

## Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments

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### INTRODUCTION

Affecting 7.1% of married couples,<sup>1</sup> infertility interferes with a couple's ability to participate in "one of the most fundamental and highly valued human activities—building a family."<sup>2</sup> Infertility is a "major life crisis"<sup>3</sup> and can cause depression and feelings of anger, frustration, and helplessness.<sup>4</sup> Moreover, couples who experience infertility often isolate themselves from their friends, families, and society at large in order to avoid being reminded of their inability to conceive.<sup>5</sup> Fortunately, improvements in infertility treatments are making it possible for more infertile couples to have a child.<sup>6</sup>

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1. JOYCE C. ABMA ET AL., U.S. DEP'T HEALTH & HUMAN SERVS., SER. 23, NO. 19, FERTILITY, FAMILY PLANNING, AND WOMEN'S HEALTH: NEW DATA FROM THE 1995 NATIONAL SURVEY OF FAMILY GROWTH 7 (1997).

2. DIANE ARONSON, RESOLVING INFERTILITY 5 (1999).

3. Howard W. Jones & James P. Toner, *The Infertile Couple*, 329 NEW ENG. J. MED. 1710, 1712 (1993).

4. See Diana C. Parry, *Women's Leisure as Resistance to Pronatalist Ideology*, 37 J. LEISURE RES. 133, 135 (2005).

5. See, e.g., Keith Alan Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*, 18 J. LEGAL MED. 265, 271 (1997); Katherine T. Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1129 (2004) (discussing how others have difficulty understanding a couple's experience with infertility, which adds to the couple's sense of isolation); Gary Rotstein, *Infertile Couples Face a Maze of Hope, Strain, and Science*, PITTSBURGH POST-GAZETTE, Apr. 26, 1998, at A1 (describing couples' experiences with infertility).

6. See *infra* notes 35–37 and accompanying text.

Despite the increasing use<sup>7</sup> and success<sup>8</sup> of infertility treatments, only 25% of employers provide coverage of infertility treatments in their health plans.<sup>9</sup> The high costs associated with infertility treatments often prevent couples from utilizing these services. Infertile couples often are forced to incur substantial debt for the chance of having a family.<sup>10</sup> Thus, finances—not medical indications—frequently control a couple's treatment choices.<sup>11</sup>

Although the American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and Gynecologists (ACOG) have both recognized infertility as a disease that results in the abnormal function of the reproductive system,<sup>12</sup> Congress has failed to treat infertility as such and has not mandated health insurance companies to include coverage of infertility treatments in their policies.

Part I of this Note discusses the causes and treatments of infertility. Part II analyzes infertility with respect to the Americans with Disabilities Act (ADA) and the Pregnancy Discrimination Act (PDA). Part III surveys current state law mandating coverage of infertility treatments and its inadequacies. Part IV examines arguments proposed in support of and in opposition to legislation

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7. From 1996 to 2003 the number of Assisted Reproductive Technology (ART) cycles performed in the United States nearly doubled. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2003 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES 55 (2005) [hereinafter CDC SUCCESS RATES], available at <http://www.cdc.gov/ART/ART2003/pdf/ART2003.pdf>.

8. "The number of live-birth deliveries in 2003 [from the use of ART] (35,785) was about two and a half times higher than in 1996 (14,507)." *Id.*

9. Shorge Sato, Note, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 189, 197 (2001) (data from 1997 study). However, the majority of those plans limited their coverage to a small number of treatments. *Id.*

10. See Liza Mundy, *A Special Kind of Poverty*, WASH. POST MAG., Apr. 20, 2003, at W8; Rotstein, *supra* note 5; Adam Sonfield, *Drive for Insurance Coverage of Infertility Treatment Raises Questions of Equity, Cost*, GUTTMACHER REP. ON PUB. POL'Y, Oct. 1999, at 4, available at <http://www.guttmacher.org/pubs/tgr/02/5/gr020504.pdf>; see also Cintra D. Bentley, Note, *A Pregnant Pause: Are Women Who Undergo Fertility Treatment to Achieve Pregnancy Within the Scope of Title VII's Pregnancy Discrimination Act?*, 73 CHI.-KENT L. REV. 391, 395 (1998) ("For infertile couples, the chance to have a child has suddenly become no longer a right, but a privilege.").

