to mandate coverage for infertility still persist with the Family Building Act of 2009. The Act, which was introduced by Representative Anthony Weiner (D-NY), has been referred to the House Oversight and Government Reform Committee.⁶⁰ Additionally, since the 1980s, fourteen states have successfully mandated some type of insurance coverage for fertility treatment.⁶¹

Among these fourteen states, most do not require broad insurance coverage of ART. Many exclude certain types of infertility or certain treatments (especially IVF, the most expensive treatment).⁶² Additionally, many of these state mandates do not encompass employer-funded health benefit plans because of the Employee Retirement Income Security Act.⁶³ In states that mandate some form of coverage, “rates of access to assisted reproduction have been significantly higher.”⁶⁴ However, many people in these states are still left without coverage because they either do not have insurance or are covered by self-insured employers that fall outside of these mandates.⁶⁵ Additionally, many of these statutes implicitly bar unmarried or same sex couples from coverage, regardless of whether they have a medical infertility that might otherwise qualify under the statute. Lastly, because persons in same sex relationships are unable to legally marry in most states, they often cannot be covered under their partners’ insurance.⁶⁶

59. Benjamin, *supra* note 57, at 1121.

60. Family Building Act of 2009, H.R. 697, 111th Cong. (2009), available at <http://www.govtrack.us/congress/billtext.xpd?bill=h111-697>. The act would have required any insurer covering impotence to also cover fertility treatment, but it failed to survive House subcommittees on health and labor-management relations and was stalled a month after it had been introduced in Congress.

61. Benjamin, *supra* note 57 at 1121–22; Aaron C. McKee, *The American Dream - 2.5 Kids and a White Picket Fence: The Need for Federal Legislation to Protect the Insurance Rights of Infertile Couples*, 41 WASHBURN L.J. 191, 205 (2001).

62. See Maren Minnaert & Melissa Tai, *Fourth Annual Review of Gender and Sexuality Law: Family Law Chapter: Assisted Reproductive Technology*, 4 GEO. J. GENDER & L. 299, 323–24 (2002).

63. Benjamin, *supra* note 57, at 1121–22.

64. Jacoby, *supra* note 42, at 152.

65. *Id.*

66. Rank, *supra* note 7, at 130.

III. REGULATION OF ART AND MANDATED INSURANCE COVERAGE

To understand how medical and structural fertility are treated under the regulatory framework of ART, one must first understand the status of ART regulation more generally. Currently, federal laws provide little guidance on the practice or provision of ART to the public, including whether or not insurance providers are required to cover ART. The duty of regulating who can access ART and whether it should be paid for by insurance companies has mainly fallen to the individual states and, in some instances, the infertility treatment centers and providers.

In the fourteen states that have enacted laws requiring insurers to cover diagnosis and/or treatment of infertility, there are varying levels of coverage depending on a number of factors. Factors such as the types of treatments covered by a mandate and how much of the treatment must be covered are, for our purposes, referred to as “external factors.” These external factors place limits on access to ART, regardless of who is seeking treatment. Factors determining *who is permitted to seek treatment* under a given mandate are referred to as “internal factors” because they base coverage decisions on the individual’s personal characteristics, such as marriage status, sexual orientation, or medical disability.

External factors include a number of limits on the scope of coverage provided under the mandates. For example, some mandates require that coverage *be provided* for fertility treatments, as seen in Arkansas, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Jersey, New York, Ohio, Rhode Island, and West Virginia.⁶⁷ Other states, such as

67. Arkansas’ statute provides coverage only for IVF and does not mention other fertility treatments. ARK. CODE ANN. §23-86-118 (2004) (stating all health insurance companies “shall include, as a covered expense, in vitro fertilization”). Connecticut’s statute requires that health insurance policy “shall provide coverage for the medically necessary expenses of . . . infertility.” CONN. GEN. STAT. § 38a-536 (West 2007). Hawaii mandates pregnancy-related benefits “shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization.” HAW. REV. STAT. § 431:10A-116.5 (2005). Illinois’ statute mandates that “[n]o group policy. . . may be issued . . . unless the policy contains coverage for the diagnosis and treatment of infertility.” 215 ILL. COMP. STAT. ANN. § 5/356m (West 2008). Maryland’s statute mandates that “[a]n entity . . . that provides pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from in-vitro fertilization.” MD.

California and Texas, only require that infertility treatment *be offered*.⁶⁸ Some states place limits that depend on the specific treatment in question. For instance, California and New York have expressly excluded IVF from the fertility treatments covered,⁶⁹ while Arkansas specifically includes IVF but does not identify other fertility treatments.⁷⁰ A number of the states limit coverage by placing a maximum dollar amount or by limiting the number of procedures that are covered.⁷¹

CODE ANN., INS. § 15-810 (LexisNexis 2006). Massachusetts requires any blanket or general policy of insurance “shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility.” MASS. ANN. LAWS ch. 175, § 47H (LexisNexis 2008). Montana requires health maintenance organizations to cover “basic health services” which are defined to include “infertility services.” MONT. CODE ANN. § 33-31-102 (2009). New Jersey mandates that group health insurance policy “shall provide coverage which includes, but is not limited to, the following services related to infertility.” N.J. STAT. § 17:48-6x (West 2008). New York’s statute states that “[e]very policy which provides coverage for hospital care shall not exclude coverage . . . solely because the medical condition results in infertility.” N.Y. INSURANCE LAW § 3216 (2010). Ohio requires health maintenance organizations to cover “basic health services,” which include “infertility services.” OHIO REV. CODE ANN. § 1751.01 (A)(1)(h) (LexisNexis 2009). Rhode Island requires any health insurance contract “shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility.” R.I. GEN. LAWS § 27-18-30 (2008). West Virginia requires health maintenance organizations to cover “basic health care services,” which includes “infertility services.” W. VA. CODE § 33-25A-2(1) (LexisNexis 2006). *See generally State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONF. OF STATE LEGISLATURES, <http://www.ncsl.org/IssuesResearch/Health/InsuranceCoverageforInfertilityLaws/tabid/14391/Default.aspx> (last updated September 2010) [hereinafter *NCSL*].

68. *See* CAL. HEALTH & SAF. CODE § 1374.55 (West 2008) (requiring that “every health care service plan . . . shall offer coverage for the treatment of infertility, except in vitro fertilization”); TEX. INS. CODE 1366.003 (West 2009) (stating that “an issuer of a group health benefit plan that provides pregnancy-related benefits . . . shall offer and make available . . . coverage for . . . expenses incurred . . . from in vitro fertilization procedures.”); *see generally NCSL, supra* note 67.

69. *See* CAL. HEALTH & SAF. CODE § 1374.55 (West 2008) (“[e]very health care service plan . . . shall offer coverage for the treatment of infertility, except in vitro fertilization.”); N.Y. INS. LAW § 3216 (3)(E)(i) (2010) (stating that “[c]overage shall not be required to include . . . in vitro fertilization”).

70. The Arkansas statute provides that health plans “shall include, as a covered expense, in vitro fertilization.” ARK. CODE ANN. § 23-86-118 (2004).

71. For example, Hawaii provides only a “one-time benefit for all outpatient expenses arising from in vitro fertilization.” HAW. REV. STAT. § 431:10A-116.5 (2005). Maryland places a limit at “three in vitro fertilization

Additionally, some states only offer more expensive procedures such as IVF as a last resort and require that the patient undergo less expensive procedures first.⁷² Some statutes also place limits on the types of plans that must cover certain infertility treatments. For example, Ohio's mandate only applies to health maintenance organizations (HMOs),⁷³ and other states allow religious institutions to opt out of coverage that is "inconsistent with the religious organization's religious and ethical principles."⁷⁴

For the most part, state insurance mandates based on external factors apply equally to all individuals. While such external factors are important with respect to individuals' access to ART, it is those laws that use internal factors to determine insurance coverage that are most significant with respect to the rights of gay and/or unmarried persons. These states' insurance mandates contain one or more of the following preconditions: (1) requirements that a person engage in unprotected sexual intercourse for a particular number of years without pregnancy, (2) requirements that the experience of infertility last a particular number of years, (3) use of spousal language, (4) requirements that the cause of infertility be either medically caused or unexplained, and (5) requirements that the infertility treatment be medically necessary. Tables 1a and 1b describe which states require which preconditions. These preconditions often translate into unequal access to mandated insurance coverage on the basis of marriage status, sexual orientation, and/or medical disability. Resulting legal

attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000." MD. CODE ANN., INS § 15-810(5)(d) (LexisNexis 2006). Illinois limits oocyte retrieval to four, or two extra if a live birth follows oocyte retrieval. 215 ILL. COMP. STAT. ANN. § 5/356m (West 2008) New Jersey limits to four oocyte retrievals in a lifetime. N.J. STAT. § 17:48-6x (West 2008). Connecticut makes separate lifetime limits on cycles for each type of fertility treatment covered. CONN. GEN. STAT. § 38a-536 (West 2007).

72. New Jersey limits availability to those who have "used all reasonable, less expensive, and medically appropriate treatments." N.J. Stat. § 17:48-6x (West 2008). Illinois statute states that coverage for IVF, GIFT and ZIFT is only available where "the covered individual has been unable to attain or sustain a successful pregnancy though reasonable, less costly . . . treatments." 215 ILL. COMP. STAT. ANN. § 5/356m (West 2008).

73. Ohio law requires health maintenance organizations to cover "basic health services" which include "infertility services." OHIO REV. CODE ANN. § 1751.01 (A)(1)(h) (LexisNexis 2009).

74. See e.g. CONN. GEN. STAT. § 38a-536 (West 2007). Among states providing religious exemption are California, Connecticut, Illinois, Maryland, New Jersey, and Texas.

challenges will be discussed in turn.

Table 1a: Summary of State's Statutory Language in Mandates for Insurance Coverage of ART

	(X) number of years of sexual relations without contraception	(X) number of years of infertility
Arkansas		
California	X	
Connecticut		X
Hawaii		
Illinois	X	
Maryland		
Massachusetts		X
New Jersey	X	
New York		
Ohio		
Rhode Island		X
Texas		
West Virginia		

Table 1b: Summary of State's Statutory Language in Mandates for Insurance Coverage of ART

	Spouse language	Medical or unexplained cause of infertility	Medical necessity
Arkansas			
California			
Connecticut			X
Hawaii	X	X	
Illinois			
Maryland	X	X	
Massachusetts			X
New Jersey			
New York			
Ohio			X
Rhode Island	X		X
Texas	X	X	
West Virginia			

A. STATUTORY CONSTRUCTION OF STATE MANDATES

1. Statutes That Require Sexual Relations Without Contraception

Three states, California,⁷⁵ Illinois,⁷⁶ and New Jersey,⁷⁷ have statutory language requiring that individuals engage in a certain period of unprotected sex without successful pregnancy in order to qualify for mandated insurance coverage. The implications of this requirement are unclear for both structurally and medico-structurally infertile persons. “While the drafters of the legislation may not have intended to extend coverage to [gay persons,] . . . it is conceivable that the language and definition may be construed to include such couples . . . through the acknowledgment that ‘regular sexual relations’ could include sexual interactions between two people of the same sex.”⁷⁸ However, the issue of what types of intercourse would be included is a matter for the legislature and the courts.

Among these three states, New Jersey’s language is the most exclusionary. The statute requires that the inability to conceive after the period of unprotected intercourse be caused by a “disease or condition that results in the abnormal function of the reproductive system.”⁷⁹ Gays, lesbians, and unmarried persons with structural infertility are not likely to be viewed as having abnormal functioning of their reproductive systems given the very definition of structural infertility. Medico-structurally infertile persons, however, would fall under this definition if they have proof of their medical condition.

In contrast, California’s statutory language does not

75. CAL. HEALTH & SAFETY CODE § 1374.55(b) (West 2008) (“[I]nfertility’ means either (1) the presence of a demonstrated condition recognized by a licensed physician . . . as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after *a year or more of regular sexual relations without contraception.*” (emphasis added)).

76. 215 ILL. COMP. STAT. ANN. § 5/356m(2)(c) (West 2008) (“[I]nfertility’ means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.”).

77. N.J. STAT. ANN. § 17:48-6x (West 2008) (“[I]nfertility’ means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: impregnate another person; conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older.”).

78. Rank, *supra* note 7, at 139.

79. N.J. STAT. ANN. § 17:48-6x (West 2008).

require disease and only requires a period of unprotected intercourse.⁸⁰ Consequently, California's statute does not *necessarily* eliminate gay or unmarried persons. On the contrary, this requirement could exclude persons who are heterosexual and married if they failed to engage in unprotected sex. However, the applicability of the statute to gay and unmarried persons may differ from its applicability to heterosexual married for a number of reasons. First, same sex couples may not attempt unprotected sex because their intercourse is not intended for procreative purposes, and unmarried persons may not engage in sexual intercourse, protected or unprotected, because they do not have a partner with whom they wish to procreate. Thus, while either a same sex couple or unmarried person may wish to reproduce, unprotected intercourse may not be an avenue that is possible or desirable.⁸¹ Second, it is unclear the extent to which the statute requires monogamous sexual intercourse. As an example, a single person could engage in heterosexual unprotected sexual activity with a variety of partners over a period of years without becoming pregnant, but this could be due to infertility of the partners or infrequency of intercourse, as opposed to the infertility of the individual. Furthermore, the same requirements apply to medico-structurally infertile persons. Regardless of whether they are gay or unmarried, medico-structurally infertile individuals only qualify for mandated insurance coverage if they engage in intercourse and the intercourse is unprotected.⁸² This requirement has interesting implications for both structurally and medico-structurally infertile persons, given that protection may be used during sex for both pregnancy prevention and prevention of sexually transmitted infections (STIs)—an issue which will be discussed in greater detail later in this paper.

80. CAL. HEALTH & SAFETY CODE § 1374.55(b) (West 2008).

81. Importantly, a requirement that a couple engage in unprotected sex is also unusual in circumstances where individuals have known infertility, such as an instance where a woman has a cancer-related hysterectomy. While the unprotected sex requirement is likely in place to ensure that individuals who can achieve natural pregnancy do so, it serves as a unique burden for those who already know that intercourse will not achieve their reproductive goals.

82. N.J. STAT. ANN. § 17:48-6x (West 2008).

2. Statutes That Require Number Of Years Of Infertility

Perhaps the most inclusive statutory language defines infertility as the “condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.”⁸³ Connecticut,⁸⁴ Massachusetts,⁸⁵ and Rhode Island⁸⁶ all use this language in their statutes, and New Jersey, while also requiring unprotected intercourse, also uses the “condition” language.⁸⁷ While Rhode Island’s language also requires that the presumably healthy individual be married,⁸⁸ thus eliminating all forms of structurally infertile persons, the statutes of Connecticut and Massachusetts offer the broadest language and greatest chance for inclusion of structurally infertile persons. In these two states, the statutory language does not require any type of medical cause for the infertility, nor does it require that there be unprotected intercourse or an abnormal functioning of the reproductive system. Given the breadth of these statutes, structurally infertile persons and medico-structurally infertile persons who have not reproduced in a certain period of time may qualify in the same manner as heterosexual individuals, depending on the interpretation of the term “condition.” If, as one scholar argues, homosexuality could easily be included as a condition that would prevent a healthy individual from reproducing,⁸⁹ then structurally infertile persons would be covered under these types of mandates. However, a court could interpret the term “condition” as meaning a medical condition that prevented pregnancy. Furthermore, it is unclear what the statutes mean by the term “condition” and whether there are certain efforts which must be made during that year period to prove infertility, or, alternatively, whether one must simply live for a year without producing pregnancy. This language is, however,

83. CONN. GEN. STAT. ANN § 38a-536 (West 2007).

84. *Id.*

85. MASS. GEN. LAWS ANN. ch. 175, § 47H (LexisNexis 2008) (“[I]nfertility’ shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.”).

86. R.I. GEN. LAWS § 27-18-30 (2008) (“[I]nfertility’ means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.”).

87. N.J. STAT. ANN. § 17:48-6x (West 2008).

88. R.I. GEN. LAWS § 27-18-30 (2008).

89. Rank, *supra* note 7, at 139–40.

the broadest statutory language and offers the greatest hope for inclusion of the structurally and medico-structurally infertile.

The language in these statutes also presents another interesting question about the definition of infertility: Can an individual who has never engaged in intercourse (or not recently engaged in intercourse) claim to be infertile because he or she has not procreated? Because this statutory language does not explicitly require intercourse, but does require infertility, this issue is unclear.

3. Statutes That Use Spouse Language

Regulations in Hawaii,⁹⁰ Maryland,⁹¹ and Texas⁹² all require that a patient's eggs be fertilized with her spouse's sperm and, thus, strictly eliminate the possibility that single or gay persons can be covered under the mandates.⁹³ Similarly, Rhode Island, as discussed above, requires marriage for coverage under its mandate.⁹⁴ Strictly limiting coverage to those who engage in heterosexual, married relationships, "[t]here is no question . . . that the [Texas] statute does not require coverage of assisted reproductive technologies for single parents or unmarried couples (which encompasses lesbians, [where] homosexual marriage is not recognized . . .)."⁹⁵ Furthermore, gay couples would not qualify because they cannot provide both an egg and sperm, as the statutory wording requires. Unmarried heterosexual persons are also excluded based on the marriage requirement. In addition, medico-structurally infertile persons are excluded because of the spouse language and the requirement of heterosexual gametes. It is important to note that, regardless of statutory

90. HAW. REV. STAT. § 431:10A-116.5 (2005).

91. MD. CODE ANN., INS. § 15-810 (LexisNexis 2006).

92. TEX. INS. CODE ANN. Art. 1366.005 (West 2009).

93. Hawaii, Maryland, and Texas all have language in their statutes which states that insurance need only cover forms of ART where the patient's eggs are fertilized with spouse's sperm. See HAW. REV. STAT. § 431:10A-116.5 (2005); MD. CODE ANN., INS. § 15-810 (LexisNexis 2006). Similarly, the Rhode Island statute defines fertility as "the condition of an otherwise healthy *married* individual who is unable to conceive." R.I. GEN. LAWS § 27-18-30 (2008) (emphasis added). This marriage requirement again naturally eliminates same sex couples and the unmarried.

94. R.I. GEN. LAWS § 27-18-30 (2008).

95. Rank, *supra* note 7, at 137-38.

intent, this statutory language removes the possibility of gamete donation more generally, thus excluding even heterosexual, married persons who are infertile because of egg or sperm-based infertility.

4. Statutes That Require Medical or Unexplained Cause of Infertility

For the state mandate to apply, some states require that the period of infertility either be unexplained or linked to certain specific medical conditions that cause infertility. As Table 1b above shows, statutes in Hawaii, Maryland, and Texas all contain such language. Interestingly, states with this requirement are the same states that require a spouse's sperm to fertilize an egg, as discussed in the previous section.⁹⁶ The requirement that the cause of infertility be medical or unexplained automatically eliminates non-medically infertile gay persons, whose infertility is both explained and not caused by a medical condition. For unmarried persons without medical infertility, it is harder to determine whether they would qualify for unexplained infertility. If they were abstinent, rarely engaged in intercourse, or engaged in intercourse with multiple partners, it would arguably be difficult to say that infertility is unexplained. Those individuals who engage in monogamous, heterosexual sex, however, would still not qualify in these states because they are excluded based on the spousal requirement discussed previously. Furthermore, while medically infertile persons would qualify under this language because they have a medical reason for their infertility, they too would be disqualified in these states because of the spousal and heterosexual gamete requirements.⁹⁷

5. Statutes Which Require that Treatment Be Medically Necessary

Other states, like Connecticut, Massachusetts, Ohio, and Rhode Island indicate that the procedure must be "medically

96. See HAW. REV. STAT. § 431:10A-116.5 (2005); MD. CODE ANN., INS. § 15-810 (LexisNexis 2006).

97. The statute in New Jersey is equally problematic. It requires that the infertility be caused by a disease or condition, without defining what a condition is. N.J. STAT. ANN. § 17:48-6x (West 2008). Does a condition mean a medical condition or an aspect of one's life (such as having intercourse with a member of the same sex) which would result in the inability to have children?

necessary.”⁹⁸ Again, statutory interpretation will dictate whether structurally infertile persons are covered under this type of statute. If “medically necessary” means that there has to be a medical cause that requires the treatment, then only medico-structurally infertile persons would be covered under the statute. Some argue that fertility treatment is not viewed as medically necessary for same sex couples because “[b]y definition, gays and lesbians are not medically infertile, rather, they are constructively infertile because they do not have sexual intercourse with members of the opposite sex.”⁹⁹ If interpreted more broadly to include instances where technology is medically necessary to procreate, however, these types of statutes would also include those with structural infertility, regardless of whether because they are single or gay, and ART would be equally medically necessary for both medically infertile and constructively infertile persons. Medico-structurally infertile persons, however, definitely qualify under the medical necessity requirement, provided they can show medical cause.

The implications of this statutory phrasing have received some attention in the literature. One scholar has argued that fertility treatment of gay persons is not medically necessary because (a) adoption and intercourse with the opposite sex are potential alternatives, (b) medical insurance should only cover what is medically legitimate and not what is the foreseeable result of one’s social choice, (c) medical insurance is intended to treat dysfunction, which is not present in the socially infertile, and (d) medical treatments are for medical conditions.¹⁰⁰ In opposition, another scholar argues that (a) many medical treatments are available which are not the exclusive cure for a problem, (b) being gay is not a choice, and, even if it were, people receive medical care even where the harm caused was a result of their choice, (c) dysfunction is a fluid concept, and plenty of legitimate medical treatments address issues other

98. See CONN. GEN. STAT. ANN. § 38a-536 (West 2007); MASS. GEN. LAWS ANN. ch. 175, § 47H (LexisNexis 2008); OHIO REV. CODE ANN. § 1751.01(A)(1) (LexisNexis 2009); R.I. GEN. LAWS § 27-18-30 (2008).

99. DeLair, *supra* note 33, at 175.

100. Rank, *supra* note 7, at 131–34 (citing Maurice Rickard, PARLIAMENT OF AUSTRALIA, IS IT MEDICALLY LEGITIMATE TO PROVIDE ASSISTED REPRODUCTIVE TREATMENTS TO FERTILE LESBIANS AND SINGLE WOMEN? 8 (2000), available at <http://www.aph.gov.au/library/pubs/rp/2000-01/01RP23.pdf>).

than outright dysfunction, and d) medicine is intended to treat not just conditions, but also symptoms, and, furthermore, medical treatment is deemed appropriate even in the ten percent of infertility cases that are unexplained.¹⁰¹ The issue of whether gay, unmarried, and medico-structurally infertile persons' use of ART is medically necessary deserves further attention in the future.

Other states like West Virginia have statutes that are very broad and harder to define. Here, the law requires that HMOs cover "basic health care services," which includes "infertility services." This breadth of coverage seems to include both the structurally and medico-structurally infertile. Where a statute provides little guidance as to which fertility treatments are covered and for whom, provisions are generally interpreted in favor of the insured. Courts look to the average person in determining the reasonable expectations of the insured, leaving it unclear whether gay, unmarried, or medico-structurally infertile persons could successfully argue coverage under these mandates.¹⁰²

Table 2 summarizes the results of this section as to which states are most and least likely to exclude structurally and medico-structurally infertile persons from coverage under the mandate, based on the five different statutory requirements. As the table shows, all of the states implicitly exclude gay and unmarried persons from coverage or have laws that could potentially be interpreted in a way that excludes at least some unmarried or gay persons, with the exception of West Virginia, which adopted broad statutory language. States like Hawaii, Maryland, Rhode Island, and Texas use spousal language and eliminate gamete donation, thereby more directly eliminating coverage for gay and unmarried persons. Other states' exclusions are more subtle and less clear, like California's. Table 2 suggests that, in most statutory frameworks, medico-structurally infertile persons are also excluded from coverage for the same reasons, apart from those states like Ohio where the treatment is covered if it is medically necessary.

101. Rank, *supra* note 7, at 133–34 (citing Rickard, *supra* note 100).

102. Minnaert & Tai, *supra* note 62, at 325–27.

Table 2: Implications of Statutory Language on Exclusion of Gay, Unmarried, and Medico-structurally Infertile Groups by State

	Implicit exclusions	Potential exclusions	No exclusions
Arkansas	Gay, Unmarried, Medico-Structural		
California		Gay, Unmarried, Medico-Structural	
Connecticut		Gay, Unmarried, Medico-Structural	
Hawaii	Gay, Unmarried, Medico-Structural		
Illinois		Gay, Unmarried, Medico-Structural	
Maryland	Gay, Unmarried, Medico-Structural		
Massachusetts		Gay, Unmarried, Medico-Structural	
Montana		Gay, Unmarried, Medico-Structural	
New Jersey		Gay, Unmarried, Medico-Structural	

New York		Gay, Unmarried, Medico- Structural	
Ohio		Gay, Unmarried	Medico- Structural
Rhode Island	Gay, Unmarried, Medico- Structural		
Texas	Gay, Unmarried, Medico- Structural		
West Virginia			Gay, Unmarried, Medico- Structural

B. LEGISLATIVE HISTORY OF STATE MANDATES

A brief discussion of the legislative history of these statutes provides some guidance with respect to states' intent in mandating insurance coverage of ART, including whether there was overt discriminatory exclusion of the structurally infertile. Session laws and press releases of four states, California, Maryland, Massachusetts and New Jersey will be explored.

California's session laws related to its state mandate make four points: (1) that "[i]nfertility is a significant health problem that affects millions of Californians," (2) "[i]nfertility is a medical illness . . . similar to other illnesses or conditions that is created by the malfunction of other bodily organs . . . and should be treated for purposes of insurance the same as any other body disfunction," (3) "[i]f properly treated, successful pregnancies can result in 70 percent of the cases," and (4) "[i]nsurance coverage for infertility is uneven, inconsistent, and frequently subject to arbitrary decisions which are not based on legitimate medical considerations."¹⁰³

Maryland's session laws address the obligations of health maintenance organizations (HMO's) as insurers.¹⁰⁴ The state

103. 1989 Cal. Stat. 2428.

104. 2000 Md. Laws 1657.

requires that “[a]n entity . . . provid[ing] pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures The benefits . . . shall be provided [by] health maintenance organization, to the same extent as the benefits provided for other infertility services.”¹⁰⁵

The session laws of Massachusetts regarding mandated insurance coverage for assisted reproduction, entitled An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses, call for “containment, transparency and efficiency in the provision of quality health insurance”¹⁰⁶

Lastly, New Jersey has a relevant press release related to this matter. New Jersey Governor Donald DiFrancesco released a statement after the passage of New Jersey statute which emphasized his personal experiences being a father of three; in the statement he described “the joys of looking into [his] newborn child’s eyes for the first time.”¹⁰⁷ He continued that the “new law will offer those [New Jersey] couples a better chance of having a baby. A better chance of realizing a dream many of us take for granted—the dream of becoming a parent.”¹⁰⁸

There are a number of themes running through these legislative actions. First, some legislatures, like California, are medicalizing infertility. It is unknown whether, in characterizing infertility as a medical issue, the legislature seeks to overtly exclude those from coverage who suffer from infertility that is non-medical or whether the legislature simply does not address or consider the structurally infertile.

Another common theme is the significance of infertility in terms of both its high incidence and its impact on citizens of the state. California emphasizes that millions of citizens struggle with infertility, thus highlighting its import, though it is unclear whether they include structurally or medico-

105. *Id.*

106. An Act to Promote Cost Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses, 2010 Mass. Acts 288.

107. News Release, DiFrancesco Signs Law to Provide Health Insurance Coverage of Infertility, Office of the Governor (Aug. 31, 2001) (on file at the New Jersey State Library).

108. *Id.*

structurally infertile persons. New Jersey, interestingly, focuses its media release on the social importance of having a child, a statement which is presumably neutral to marital status and sexual orientation or otherwise not contemplated.

Some states also focus on the efficacy of treatment as a justification for mandating coverage, including California. This, again, constitutes an argument in support of ART coverage that does not rely on internal factors, like marriage or sexuality. Similarly, another theme, affordability and/or reduction of waste (Massachusetts), arguably applies equally to all types of infertility—medical, structural, or medico-structural.¹⁰⁹

The legislative intent, exhibited in drafting insurance coverage mandates for ART, supply a useful context when considering possible discriminatory intent on the part of legislatures.¹¹⁰

The next section will discuss some of the legal, ethical, and policy considerations raised by state-mandated insurance statutes and their implications for gay, unmarried, and medico-structurally infertile people.

IV. DISCUSSION

State-mandated insurance coverage for ART has unique legal and ethical implications for the structurally and medico-structurally infertile. These mandates arise from recognition of the emotional toll of untreated infertility and a desire to increase access to these expensive technologies.¹¹¹ However,

109. Here, it is difficult to predict what types of waste the legislatures may have meant in the context of ART. However, data supports the notion that where insurance covers ART, multiple births (and thus the overwhelming costs associated with prenatal and maternal care in this context) are reduced. Georgina M. Chambers et al., *The Economic Impact of Assisted Reproductive Technology: A Review of Developed Countries*, 91 FERTILITY & STERILITY 2281, 2292 (2009). One potential reason for this may be that, in IVF cases, women choose to implant higher numbers of embryos in instances where they are paying out of pocket, in hopes of minimizing the number of ART cycles they undergo. *Id.* Additionally, insurance coverage could prevent waste because full coverage allows for individuals to go for the most effective treatment, rather than multiple attempts at various less-effective treatments. See Pendo, *supra* note 11, at 342 (explaining that plans with certain ART exclusions may cause patients to undergo less effective treatment simply because the less effective treatments are covered rather than undergo the more effective treatments that are excluded).

110. See *infra* Part IV.B.2.

111. Numerous studies link infertility with depression and lesser well-being in women and men. See e.g. Alice D. Domar et al., *The Prevalence and*

state mandates have done little to ensure access for gay and unmarried persons including those who, like the individuals that the laws aim to protect, have a medical cause for their infertility. Indeed, many state mandates are structured in such a way as to determine coverage specifically on the basis of marital status (and, by proxy, sexual orientation), a prerequisite period of unprotected intercourse (again, implicating sexual orientation), and/or the existence of a medical condition or particular type of medical condition. Given procreative liberty considerations, high rates of use of ART by gay and unmarried persons, and the fact that ART is the sole means of procreation for some of these individuals, it is important to explore the consequences of these mandates for the structurally and medico-structurally infertile.

The implicit exclusion of gay, unmarried, and medico-structurally infertile persons from state-mandated insurance coverage of ART, raises three particular legal challenges: Fourteenth Amendment Due Process challenges, Equal Protection challenges, and Americans with Disabilities Act (ADA) challenges.

A. FOURTEENTH AMENDMENT DUE PROCESS CONSIDERATIONS

1. Fourteenth Amendment Legal Constructs

The Due Process Clause of the Fourteenth Amendment declares that no State shall “deprive any person of life, liberty, or property, without due process of law.”¹¹² From this protection of human liberty springs a right to privacy, and “only personal rights deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty’ are included in this guarantee of personal privacy.”¹¹³ Using notions of privacy and fundamental rights, the Fourteenth Amendment has often been used as a talisman in the battle over reproductive freedom and choice. Although a positive right to assisted reproduction has not yet and may never be articulated by the courts, there exist a

Predictability of Depression in Infertile Women, 58 FERTILITY & STERILITY 1158 (1992); Reija Klemetti et al., *Infertility, Mental Disorders and Well-Being—a Nationwide Survey*, 89 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 677 (2010).

112. U.S. CONST. amend. XIV, § 1.

113. *Roe v. Wade*, 410 U.S. 113 (1973) (citing *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

number of cases that protect a certain level of reproductive freedom, particularly in freedoms from unwanted intervention by the state in the realm of family and childbearing.

One of the first U.S. Supreme Court cases to deal with procreative liberty was *Buck v. Bell*, an early 20th century case in which the Court upheld a statute mandating compulsory sterilization of “mental defectives.”¹¹⁴ Attorneys for Carrie Buck argued that mandated sterilization was in violation of her due process right to procreate, but the Court ultimately likened compulsory sterilization to that of compulsory vaccination and held it to be in the state’s interest to have her sterilized.¹¹⁵ The concept of a due process right to procreation evolved with *Skinner v. Oklahoma*, in which the Supreme Court held that a statute allowing for the sterilization of repeat felons was invalid based on the idea that there is a due process right to reproduce “which is basic to the perpetuation of a race.”¹¹⁶

Further shedding light on the boundaries and privileges of reproductive choice, the Court held in *Griswold v. Connecticut* that the same due process protections that shield persons from involuntary sterilization also afford one the right to choose to prevent pregnancy by using contraception.¹¹⁷ Seven years later, the Court extended that same protection to individuals who are not married by stating that “[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”¹¹⁸ Thus, the right to engage in procreation and sex, regardless of marital status, was protected under the Due Process Clause and notions of sexual intercourse for reproductive purposes began to pull away from notions of sexual intercourse for other reasons. As one scholar summarized it, these court cases all “stand for a constitutional right to procreate regardless of marital status.”¹¹⁹ Landmark cases like *Roe v. Wade* and *Planned Parenthood v. Casey*

114. *Buck v. Bell*, 274 U.S. 200 (1927).

115. *Id.*

116. *Skinner v. Oklahoma*, 316 U.S. 535, 536 (1942).

117. This case held that it was unconstitutional to ban the use of contraceptives for married persons under a penumbra rights theory under the Due Process Clause of the Fourteenth Amendment. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

118. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

119. DeLair, *supra* note 33, at 178.

further evidenced a strong commitment of the Court to defining procreative autonomy as grounded in due process privacy protections.¹²⁰ Further, a woman's right to choose abortion "irrespective of her marital status" has been interpreted as further bolstering the concept that procreative rights and freedoms are grounded in the individual, not the married couple.¹²¹

To date, the court system has mainly framed the due process privacy rights related to procreation as negative rights, meaning a right to be free from government intervention into the individual's procreative activities.¹²² This is distinguishable from a positive right to procreate, where the government would be obligated to provide one with the means necessary to do so.¹²³ Though courts have made no clear ruling on this matter, cases like *Harris v. McRae*,¹²⁴ where the Court held that women had no positive right to financial assistance from the government in order to procure an abortion despite having a negative right to an abortion, demonstrate a "reluctance to extend the right to procreate" into the realm of positive obligations.¹²⁵ Given this unwillingness to acknowledge a positive right to procreate in more traditional senses, courts are even less likely to declare a positive right to high-tech, expensive, and third-party-dependent interventions like ART because where it would be more challenging for a court to

120. *Roe v. Wade*, 410 U.S. 113, 153. (1973). ("The right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 857 (1992) ("Roe is clearly in no jeopardy, since subsequent constitutional developments have neither disturbed, nor do they threaten to diminish, the scope of recognized protection accorded to the liberty relating to intimate relationships, the family, and decisions about whether or not to beget or bear a child.").

121. Note, *Reproductive Technology and the Procreation Rights of the Unmarried*, 98 HARV. L. REV. 669, 677 (1985) [hereinafter *Procreation Rights*].

122. See, e.g., *Lawrence v. Texas*, 539 U.S. 558 (2003).

123. Though scholars like John Robertson have examined to what extent reproductive liberty has or is worthy of greater protections, this paper will not focus on these issues. Instead, it focuses on what legal arguments can be made even if reproductive freedom is viewed more narrowly as a negative right with lesser government protection. For more information on the debate around expanded reproductive protections, see JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* (1994).

124. *Harris v. McRae*, 448 U.S. 297 (1980).

125. DeLair, *supra* note 33, at 179.

ensure that individuals were given the means necessary to reproduce.

Despite the courts' apparent reluctance to broaden the scope of privacy rights around reproduction, some scholars assert that courts already view access to assisted reproductive technology as a fundamental right because, while it is historically new, it "subsumes several aspects of liberty that have a long history of constitutional protection" including contraception, abortion, and sterilization.¹²⁶ On the other hand, some scholars argue that there will be no fundamental right to ART because, while contraceptive and abortion cases have involved the removal of something from one's body, which invokes the protection of bodily integrity, ART involves requesting that something be done to one's body.¹²⁷ This distinction between "freedom from unwanted bodily invasions and freedom to obtain bodily invasions" separates ART from other rights granted under the fundamental right of procreation.¹²⁸

2. Fourteenth Amendment Due Process Implications for State-Mandated Insurance Coverage of ART and Structural and Medico-Structural Infertility

Given the unsettled state of the law in this arena, as well as the signs of reluctance within the courts to broadly construe reproductive rights, it is unlikely that a structurally or medico-structurally infertile person would succeed in a claim that a state-mandated insurance statute violated his due process rights under the Fourteenth Amendment.

Though the government is obligated not to interfere with an individual's right to reproduce, this obligation is likely not violated by the state mandates of insurance coverage for ART. No federal law requires that individuals have access to ART, and, as such, states are acting above their obligations in ensuring that certain members of the population have access to ART. Regardless of whether these mandates result in unequal distribution of or costs for ART across differing marital statuses and sexual orientation, they are not outright denying any individual access to ART. Instead, they are providing a

126. Rhadika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457, 1463 (2008).

127. *Id.* at 1465.

128. *Id.*

positive right to some, but not others. Thus, the state action of mandating insurance for ART is distinguishable from cases like *Griswold*¹²⁹ and *Eisenstadt*,¹³⁰ where the government was acting to prohibit or prevent access for individuals.

Even where the special protections to certain groups like unmarried persons or gay persons are considered, a right to assisted reproduction is still not afforded. For example, *Eisenstadt* spoke to the idea that unmarried individuals cannot be treated differently than married individuals with respect to state interference in reproduction or sexual practices.¹³¹ However, while the holding in *Eisenstadt* is interpreted to mean that the unmarried have a right to engage in intercourse without procreative intent, this protection does not necessarily extend to a right to have insurance pay for them to use ART.

Cases dealing particularly with homosexual rights to privacy in sexual activity also do not seem to ensure insurance coverage of ART. In a landmark case for gay rights, *Lawrence v. Texas*, the Supreme Court held that the right to adult, consensual intercourse is protected under the due process right of privacy, and, thus, anti-sodomy laws are illegal.¹³² In essence, the case held that gay men have as much right to privacy in sexual activity as everyone else, even where the sexual activity is engaged in for purposes other than reproduction.¹³³ Again, however, this case speaks to a negative right that the government not interfere in one's sexual practices, not a positive right for the state to enable those practices.

Instances of medico-structural infertility meet the same barriers. As with infertile heterosexual married couples, the law has yet to afford the positive right to procreate, and it

129. *Griswold v. Connecticut*, 381 US 479 (1965).

130. *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

131. *Id.* at 453.

132. *Lawrence v. Texas*, 539 U.S. 558, 558 (2003).

133. *Id.* at 578

The case does involve two adults who, with full and mutual consent from each other, engaged in sexual practices common to a homosexual lifestyle. The petitioners are entitled to respect for their private lives. The State cannot demean their existence or control their destiny by making their private sexual conduct a crime. Their right to liberty under the Due Process Clause gives them the full right to engage in their conduct without intervention of the government.”

Id.

follows that there is no right to ART yet evoked. Irrespective of whether unmarried, gay, or medico-structurally infertile persons are the group being excluded by law, a state government is currently under no obligation to provide access to ART for anyone and, thus, can act to provide access to some and not others without infringing on the due process privacy rights of its citizens. State mandates that implicitly exclude these groups either by requiring marriage, unprotected sex, or medical necessity are not in violation of the Due Process Clause under current interpretations of the law. This does not mean that a court can never find a due process privacy right being infringed upon by state-mandated insurance coverage of ART on behalf of the structurally infertile. Rather, current law and current behaviors of the courts tend to suggest that this freedom would not be recognized at this point in time. As notions of reproductive freedom continue to develop and as technologies like ART continue to become more mainstream, courts may more readily be willing to acknowledge a positive right of reproduction and even ART. If such a positive right were recognized, it would reinforce claims that a state mandate excluding groups with structural or medico-structural infertility from mandated insurance is a Fourteenth Amendment Due Process violation.

B. FOURTEENTH AMENDMENT EQUAL PROTECTION CONSIDERATIONS

1. Fourteenth Amendment Equal Protection Legal Constructs

Another potential area where claims of unequal access to reproductive technology may be raised is through the Equal Protection Clause, which requires equal treatment of those who are similarly situated. The Fourteenth Amendment Equal Protection Clause requires that “[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws.”¹³⁴ Equal Protection claims can involve three different levels of scrutiny—strict scrutiny, intermediate scrutiny, and rational basis scrutiny—depending on the basis by which the challenged law classifies people.¹³⁵ The highest level of scrutiny, strict scrutiny, is applied to laws that implicate fundamental rights or that use so-called “suspect

134. U.S. CONST. amend. XIV, § 1.

135. DeLair, *supra* note 33 at 181.

classifications” based on race, national origin, or religion. Strict scrutiny requires that the government demonstrate that the law and its use of classifications are necessary to serve a compelling state interest and are narrowly tailored to be as least restrictive on individual rights as possible.¹³⁶ Intermediate scrutiny is applied to challenges of a law’s constitutionality based on its use of “quasi-suspect classifications” of gender or illegitimacy and requires that the government prove that the classification serves an important state interest to which the classification is substantially related.¹³⁷ Most equal protection claims are subject to a rational basis standard where the law does not implicate a fundamental right or use suspect or quasi-suspect classifications, as is the case with marriage status, sexual orientation, and disability. For a law having discriminatory effects on these bases to be found unconstitutional under rational basis review, the challenger must show that the law is not rationally related to a legitimate state interest.¹³⁸

Furthermore, violations of Equal Protection do not always require that the law classify a group and discriminate on its face. As shown in *Washington v. Davis*, violations of equal protection are also present where there is evidence of discriminatory intent.¹³⁹ Importantly, “a law or other official act is [not] unconstitutional *solely* because it has a racially disproportionate impact Disproportionate impact is not irrelevant, but it is not the sole touchstone of an invidious racial discrimination forbidden by the Constitution.”¹⁴⁰ To prove discriminatory intent, it must be shown that the law was enacted to lead to a particular discriminatory result—a discriminatory side-effect or consequence of the law is insufficient.¹⁴¹ For example, discriminatory intent could be proven by showing that “the discrimination is very difficult to explain on nonracial grounds.”¹⁴²

Courts have examined issues of reproductive equality in many of the same cases discussed in the previous section,

136. *Id.*

137. *Id.*

138. *Id.*

139. *Washington v. Davis*, 426 U.S. 229, 241 (1976).

140. *Id.* at 230, 242.

141. *Id.*

142. *Id.*

though these cases have been specific to laws directly interfering with the rights of certain people to exercise reproductive freedom. The courts' positions in these cases, however, still provide a starting point from which to consider how a court might go about performing a rational basis review for an Equal Protection claim in the instance of state insurance mandates for ART. For example, in *Skinner v. Oklahoma*,¹⁴³ the Supreme Court struck down the compulsory sterilization law because "it discriminated between chicken thieves and embezzlers."¹⁴⁴ The Court elaborates that "strict scrutiny of the classification which a State makes in a sterilization law is essential, lest unwittingly, or otherwise, invidious discriminations are made against groups or types of individuals in violation of the constitutional guaranty of just and equal laws."¹⁴⁵ One scholar has argued that, based on this holding, "[a] law that prohibits ARTs under some circumstances, but not others, must at the very least be based upon a legitimate governmental interest in order to be constitutional."¹⁴⁶ Examining the holdings in *Eisenstadt*¹⁴⁷ (where the Court struck down a law that discriminated between married and non-married persons with respect to contraception) and *Lawrence v. Texas*¹⁴⁸ (where the Court struck down a law forbidding homosexual, but not heterosexual, sodomy) the scholar further argues that:

a law limiting ARTs to married persons or to heterosexual persons should fail because it would treat the very same act—the use of a particular technology—differently based upon the marital status or sexual preference of the persons involved, with no real basis for the distinction other than societal disapproval or prejudice.¹⁴⁹

These issues become highly complex when the discrimination is non-facial, as is often the case in state-mandated insurance coverage of ART.

Specifically with respect to unmarried persons and their use of reproductive technology, one scholar has argued strongly

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

144. Rao, *supra* note 126, at 1474.

145. *Skinner*, 316 U.S. at 541.

146. Rao, *supra* note 126, at 1475.

147. *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

148. *Lawrence v. Texas*, 539 U.S. 558 (2003).

149. Rao, *supra* note 126, at 1475–76. This argument was used to challenge an Italian law which facially discriminated against gay, unmarried person in distribution of ART. *Id.* at 1476.

for heightened scrutiny in Equal Protection claims.¹⁵⁰ Arguing that the state has an interest in protecting “legitimate family relationships,” the author writes that “both marital and nonmarital families can foster the familial values the Constitution seeks to protect” “[C]ertain ‘objective characteristics’—blood relationship with their children, parental duty to support those children, parental intention to form a family . . . should locate their families at the intimate end of the relationship ‘spectrum,’” thus ensuring them heightened equal protection review.¹⁵¹ This argument can naturally be extended to gay persons wishing to procreate via ART as well.

2. Fourteenth Amendment Equal Protection Implications for State-Mandated Insurance Coverage of ART and Structural and Medico-Structural Infertility

To prove that any of the state-mandated insurance statutes violates the Fourteenth Amendment Equal Protection Clause is a challenging endeavor. Most of the statutes do not, on their face, discriminate on the basis of a classification. Of the five different categories of language shown in Tables 1a and 1b, only those statutes that use spousal language could be considered facially discriminatory because they require that eligible participants be spouses, implying that only married individuals qualify under the law. The remaining types of statutes, while they may have discriminatory effects, do not contain any facially discriminatory language.

Though marriage has been viewed as a fundamental right in the courts, state mandates with marriage requirements do not put discriminatory barriers in front of the right to marry.¹⁵² Rather, they provide certain privileges to those who are married and are, thus, more akin to cases like *Eisenstadt*.¹⁵³ In addressing equal protection issues in *Eisenstadt*, the Court performed a rational basis analysis and overturned the Massachusetts law for “providing dissimilar treatment for married and unmarried persons.”¹⁵⁴ In *Eisenstadt*, the state

150. *Procreation Rights*, *supra* note 121, at 680.

151. *Id.* at 679–80.

152. *See, e.g.*, *Zablocki v. Redhail*, 434 U.S. 374, 383 (1978); *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

153. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

154. *Id.* at 454.

argued that one justification for the differing treatment of non-married persons with respect to contraception was to diminish instances of premarital sex.¹⁵⁵ Similarly, laws in Hawaii,¹⁵⁶ Maryland,¹⁵⁷ and Texas¹⁵⁸ treat those who are married differently from those who are not in matters related to procreation and reproductive choice and may be handled similarly to *Eisenstadt* in a court. However, the state interest of reducing premarital sex would be irrelevant because these state mandates do not involve sexual intercourse but rather reproduction without intercourse.

The other four statutory constructs do not facially discriminate on the basis of marriage or sexual orientation; therefore, discriminatory intent would need to be proven in order for an Equal Protection claim to succeed. As Tables 1a, 1b, and 2 suggest,¹⁵⁹ statutory language in some states appears more definitive and intentional in its exclusion of unmarried or gay persons than that of others. For example, a requirement of medical necessity seems to seek to exclude structurally infertile people (that is, unmarried or gay persons who are reproductively healthy but require gamete donation and/or artificial insemination to procreate) if medical necessity is understood to mean medical infertility.¹⁶⁰ The same result is true for requirements that the infertility be either medically related or unexplained. Similarly, laws requiring a period of unprotected intercourse may have the effect of excluding gay people who do not engage in intercourse with a member of the opposite sex.¹⁶¹ For these types of statutes, it would not be enough to prove that the statute results in differing outcomes or treatment for gay or unmarried persons than for married, heterosexual persons. Rather, it would have to be proven that it was the state's intent to exclude these groups purposefully from coverage for discriminatory reasons and, further, that the state does not have a rational basis for the law.

In determining discriminatory intent, as *Davis* suggests, a

155. *Id.* at 448.

156. HAW. REV. STAT. § 431:10A-116.5 (2005).

157. MD. INS. CODE ANN. § 15-810 (LexisNexis 2006).

158. TEX. INS. CODE § 1366.005 (West 2009).

159. *See supra* Parts III, III.A.5.

160. DeLair, *supra* note 33, at 175.

161. See Rank, *supra* note 7, at 139 (explaining that although legislatures likely did not “intend[] to extend coverage to lesbian couples, it is conceivable that the language . . . be construed to include such couples”).

law could be struck down by the Equal Protection Clause if the reason for distinguishing two groups could be no other reason than discriminatory purposes.¹⁶² The legislative histories explored earlier in the paper provide some guidance here. Those states which medicalize infertility might arguably be accused of having discriminatory intent to exclude gay and unmarried people, by focusing only on medical infertility, thus excluding only those kinds of infertility which gay and unmarried people experience. However, this interpretation is unlikely because it can also be said that California simply did not contemplate the structurally infertile in its laws or found medical infertility to be the better target of mandated health insurance coverage. Interestingly, California is not one of the states requiring that the infertility be either medically explained or medically necessary, as shown in Tables 1a and 1b.¹⁶³ The other factors predominant in the legislative histories (significance of infertility, efficacy of treatment, affordability, and waste reduction) are neutral to sexual orientation and marital status. While this suggests that legislative histories are unlikely to unveil discriminatory intent, it also suggests that the legislatures should not object, based on their goals of the law, to coverage for structurally/medico-structurally infertile persons. This is because the reasons for implementing the laws arguably apply as soundly to these types of infertility.¹⁶⁴

Whether the state's interest in excluding gay and unmarried persons from coverage has a rational basis must also be considered. One interest states might argue is that the purpose of the mandates is to exclude from coverage those heterosexual people who are able to reproduce naturally, thus preserving resources.¹⁶⁵ Similarly, a state might argue that coverage should only be provided for those people who likely require more expensive ART interventions that they may not be able to afford without insurance coverage (likely the

162. *Washington v. Davis*, 426 U.S. 229, 242 (1976).

163. *See supra* Part III.

164. It is important to note that the study of legislative histories here is not exhaustive. More in-depth research could in fact reveal evidence of discriminatory intent by some states.

165. *See In Vitro Fertilization*, *supra* note 6, at 2099 (stating that mandates, in general, can be viewed as having "the effect of diverting already scarce health care resources to one particular health problem").

medically infertile) but that coverage should exclude those who require less expensive interventions like artificial insemination which they might be able to afford out-of-pocket. A true analysis of the validity of these interests requires economic analysis which is outside the scope of this work. However, it is important to note that furthering these interests does not require completely excluding gay and unmarried persons. Rather, the laws could simply be modified to state that only persons who are unable to reproduce naturally are covered and/or additionally that only those procedures which cannot be achieved by less expensive means are covered.

States might also argue an interest in preserving the status of marriage and traditional families or, on a related note, argue the necessity of safeguarding children's "emotional and psychological wellbeing," which they would suggest was compromised by having a single or gay parent(s).¹⁶⁶ This is a common argument advanced by states in past cases about custody and adoption rights of gay and unmarried persons. While it has had some historical success, more recent cases and statutes suggest a growing tolerance where most courts would no longer recognize this as a compelling argument for excluding these groups from parenting.¹⁶⁷

A long history exists regarding the struggle for single persons and gay persons seeking custody of children born via ART. Central to this history is the inability of gay persons to legally marry, the belief that gay persons are involved in short-term relationships, as well as the belief that gay persons and single persons are inadequate at parenting children.¹⁶⁸ Research, however, does not support either the notion that gay people cannot maintain stable relationships or that single and

166. See DeLair, *supra* note 33, at 181–82.

167. See cases cited *infra* note 174.

168. See e.g. John A. Robertson, *Gay and Lesbian Access to Assisted Reproductive Technology*, 55 CASE W. RES. L. REV. 323, 324, 332 (2005) (noting that the same-sex marriage debate is linked to the current access to ART controversy and furthering "that gays and lesbians are equally competent parents and that their children are as well-adjusted as other children"). Gay marriage is currently legal in six states (Connecticut, California, Iowa, Massachusetts, New Hampshire, and Vermont) as well as the District of Columbia. The issue got recent attention in 2010, when California courts overturned Proposition 8 and again permitted gay persons to marry in the state. *Judge Gives Green Light for Same-Sex Marriage in California*, CNN (Aug. 12, 2010), http://articles.cnn.com/2010-08-12/us/california.same.sex.ruling_1_marriage-last-week-couples-case-heads?_s=PM:US.

homosexual parenting is less effective than heterosexual, married parenting.¹⁶⁹

In the past, many courts and legislatures objected to or simply did not contemplate gay and unmarried persons in the role of parents, whether through adoption or through custodial rights. One example is the original Uniform Parentage Act (UPA), promulgated in 1973, which simply did not discuss unmarried women's use of ART, "leaving them vulnerable to parental claims by [gamete] donors."¹⁷⁰ Since then, however, the 2002 UPA has been updated to treat married and unmarried parents equally.¹⁷¹ Likewise, all of the states who have mandated insurance coverage of ART also provide adoption rights to gay persons and single persons by statute.¹⁷²

169. For example, studies support the idea that heterosexual and homosexual relationships can be equally stable or unstable and long or short term. Susan Golombok et al., *Children in Lesbian and Single-Parent Households: Psychosexual and Psychiatric Appraisal*, 24 J. CHILD PSYCHOL. & PSYCHIATRY 551, 553 (1983) ("[I]t seems doubtful whether transience is any more characteristic of lesbian relationships than of women's heterosexual relationships."); Charlotte J. Patterson, *Children of Lesbian and Gay Parents*, 63 CHILD DEV. 1025, 1025 (1992) (finding "no evidence that the development of children with lesbian or gay parents is compromised in any significant respect relative to that among children of heterosexual parents in otherwise comparable circumstances"); Daniel Goleman, *Studies Find No Disadvantage in Growing Up in a Gay Home*, N.Y. TIMES, Dec. 2, 1992, at C14

170. Ellen Waldman, *Cultural Priorities Revealed: The Development and Regulation of Assisted Reproduction in the United States and Israel*, 16 HEALTH MATRIX 65, 92 (2006); See UNIF. PARENTAGE ACT, Prefatory Note, 9B U.L.A. 378, 378-79 (1973.)

171. UNIF. PARENTAGE ACT, Prefatory Note (2002), available at http://www.law.upenn.edu/bll/archives/ulc/upa/final2002.htm#TOC1_1.

172. For a comprehensive exploration of all state statutes in this area, see *In Your State*, LAMBDA LEGAL, <http://www.lambdalegal.org/states-regions/> (last visited March 29, 2011). It is important to note that, for gay couples, adoption rights are important but second parent adoptions, which enable the non-genetically related partner to adopt the child, are also key. The statutes which permit adoption by gay persons are as follows: Arkansas permits "[a]n unmarried adult" to adopt, ARK. CODE ANN. §9-9-204 (2009); in California, "[a]ny a prospective adoptive parent . . . [must] be at least 10 years older than the child," CAL. FAM. CODE § 8601 (West 2004); Connecticut allows for consideration of "the capacity of the prospective adoptive parents to meet such needs [particular needs of child]" but does not have specific adoption restrictions based on sexual orientation, CONN. GEN. STAT. § 45a-726 (West 2004); in Hawaii, "[a]ny proper adult person, not married, or any person married to the legal father or mother of a minor child, or a husband and wife jointly" may petition for adoption, HAW. REV. STAT. § 578-1 (2006); in Illinois, "[a] reputable person of legal age and of either sex" may adopt a child, 750 ILL. COMP. STAT. 50/2 (2011); Maryland courts consider "all factors necessary to

Additionally, while historically there has been strong case law which did not welcome single parents; this has begun to change in the courts.¹⁷³ In cases which grant custody or adoption rights to gay persons, the courts have focused on the best interests of the child and have concluded either that the inclusion of the single or gay parent supports these interests, or at a minimum, that the sexual orientation alone cannot proscribe custody without some other evidence of actual harm to the child from the sexual orientation of the parent or from another reason.¹⁷⁴

Thus, overall, courts and legislatures in most states are becoming open to the idea of single and gay persons as parents, making it unlikely in the majority of states that fitness to parent or traditional models of family could be used as a rational basis for excluding these groups from mandated coverage of ART.

Other state interests may vary depending on the types of treatment being excluded. As one example, the spousal requirement may be intended to exclude gamete donors. Here, the state might argue that insurance companies cannot be expected to handle additional expenses of gamete donation, in

determine the prospective adoptee's best interests" and cannot deny "petition solely because petitioner . . . is single or unmarried," MD. CODE ANN., FAM. LAW § 5-3B-19 (LexisNexis Supp. 2010); Massachusetts requires only "[a] person of full age," MASS. GEN. LAWS ch. 210, §1 (LexisNexis 2003); in Montana, "an unmarried" adult may adopt, MONT. CODE ANN. 42-1-106 (2009); in New Jersey, "[a]ny [adult] person" may adopt, N.J. STAT. ANN. 9:3-43 (West 2002); New York requires "[a]n adult unmarried person," N. Y. DOM. REL. LAW § 110 (McKinney 2010); Ohio requires, "[a]n unmarried adult," Ohio Rev. Code Ann. §3107.03 (LexisNexis 2008); in Rhode Island, "[a]ny person" may adopt, R.I. GEN. LAWS §15-7-4 (2003); in Texas, "any adult" may adopt, TEX. FAM. CODE ANN. §162.001 (West 2008); and in West Virginia, "[a]ny person not married" may adopt, W. VA. CODE ANN. § 48-22-201 (LexisNexis 2009).

173. For an excellent overview of the cases denying women as single parents in favor of inclusion of donor fathers, see Waldman, *supra* note 170, at 92-96.

174. *In re Marriage of Birdsall*, 197 Cal. App. 3d 1024, 1031 (Cal. Ct. App. 1988) ("Evidence of one parent's homosexuality, without a link to detriment to the child, is insufficient to constitute harm."); *Teegarden v. Teegarden*, 642 N.E.2d 1007, 1010 (Ind. Ct. App. 1994) ("[H]omosexuality standing alone without evidence of any adverse effect upon the welfare of the child does not render the homosexual parent unfit as a matter of law to have custody of the child.") (emphasis added); *Boswell v. Boswell*, 721 A.2d 662, 674 (Md. 1998) ("[W]e agree with those courts from other jurisdictions that have held that the primary consideration in . . . custody proceedings is not the sexual lifestyle or conduct of the parent, but whether the child will suffer harm from the behavior of the parent . . .").

addition to the other services they are providing or that gamete donation is against the policies of the state. However, these types of limitations, if valid, can again simply be altered by specifying this in the statute; thus removing gamete donation but not also excluding unmarried and gay persons.

Despite the willingness of courts and legislatures to recognize the structurally infertile as appropriate parents, equal protection challenges here still remain difficult unless discriminatory intent can be proven. Equal protection challenges would be strongest when brought against the state mandates with spousal language because there is some evidence of unequal treatment surrounding the fundamental right of marriage. While such an equal protection challenge could be complex, it does present a stronger challenge to state-mandated insurance coverage than Due Process challenges, particularly where the statutes discriminate facially on the basis of marriage.

C. AMERICANS WITH DISABILITIES ACT CONSIDERATIONS

1. ADA Legal Constructs

Another potential claim with respect to state-mandated insurance for ART is the Americans with Disabilities Act (ADA)¹⁷⁵ and its respective legal claims. Specifically, Title II of the ADA deals with government violations. Title II applies to “any State or local government,” which includes state legislatures in their role of making laws.¹⁷⁶

Title II provides that no “qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”¹⁷⁷ A person has a disability under the ADA if he or she has a “physical or mental impairment that substantially limits one or more major life activities,” has “a record of such an impairment,” or is “regarded as having such an impairment.”¹⁷⁸ Infertility was

175. Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2006).

176. *Id.* §§ 12131(1)(A).

177. *Id.* § 12132.

178. *Id.* § 12102(1).

famously held to be disability in *Bragdon v. Abbott* where the Supreme Court ordered that reproduction was a major life activity when an HIV-positive patient brought suit against a dentist who refused to perform certain dental procedures on her in his office.¹⁷⁹ The Court stated that “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself,”¹⁸⁰ and “found that the HIV infection substantially limited her ability to reproduce and bear children, thus drawing protection under the ADA.”¹⁸¹ More recently, the ADA Amendments of 2008 listed reproductive functions as a major life activity within the meaning of the ADA.¹⁸²

Under Title II a qualified individual with a disability is “an individual with a disability who, with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.”¹⁸³ Thus, a) modification to rules and policies is one way in which a public entity like a state must accommodate a person with a disability and b) that modification need only be made if it is reasonable. The state must make these reasonable modifications to policies to avoid discrimination on the basis of disability unless it can be demonstrated “that making the modifications would fundamentally alter the nature of the service, program, or activity.”¹⁸⁴ Under this provision, a state statute which excluded a woman with both multiple sclerosis and schizophrenia from a state program that helped enable physically disabled persons to live at home did not to violate

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

180. *Id.* at 638.

181. Jessica L. Hawkins, *Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments*, 23 WASH. U. J.L. & POL'Y 203, 210 (2007).

182. ADA Amendments Act of 2008, Pub. L. No. 110-325, available at <http://www.access-board.gov/about/laws/ada-amendments.htm>. For a discussion of the legal and ethical considerations which led to infertility being considered a disability requiring reasonable accommodation as well as how this is supported by Equal Employment Opportunity Commission's (EEOC) guidelines, see Sandra M. Tomkowicz, *The Disabling Effects of Infertility: Fertile Grounds for Accommodating Infertile Couples Under the Americans with Disabilities Act*, 46 SYRACUSE L. REV. 1051 (1996).

183. 42 U.S.C. § 12131.

184. 28 C.F.R. § 35.130 (2011).

the ADA.¹⁸⁵ In *Easley*, the woman was not able to participate in the program because she was not mentally alert.¹⁸⁶ The court did not think it a reasonable modification to the policy to include her through use of a surrogate decision-maker because mental alertness is a necessary prerequisite for the services to be provided.¹⁸⁷ The court clarified that this is not case of discrimination against a group or sub-group because of disability. “On the contrary, this is a case where an additional handicap . . . renders participation in the program ineffectual.”¹⁸⁸ Quoting another case, the court added that there is no requirement that “any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons.”¹⁸⁹ In another case from the same circuit, *Juvelis*, a mentally disabled boy was allowed to be included in special benefits for the mentally disabled, even though he was not able to declare his domicile—which was part of the process to qualify for the program—because making an exception would not modify the essential nature of the program.¹⁹⁰ The court reasoned that the program was intended for people with that particular type of disability and his inability to determine his domicile did not disrupt the objectives of the program or alter his ability to participate in the program.¹⁹¹

2. ADA Implications for State-Mandated Insurance Coverage of ART and Structural and Medico-Structural Infertility

The ADA and case law like *Bragdon* make clear that reproductive function is a major life activity and the inability to reproduce is a disability under the ADA. There is still, however, a question as to what this means for structurally and medico-structurally infertile individuals. Reproduction is a major life activity for gay and unmarried persons, regardless of whether their infertility is solely structural or both medical and

185. *Easley ex rel. Easley v. Snider*, 36 F.3d 297 (3d. Cir. 1994).

186. *Id.* at 299.

187. *Id.* at 306.

188. *Id.*

189. *Id.* at 305, (citing *Traynor v. Turnage*, 485 U.S. 535, 548 (1987)).

190. *Juvelis ex rel. Juvelis v. Snider*, 68 F.3d 648, 656 (3rd Cir. 1995).

191. *Id.*

structural. However, *Bragdon* would likely not support the premise that gay or unmarried persons with healthy reproductive function are disabled under the meaning of the ADA.¹⁹² For medico-structurally infertile persons, the reason for which they cannot reproduce is linked to a physical impairment, as well as a structural one. Thus, under the ADA, medico-structurally infertile persons should qualify as disabled like other people with medical-based infertility.¹⁹³ While persons with structural infertility are limited in this major life activity as well, it is not due to a physical impairment and thus, though ultimately a matter for the legislature and the courts, does not likely fall under the meaning of a disability under the ADA.

While accommodation by modifying state mandates to include medico-structural infertility is a possibility, another question is whether a court would find this reasonable, or more specifically, whether such a modification would fundamentally alter the nature of the services. For those states which have some medical component built into the mandate (Connecticut, Hawaii, Maryland, Massachusetts, Ohio, Rhode Island, and Texas) or for those states that have medicalization as part of their legislative intent (California) it appears that medico-structurally infertile people would fare very similar to the plaintiff in the *Juvelis* case. The fact that these individuals may have to go through extra steps to establish medical infertility does not seem to alter the fundamental purpose of the statute, which is to provide insurance coverage for procedures dealing with medical infertility. They are still

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

193. Interestingly, however, while same sex couples or unmarried people may not be able to show that a physical impairment prevents the ability to reproduce, as in *Bragdon*, with HIV they may be able to satisfy the substantial limitation prong. *Bragdon*, 524 U.S. at 624. In *Bragdon*, a woman with HIV was viewed as substantially impaired with regards to her ability to procreate because she was HIV positive and was unable to find an individual willing to procreate with her. *Id.* Thus, while she had a medical condition, it was more the fact that she could not find a partner to procreate with (indirectly a result of her illness) which made her infertile, not an actual medical condition that prevented her reproductive system from working. In this way, unmarried persons could be argued to be infertile if they cannot find a partner with whom they wish to procreate, or same-sex couples could be viewed as infertile because they are not naturally able to produce children. However, the fact that unmarried persons and same sex couples would not have a medical condition that caused their constructive infertility would likely bar them from protection under the ADA.

qualified individuals with the same disability for which the state is providing services and the fact that they are gay or unmarried does not render these services ineffectual if treatment will work for them. Unlike *Easley*, this reading of the statute does not open the gates for people with other disabilities to be included, but instead solely sticks to the disability of infertility.

As one court put it, the purpose of the ADA is to deal both with invidious discrimination of those with disabilities and also sheer indifference and apathy.¹⁹⁴ States without mandates for the medico-structurally infertile may not have adequately considered their exclusion from coverage because these groups are often not infertile in the same way as the medically infertile. However, the medico-structurally infertile nonetheless benefit from the same treatments and insurance coverage as the medically infertile. Denying them coverage in this way would be akin to denying seeing eye dogs for persons who are blind because of a congenital defect but providing seeing eye dogs to those with trauma-related blindness. If both are equally blind and require the use of a seeing eye dog, then why should the origin of the disability matter? However, in these states, a court may view the difference between medically and medico-structurally infertile individuals more akin to *Easley* because, if the intent of the law was to treat medical infertility, other forms of infertility may alter the nature of the coverage in some way. In this case, the state would need to advance an adequate argument for why this inclusion would go against the purpose of the policy.

For those states which do not have some medical mandate in their statutes, it is less clear what the intent of the laws were and thus it is harder to see whether inclusion of medico-structurally infertile would alter the original purpose of the program. However, the same values and considerations articulated above would apply. While the ADA does not call for similar treatment of all people with different types of disabilities, it does call for similar treatment of persons with the same disability under a given program or policy. Thus there should be equivalent treatment of the same condition of infertility regardless of origin under a given law.

In summary, constitutional and ADA protections in the

194. *Alexander v. Choate*, 469 U.S. 287, 296–97 (1985).

areas of reproductive freedom and assisted reproduction, as well as state-mandated insurance for these treatments, are somewhat complex, unclear, and still developing. While many of the state mandates do not appear to violate constitutional and other legal protections explicitly, there are a few troubling areas. For example, some of the mandates, such as those requiring marriage or those requiring medical or unexplained causes for infertility, may be vulnerable to Equal Protection challenges. Likewise, those statutes that exclude medically-structurally infertile persons may be susceptible to ADA claims. These legal concerns, along with other important ethical and practical considerations discussed in the next section, raise important questions for policymakers, legislators, and academics about the purpose and goal of state-mandated insurance coverage of ART and the role of the state therein.

D. PRACTICAL AND ETHICAL CONSIDERATIONS AND COMPETING INTERESTS IN STATE-MANDATED INSURANCE COVERAGE OF ART

As the catalogue of state mandates that require insurance coverage of ART suggests, though it may be unwritten or often unacknowledged, these statutes mainly intend to promote heterosexual, monogamous, married family development. Between the lines, gay and single persons are excluded from being ensured the same fertility benefits as other individuals. While state statutes may leave out gay and unmarried persons from coverage, these individuals depend on ART to reproduce genetically-related offspring, and ART is growing increasingly popular as a way of making family life possible. However, the issue of state-mandated insurance coverage for infertility, both generally and in the context of gay and unmarried persons, is contextually situated within a number of other concerns such as healthcare justice and resource allocation, religious and political issues, and health insurance purpose and theory. To better understand how best to move forward with addressing the fertility needs of gay and unmarried persons, these factors must be considered.

1. Healthcare Justice and Resource Allocation

There has been much legal, policy, and ethical debate over notions of healthcare justice and equity, particularly in light of recent discussions around universal healthcare and healthcare reform more generally. While a prolonged discussion of healthcare justice is outside the scope of this paper, a few

general principles are important to discuss. Norman Daniels famously stated, “[H]ealthcare was special because of its impact on opportunity” and the “central function of health care is to maintain normal functioning.”¹⁹⁵ “Healthcare preserves. . . the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens . . . in all spheres of social life.”¹⁹⁶ This broad notion of health has been echoed in areas of the law, such as the ADA, where we focus on impairments that limit major life activities rather than just the illness or disease itself.¹⁹⁷ Closely related, if the goals of health policy are to promote “human flourishing,” then health *insurance* should help individuals to “function best, given their circumstances, and thus reduce the vulnerability associated with ill health.”¹⁹⁸

Healthcare justice and distributive justice issues necessarily raise the question of what should be considered healthcare in this context. Narrow definitions of healthcare that rely solely on the disease model fall short in the world of infertility. “[M]ost would acknowledge that bearing and raising children contributes significantly to the parents’ well-being,” and the ability to reproduce for those who wish it is part of “normal species functioning.”¹⁹⁹ Decisions about who can or cannot have access to infertility treatments implicate who will be able to reproduce and bring into the world and raise the next generation, thus touching on major issues of reproductive rights and the government’s role in population control.

Infertility is a complex medical and social condition that can be uniquely a “couple” problem rather than an “individual” problem and which can often have no identified medical cause. As the state mandates themselves suggest, solely linking infertility to a medical cause is problematic. While eight of the fourteen mandates require some type of medical cause of medical necessity, half of these admit that the cause can either

195. Norman Daniels, *Justice, Health, and Health Care*, 1 AM. J. BIOETHICS 2, 2 (2001).

196. *Id.*

197. Americans with Disabilities Act, 42 U.S.C. § 12102 (2006).

198. J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q J. MED 53, 53, 55–57 (2006).

199. Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 177 (2009) (quoting NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 34, 59 (2008)).

be medical *or* unexplained.²⁰⁰ Furthermore, in the context of the structurally and medico-structurally infertile, the division between medically-based and non-medically based infertility seems irrelevant. Medically infertile persons and structurally infertile persons are equally desirous of and dependent on ART to reproduce. If broader notions of health are adopted, the focus should be on impact of the condition on life and functioning, not the disease itself. Thus, the focus should be on the inability to reproduce, regardless of whether it is caused by a medical disease or otherwise. This argument is also in concert with classic theories of healthcare needs and distributive justice, which include “non-medical personal (and social) support services” within the broader definition of healthcare needs.²⁰¹ If the state mandates were solely intended to treat strictly medically-defined models of infertility, then, at a minimum, medico-structurally infertile persons must be covered, even if including gay and unmarried persons may not be required. But because these mandates do cover infertility which has no medical basis, we should consider whether to broaden them under theories of health justice to include unmarried and gay persons because all groups are seeking the same end result of procreation.

John Robertson has also argued that the focus should be on the human interest of reproduction rather than on a strict medical definition. He wrote:

The label of “natural” or “medical” becomes a way to hide a normative judgment about the importance of reproduction to gay and lesbian persons . . . the question then becomes whether unmarried persons, whatever their gender or sexual orientation, have an important human interest or need in reproducing. If they do, then they should not be excluded from ART services provided to others.²⁰²

Alternatively, if state mandates wish to pursue or continue to pursue a more narrow reading of the statutes, then notions of healthcare justice would require that they do so across the board. If medically-derived infertility really does deserve to be

200. These states are Hawaii, Texas, and Maryland. *See supra* Table 2.

201. Norman Daniels, *Health-Care Needs and Distributive Justice*, 10 PHIL. & PUB. AFF. 146, 158 (1981). Daniels uses the analogy of Medicaid to support the notion of broader health needs. If Medicaid is solely intended to promote narrow definitions of healthcare, then funds cannot be used to support abortions. However, if Medicaid “should serve other important goals, like ensuring that poor and well-off women can equally well control their bodies, then there is justification for funding abortions.” *Id.* at 157 n.19.

202. John A. Robertson, *Gay and Lesbian Access to Assisted Reproductive Technology*, 55 CASE W. RES. L. REV. 323, 331 (2005).

prioritized or completely privileged over structural infertility, then legislatures should provide good reasons for why this type of infertility deserves such treatment and how exclusion of structural infertility is justified. Furthermore, any states that allow for any infertility treatment that is non-medical should discontinue doing so. Thus, Hawaii, Maryland, and Texas should discontinue providing services to those who have “unexplained” causes for infertility.²⁰³

Mandated insurance coverage has also raised a number of health justice concerns more generally. Some have argued that state mandates are unjust because they divert scarce health resources to one particular health need.²⁰⁴ Countering this, others argue that insurance coverage to treat infertility should be mandated because insurance companies have adversely selected against it and such mandates are, thus, necessary to widen access to such treatments.²⁰⁵ Others argue that infertility should not be prioritized because it is not a lethal condition, and resources should be prioritized to life-saving treatments.²⁰⁶ In opposition to this, some raise the issue of multiple births explaining that “infertile patients who pay out-of-pocket for these treatments have a financial incentive to achieve pregnancy with their first attempt, and they are often willing to accept the risks associated with a multiple birth in order to maximize their chances of pregnancy.”²⁰⁷ If insurance covers IVF, patients will be more likely to select a procedure

203. See *supra* Table 2.

204. See, e.g., *In Vitro Fertilization*, *supra* note 6, at 2099.

205. See Monahan, *supra* note 199, at 176; *In Vitro Fertilization*, *supra* note 6, at 2099. See Monahan, *supra* note 199, at 176.

206. Hawkins, *supra* note 181, at 224, 225 n.5. In conjunction with this, ART is a challenging endeavor which often requires multiple rounds of treatment in order to achieve a successful live birth. For example, according to a 2007 CDC report, of 101,897 fresh non-donor ART cycles that were started, 29% resulted in a live birth. CTRS. FOR DISEASE CONTROL & PREVENTION, 2007 ASSISTED REPRODUCTIVE TECHNOLOGY REPORT 6 (2009) [hereinafter *CDC ART Report*], available at http://www.cdc.gov/art/ART2007/PDF/COMPLETE_2007_ART.pdf.

207. Hawkins, *supra* note 181, at 223. In 2003, 34% of all live births conceived via IVF were multiples compared with 3% in the general population. *Id.* at 222. “A study published in the *New England Journal of Medicine* found that the number of embryos transferred per IVF cycle was lower in states that required complete coverage of IVF than in states that mandated partial or no coverage. Consequently, the states with mandated coverage had a lower percentage of pregnancies of triplets or more than in the other states.” *Id.* at 223–24.

based on safety than on finances, thus reducing the harms associated with multiple births, including premature labor, hypertension, hemorrhage, and gestational labor for the mother and various physical, developmental, and mental disabilities or death for the child.²⁰⁸

At the core of this debate is the issue of how best and how justly to allocate scarce medical resources. It is important to note, first, that there is a huge and central debate about focusing on infertility as a primary area for allocating scarce health resources. This paper does not discuss whether it is ethical, just, or practical even to allocate resources for fertility treatment over other health treatments. Instead, it suggests that, if society wishes to allocate these resources in such a manner, it is problematic from a legal, ethical, and health-justice perspective to do so only for heterosexual married couples. Even if inclusion of gay and unmarried persons increases that wedge of health resources, it is important that health goods be distributed based on fair distributive justice concerns, not based on social characteristics. Thus, if the allocated health goods are too great, limitations should be set in other manners.

For example, ART could be prioritized to those people who have the greatest need—perhaps because they have fewer reproductive years remaining or do not have any other children. Alternatively, one could argue that it is preferable to give a larger number of persons an opportunity and to provide a capped service based on price or number of cycles.²⁰⁹ Under this argument, single women and lesbians may be prioritized over others because of the low cost of artificial insemination compared to ART.

The source of funding for mandatory coverage of ART is also important. For the most part, current mandates require that insurance companies either offer or provide coverage, thus placing the expense on the insurer and, in turn, the insured via premiums. However, a few states have begun efforts to fund infertility treatment through state-funded health insurance as well. For example, Massachusetts has included infertility related costs in its MassHealth comprehensive family planning

208. *Id.* at 222.

209. This of course is a version of utilitarianism prioritizing the greatest good to the greatest number of people.

services for those who qualify by income.²¹⁰ New York has also initiated a “grant program to improve access to infertility services” which is funded by the tobacco control and insurance initiatives pool.²¹¹ Making use of taxpayer dollars to fund infertility treatments may argue for a larger legislative and taxpayer debate around who should be prioritized by these funds.

2. Health Insurance Theory and Purpose

State-mandated insurance and coverage for structural infertility also implicates issues of the purpose of health insurance and the theories supporting it. The basic tenets of health insurance involve the transfer of risk from those individuals with high healthcare costs to a large pool of low-risk insured who pay premiums to compensate for losses.²¹² While scholars have debated in recent years as to the extent to which people make insurance choices based on risk-aversion versus income-loss, health insurance involves, at its core, the spreading of financial losses associated with healthcare across broader pools of persons rather than concentrating those costs on single individuals.²¹³

Within the broader context of insurance, mandated insurance coverage for infertility has unique implications. Mandated insurance coverage may lead to higher utilization which could, in turn, lead to better quality and reduced cost, thus helping the structurally infertile to gain access even where they are excluded from coverage.²¹⁴ However, there is also a concern that mandates may raise insurance premiums. Here, estimates of premium increases vary significantly, with some studies approximating lower increases ranging from \$2.79 to \$27.00 per member per year while other studies project larger increases such as \$105 to \$175 per member per year.²¹⁵

210. *An Act Maximizing Federal Reimbursement for Family Planning Services*, MASS. ACTS 596 (2005).

211. N.Y. PUB. HEALTH LAW § 2807-v(jj) (McKinney 2010).

212. HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 572 (Barry F. Furrow et al. eds., West Group 5th. ed. 2001); Ruger, *supra* note 198, at 53–54.

213. John A. Nyman, *Health Insurance: The Case of the Missing Welfare Gain*, 9 EUR. J. OF HEALTH ECON. 369, 380–381 (2008), available at <http://www.aria.org/rts/proceedings/2005/Nyman%20-%20Vanishing.pdf>; Ruger, *supra* note 198, at 53; .

214. See *In Vitro Fertilization*, *supra* note 6, at 2099.

215. One scholar estimates a \$7.20 to \$27.00 per member per year raise.

If inclusion of ART in insurance policies does, indeed, raise premiums, then there is an additional justice concern raised because gay and unmarried persons would be paying increased premiums for a healthcare option that they want but are not permitted to access under the plan. Admittedly, while insured people cannot opt out of all undesirable situations, say for example the case where a non-smoker has to pay larger premiums due to smokers in his insurance pool, this is a different case.²¹⁶ In the smoker case, the non-smoker is not being denied access to the same care as the smoker, he simply does not need it. If he, too, were to later need lung cancer treatment, as an example, it would be available to him in the same way as the smoker. In the case of gay and unmarried persons, and particularly medico-structurally infertile persons, they are potentially paying higher premiums for a procedure which others are accessing and which they also want but are denied. Just as some people have argued that it is unjust to expect infertile persons to pay premiums that cover childbirth for fertile persons (thus justifying mandated insurance coverage of ART more generally), so too is it unjust to require gay and unmarried persons to pay premiums to support state-mandated ART without being able to access these benefits.²¹⁷

Rationales for mandating insurance coverage of ART for heterosexual married persons remain the same for gay and unmarried persons. One author argued that there is a justice claim generally which calls for insurance mandates covering ART because it would (1) eliminate adverse selection where insurers avoid covering infertility and, instead, allow infertility risk to be pooled across a larger population, (2) reduce suboptimal utilization of ART, thus reducing risk of high order multiple births, and (3) benefit infertility patients and the children resulting from these treatments while likely harming

Monahan, *supra* note 199, at 174. Another study, however, estimates the added cost to a standard benefits plan to be only \$2.79 per year. Ringo, *supra* note 16, at 880. Yet another study “found that even if utilization of IVF rose 300% as a result of the procedure being covered by insurance, premiums would only increase about nine dollars (\$9) per employee per year.” Hawkins, *supra* note 181, at 221. The National Center for Policy Analysis projects one of the larger increases at \$105–\$175. John Goodman & Merrell Matthews, *The Cost of Health Insurance Mandates*, NAT’L CTR. FOR POL’Y ANALYSIS (Aug. 13, 1997), available at <http://www.ncpa.org/pub/ba237>.

216. *In-Vitro Fertilization*, *supra* note 6, at 2099.

217. See Monahan, *supra* note 199, at 176 (arguing that it is unjust to require infertile people to pay for insurance).

individuals unaffected by infertility minimally.²¹⁸ The author admitted that there may be a risk for moral hazard where a larger group of persons unlikely to benefit from ART may attempt cycles, but thought this could be minimized by concentrating efforts towards those who were most likely to have successful ART cycles.²¹⁹ In the instance of state-mandated coverage for the structurally-infertile, the arguments in favor of mandates remain the same. They too would experience minimized adverse selection, would have the choice to opt for lower-risk but more expensive technologies that reduce multiple birth risks, and they would benefit in the same manner as described for heterosexual married persons. In addition, because many of the unmarried or gay persons using ART would not have medically-problematic reproductive issues, their chances of success with ART cycles would likely be higher and, in many instances, less expensive, thus reducing moral hazard concerns.

Another insurance issue particular to same-sex couples is the lack of availability of domestic partner benefits prevalent throughout the country. Even if state-mandated insurance can be construed or even altered to protect gay persons, many same sex couples find it difficult to find health plans that cover their partners. A 2007 poll quotes 20% of persons in same-sex couples as being uninsured as compared with 11.5% of married individuals.²²⁰ In a poll of 402 of the Fortune 500 companies, 342 offered domestic partner health benefits, with 210 of these companies located in a state that offers mandated coverage of ART.²²¹

218. The author argued that individuals who were infertile would naturally benefit from mandated insurance because it would make fertility treatment more available to them. Additionally, risk to children would be lessened because the reduced risk of multiple births that occur where patients can choose less risky, more expensive ART, rather than opting for low-cost, high-risk procedures. *Id.* at 181–83. For fertile persons, the concern was that increased premiums may cause some individuals to lose insurance, though the author expected this figure to be low and arguably outweighed by the benefits to the infertile individuals and children. *Id.*

219. The concept of moral hazard, more specifically, worries that individuals will expose themselves to greater risks because they have less fiscal responsibility for the results. *See id.*

220. Michael Ash & Lee Badgett, *Separate and Unequal: The Effect of Unequal Access to Employment-Based Health Insurance on Same-Sex and Unmarried Different Sex Couples*, 24 CONTEMP, ECON. POL'Y 582, 588 (2007).

221. Ringo, *supra* note 16, at 884.

3. Political, Religious, and Social Issues

The battle over whether to include the structurally infertile in mandated insurance coverage of infertility is situated within a much broader discussion centering on the political rights of gay and unmarried persons, religious and political views on ART and gay marriage, and the historic battle over parental rights of gay and unmarried persons, among other issues. This paper does not begin to attempt to summarize the complex social, religious, and political pressures that impact legislation around this issue, but only raises a few of the important and relevant issues and concerns.

Although beliefs vary by different faiths, religious disapproval generally exists against homosexuality, procreation outside of marriage, and ART itself. Catholic teachings, for example, hold that “procreation should only occur in the sanctity of a marriage between a man and a woman.”²²² This belief makes procreation without intercourse problematic, as well as procreation of unmarried individuals, whether single or gay. The Jewish faith, in general, is more accepting of ART. However, when ART is used by lesbians or unmarried women, the resulting children can be considered illegitimate.²²³ Further, artificial insemination is considered immoral because of the implied need for male masturbation.²²⁴ Protestant views on ART vary widely, and Islamic views (in Iran at least) do not “restrict access to ARTs . . . for married, heterosexual couples,” but withhold ART for same-sex couples and single women because they view reproduction by those groups as undesirable.²²⁵ The general religious disfavor of ART, homosexuality, and procreation outside of marriage may have significant impact on laws and public policy, along with societal views on these practices.

In conjunction, it is important to note that some of the states mandating insurance coverage for infertility have created statutory protections that allow religious institutions to opt out of coverage²²⁶ that is “inconsistent with the religious

222. DeLair, *supra* note 33, at 154.

223. *Id.* at 155–56

224. *Id.* at 155–56; Rank, *supra* note 7, at 124.

225. Rank, *supra* note 7, at 123–24.

226. Among states providing religious exemption are California, Connecticut, Maryland, New Jersey, and Texas. *NCSL, supra* note 67.

organization's religious and ethical principles."²²⁷ Given some of the religious views discussed above, it would not be surprising if religious institutions frequently used these statutory protections as a means of avoiding coverage of ART. However, it is unclear if institutions have attempted to avoid coverage of ART for a structurally infertile person. Interesting civil rights and religious rights issues may be raised if a legal challenge was brought on behalf of a gay or unmarried person because a religious institution was denying ART specifically to him or her under one of these mandates. Though this is outside the scope of this paper, it is an important area for future research and attention.

In line with religious objections, there is also the possibility that personal prejudice or religious views of physicians will have an impact at the level of healthcare delivery. One California case, *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*, struggled with this issue.²²⁸ A physician in the medical group denied Ms. Guadalupe Benitez, a lesbian, access to intrauterine insemination for her and her partner based on religious objections.²²⁹ The California Supreme Court held that the First Amendment right of free exercise of religion did not guarantee a right to deny fertility treatment based on sexual orientation.²³⁰ Other states have not yet begun to deal with this issue in their court systems, but the case highlights another area where structural infertility may be impacted. In line with this concern, a study published in 2005 suggested that fertility clinics believe that it is part of their role to screen

227. CAL. HEALTH & SAFETY CODE §1374.55 (West 2008). *Accord* CONN. GEN. STAT. § 38a-536 (West 2007) (allowing exemption for "treatment[s] of infertility that are contrary to the religious employer's bona fide religious tenets"); OHIO REV. CODE ANN. § 1751.01 (LexisNexis 2009) (requiring health maintenance organizations to cover "basic health services" which include "infertility services").

228. *N. Coast Women's Care Med. Group, Inc. v. San Diego Cnty. Superior Court*, 189 P.3d 959 (Cal. 2008).

229. *Id.* at 963-64.

230. *Id.* at 967 ("Here, defendant physicians contend that exposing them to liability for refusing to perform the IUI medical procedure for plaintiff infringes upon their First Amendment rights to free speech and free exercise of religion. Not so. As we noted earlier, California's Unruh Civil Rights Act imposes on business establishments certain antidiscrimination obligations, thus precluding any such establishment or its agents from telling patrons that it will not comply with the Act.").

potential ART recipients for parental fitness.²³¹ Clinics stated numerous considerations and reasons for turning away certain candidates. Twenty percent of clinics said they would turn down a woman who wanted to parent singly; fifty-three percent said they would turn down a single man; and forty-eight percent reported being unwilling or unlikely to provide treatment to a gay couple wanting to use surrogacy with one of the men as a sperm donor.²³² If the structurally infertile are included in state-mandated insurance coverage, extra care will need to be taken to ensure that they are not excluded from access at the patient-provider level for religious or personal views.

The state-mandates themselves also raise some clear practical issues with respect to implementation and application. For example, to whom must it be ultimately proven that an individual has engaged in unprotected intercourse for the required amount of time, and how can this fact be verified? Likewise, what are the implications of such a requirement for the transmission of sexually transmitted infections? How frequently and how monogamously does one have to engage in unprotected intercourse to qualify under such a mandate? Additionally, it may be very difficult for medico-structurally infertile persons to prove medical infertility or know that they are medically infertile if they engage in same-sex intercourse or are abstinent. Similarly, how must one prove a number of years of infertility, whether it be medically or structurally based, what should fall under the heading of medically necessary in this arena, and who should decide? Though specific requirements in the statute may be necessary to prioritize limited resources and to ensure that those with the greatest need receive appropriate care, many of the current requirements are difficult to prove, ambiguous, and may potentially cause public health concerns.

Insurance coverage of ART for structurally infertile persons under state mandates is affected by a number of other factors. Gay marriage, religious objections, child welfare and custody, among many other considerations, all play into the

231. Mary Crossley, *Dimensions of Equality in Regulating Assisted Reproductive Technologies*, 9 J. GENDER RACE & JUST. 273, 275 (2005); Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 63 (2005).

232. Crossley, *supra* note 231, at 275–76; Gurmankin, *supra* note 231, at 65.

debate around whether gay and unmarried persons should have access to ART and whether insurance should cover it. Notions of health justice support providing some type of coverage of ART for the structurally infertile,²³³ but the complex interplay between political and social issues, as well as insurance theory and healthcare allocation, raises the challenging question of how best to distribute and ensure access to ART for the structurally infertile. The next section will explore some of the benefits and drawbacks of possible mechanisms of distribution.

V. PROPOSALS FOR DISTRIBUTION AND CONCLUSION

The issue of assisted reproduction and insurance is still alive and well. Currently, only fourteen states have provided some form of mandate that insurance cover ART, and no federal laws regulate the issue of whom does or does not have access to these technologies.²³⁴ Thus, there is large space for policy to still develop and change in this area. Three potential models and their benefits and drawbacks will be discussed as possible mechanisms for remaining states to consider broadening access to ART.

A. TAX REBATES

Under the tax deduction proposal, costs of assisted reproductive technologies can be declared under section 213 of the Internal Revenue Code, the medical expense deduction, and can be deducted from one's federal income tax.²³⁵ Under the current statute, "a taxpayer may claim unlimited expenses for fertility technology, but only if the taxpayer can afford to spend over 7.5% percent [sic] of his or her income on such treatment."²³⁶ Not much is known about the implications of a tax credit in this situation as the proposal to use tax credits for these purposes is fairly new. However, from a theoretical perspective, the tax deduction proposal has a number of anticipated benefits as well as a few drawbacks. This proposal presumably rids the system of bias based on sexual orientation or marital status and instead allows for all persons interested

233. Monahan, *supra* note 199, at 178–79.

234. NCSL, *supra* note 67.

235. Ringo, *supra* note 16, at 887.

236. Benjamin, *supra* note 57, at 1140.

in using ART to deduct expenses, thus eliminating issues of health injustice. It also resolves the issue that many gay people do not have domestic partner benefits because, under the tax deduction proposal, one partner can deduct expenses on his or her taxes, regardless of insurance status.²³⁷ However, it does not resolve issues at the provider-patient level. Though the tax deduction method also widens the ability for some to access ART, it does not provide further options for those who lack the finances to pay up-front costs for ART.²³⁸

Due to the tax deduction model's inability to cover up-front costs combined with the high cost of ART, for some people, whether medically or structurally infertile, issues of access would not be resolved. For lesbians and single women, the model may be ideal because the procedures sought, such as artificial insemination, are inexpensive, but this method is not helpful if multiple attempts are needed.²³⁹ Also, for the medico-structurally infertile or for single or gay men who need more expensive interventions, having to front-load several tens of thousands of dollars likely means that access will not be possible.²⁴⁰ According to one commentator, "This perhaps explains the heavy emphasis on insurance in debates about assisted-reproduction finance."²⁴¹ While further research into this area is important, it will be crucial to determine if there is a manner to manage front-loaded costs of ART within this system.

B. INSURANCE MANDATES

As insurance mandates currently stand, they result in inequitable distribution of resources by prioritizing all fertility treatments to heterosexual married couples and excluding access primarily for gay and unmarried persons with or without medical causes of their infertility. While the current structure of state mandates poses some legal issues and health justice problems, the idea of state-mandated insurance for ART is not in and of itself *inherently* inequitable. Insurance mandates could result in more equitable distribution of resources, but a number of considerations must be addressed.

237. Ringo, *supra* note 16, at 887.

238. Jacoby, *supra* note 42, at 152.

239. DeLair, *supra* note 33, at 160–61.

240. *Id.*

241. Jacoby, *supra* note 42, at 152.

Both internal and external exclusionary factors, as discussed in previous sections, need to be explored in greater detail to determine their impact on different groups.

With respect to some of the external factors discussed previously, a mandate to offer rather than a mandate to cover, as seen in California and Texas, could lead to greater equity.²⁴² It would give everyone, regardless of marital status or sexual orientation, the ability to bargain for ART if it is important to them and, if desired, to pay the resulting insurance premiums for such treatments. It would also likely reduce costs of ART overall given the presumably higher use of ART throughout the country, which could potentially increase access for individuals who either lack insurance or live in states without mandated insurance. However, because insurance companies would only be required to offer but not to provide coverage, there is a possibility that a smaller pool of persons will be willing to buy infertility coverage.²⁴³ This will make premiums higher²⁴⁴ and possibly too expensive for many to afford.

Other external factors utilized in state-mandated insurance coverage could also expand access to gay and unmarried persons and resolve healthcare justice issues. Caps on the amount of money available for ART or on the number of procedures are limits which could give everyone an opportunity to procreate via ART without limiting access for gay and unmarried persons.²⁴⁵ Of course, this type of limit would restrict coverage of ART overall; thus, some individuals who would require multiple rounds of IVF (for example, due to older maternal age or severe fertility disorder) may not be able to achieve a live birth before they have run out of their allotted funds. However, this approach provides a larger number of people with at least some opportunity to attempt to procreate, and there are no guarantees that ART will achieve pregnancy

242. California: “every health care service plan . . . shall offer coverage for the treatment of infertility, except in vitro fertilization,” CAL. HEALTH & SAFETY CODE § 1374.55 (West 2008); Texas: “an issuer of a group health benefit plan that provides pregnancy-related benefits . . . shall offer and make available . . . coverage for . . . expenses incurred . . . from in vitro fertilization procedures.” TEX. INS. CODE ANN. art. 1366.003 (West 2009). *See generally* NCSL, *supra* note 67 (listing the insurance coverage laws for infertility applicable to each state).

243. *In-Vitro Fertilization*, *supra* note 6, at 2100.

244. *Id.*

245. *See* statutes cited *supra* note 71.

for everyone anyway. Furthermore, limits like the ones in New Jersey and Illinois, which require that an individual go through the most inexpensive treatments first, could help to broaden access without harming the structurally infertile.²⁴⁶

Additionally, as the section on legal analysis suggests, there are some internal factors within the statutes that are more desirable than others with respect to the needs of the structurally infertile and medico-structurally infertile. For example, requirements of a stated period of infertility or even unprotected intercourse for a period of time are not problematic if they are adapted to include the structurally and medico-structurally infertile. So long as gay and unmarried persons can prove structural infertility without having to engage in unprotected sex, there is no public health concern nor are there the wasted resources of attempting to prove medical infertility for someone who does not have medically-related complications.

Spousal language is not advisable due to its exclusion of most groups of structurally and medico-structurally infertile regardless of medical cause and its potential resulting legal issues. Issues of medical causality or medical necessity are interesting and more complex. While they, without a doubt, do not exclude medico-structurally infertile, the issue is much less clear for structurally infertile persons. While there is an argument to be made on either side as to whether structural infertility is a health issue (which greatly depends as previously discussed on how broadly one defines health), it is not clear that the medical cause is what we are concerned about. As discussed earlier, the real toll to society from infertility seems to be the infringement of the rights of individuals to become parents, which is viewed as a life achievement, and this argument holds true regardless of whether one is speaking of heterosexual married couples or not.²⁴⁷

Additionally, it is unclear whether it is desirable to attach a medical diagnosis and the related social and other implications to structural infertility. Some have encouraged a medicalized model of infertility covered by insurance. Such a model can reduce other inequities, such as financially helping those infertile individuals who go into debt in trying to finance their pregnancies. It could also create standards for “what

246. See statutes cited *supra* note 72.

247. Monahan, *supra* note 199, at 176.

kinds of fertility treatments make sense²⁴⁸ and which do not²⁴⁹ while also eliminating use of ART by heterosexual couples that do not need the technology to reproduce. However, in some ways, medicalizing may attach a medical diagnosis stigma to sexual orientation or marital status. Further research and discussion is needed in this area. At the outset, it seems more logical to expand these types of statutes to call for infertility, whether medical or structural, because it is an important social desire rather than just linked to medical conditions and not the other way around. Such a definition would also eliminate those instances where medical cause cannot be found. Furthermore, these concerns can be addressed in statutory language that does not, in a broad stroke, exclude whole groups of people that depend on these technologies.

Given both options, the better practice appears to be a state-mandated insurance schematic that uses external factors rather than internal factors to limit coverage and that does not make resource allocation decisions based on sexual orientation or marital status alone. Legislatures are encouraged to consider what types of external factors, such as treatment amount and dollar limits, could provide the most just and practical limits on care while ensuring broad access and successful outcomes. Mandates to offer rather than cover may be good options, along with caps on total amount per person or limits on the number of ART cycles per patient. Additionally, if internal factors are used, careful consideration should be given to whether medical definitions are necessary and, if so, to what purpose. Furthermore, spousal language is discouraged, and, where structural infertility can be shown, requirements of unprotected intercourse are also problematic. Additionally, legislatures must consider the broader context in which state-mandated insurance coverage for ART is placed. Widened access for gay and unmarried persons is not beneficial if issues of parental custody and domestic partner benefits are not resolved in this context. Furthermore, as outlined in this paper, legislatures must keep in mind the legal limitations raised by the Fourteenth Amendment and ADA claims in particular.

It is also important to note that this discussion of possible mechanisms of distribution is not intended to be exhaustive.

248. Spar & Harrington, *supra* note 5, at 68.

249. *See id.*

Certainly, other models of access could be proposed such as a hybrid-model or a social-welfare model, which treats ART more like a social issue (like food, housing, or shelter). Further research and policy development in this area is important, as is more empirical work into the implications—financial, social, and otherwise—of state-mandated insurance coverage of ART in the context of married heterosexual persons as well as the structurally and medico-structurally infertile.

As the title insinuates, regulation of ART and deciding who receives it is truly an art and not a science. Balancing the interest of the broad host of individuals who desire ART and prioritizing needs at the same time will require much innovation. The issue of ART and who receives ART touches upon some of the most significant legal, ethical, moral, and political questions of our time. ART holds the potential for a wide variety of people to create families, who previously could not, and this group includes those who are unmarried or gay. ART, state-mandated insurance coverage of ART, and access and coverage of insurance for gay and unmarried persons, challenge the boundaries of law, medicine, and ethics. These issues also touch on a foundational question of the state's role when deciding whether to ensure or prevent the reproductive potential of individuals and groups. Such dialogue cannot be entered into lightly, and, as the debate around distribution and prioritization of ART continues, it will be important to critically analyze both the potential and limitations of state-mandated insurance coverage for ART in current and future forms and the goals which it seeks to address.