11. Bradley J. Van Voorhis et al., *Cost-Effective Treatment of the Infertile Couple*, 70 FERTILITY & STERILITY 995, 995 (1998).

12. See Definition of "Infertility," 82 FERTILITY & STERILITY S206, S206 (Supp. 2004); RESOLVE, Fast Facts About Infertility, [http://www.resolve.org/site/PageServer?pagename=fmed\\_mcff\\_ffii](http://www.resolve.org/site/PageServer?pagename=fmed_mcff_ffii) (last visited Jan. 20, 2007).

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mandating insurance companies to include infertility treatments in their coverage. This analysis includes a discussion of the costs of providing infertility treatments, the incidence of multiple births among patients utilizing assisted reproductive technologies (ART), and issues concerning the fairness of insurance coverage. This Note concludes that the Family Building Act of 2005,<sup>13</sup> a federal mandate requiring insurance companies to cover the costs of infertility treatments, should be enacted.

## I. THE PROBLEM OF INFERTILITY

Defined as “a disease of the reproductive system that impairs the body’s ability to perform the basic function of reproduction,”<sup>14</sup> infertility affects approximately 6.1 million Americans of reproductive age, or roughly about one in ten couples.<sup>15</sup> In terms of diagnosis, infertility is considered the inability to conceive after one year of unprotected sexual intercourse.<sup>16</sup> Infertility occurs equally in men and women,<sup>17</sup> with male factors and female factors each accounting for about one-third of infertility problems.<sup>18</sup> Approximately 10% of infertility cases are caused by a combination of male and female factors, while the remaining 20% of cases are unexplained.<sup>19</sup>

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13. Family Building Act of 2005, H.R. 735, 109th Cong. (2005).

14. American Society for Reproductive Medicine, Frequently Asked Questions About Infertility, <http://www.asrm.org/Patients/faqs.html> (last visited Oct. 22, 2006).

15. SERONO INT’L, INFERTILITY FACTS AND FIGURES 1 (n.d.), <http://www.fertilitylifelines.com/media/index.jsp> (follow “Infertility Facts and Figures” hyperlink) (last visited Oct. 22, 2006); see also ARONSON, *supra* note 2, at 3.

Infertility affects about 10% of the American population, striking people of all races, ethnicities, and socioeconomic levels. *Id.* Of the sixty million women of reproductive age, 15% have had an infertility-related medical appointment during their lifetime. ABMA ET AL., *supra* note 1, at 7.

16. See AM. SOC’Y FOR REPROD. MED., INFERTILITY: AN OVERVIEW 3 (2003), available at [http://www.asrm.org/Patients/patientbooklets/infertility\\_overview.pdf](http://www.asrm.org/Patients/patientbooklets/infertility_overview.pdf). Sixty percent of couples with normal functioning reproductive systems will conceive after six months of unprotected intercourse without medical assistance. See RESOLVE, *supra* note 12.

“Secondary infertility” is defined as the inability to become pregnant, or to carry a pregnancy to term, following the birth of one or more biological children. ARONSON, *supra* note 2, at 317.

17. American Society for Reproductive Medicine, *supra* note 14.

18. *Id.*

19. See *id.*

In both men and women, infertility is generally caused by hormonal imbalances, structural damage to the reproductive organs, or both.<sup>20</sup> Male infertility is often the result of problems with sperm production or sperm delivery.<sup>21</sup> For females, ovulation or hormonal disorders such as irregular periods or decreased ovulation can cause infertility.<sup>22</sup> Pelvic inflammatory disease or endometriosis can cause blocked fallopian tubes which also affect women's fertility.<sup>23</sup> Fertility also decreases with age:<sup>24</sup> lifestyle factors, such as an unhealthy body weight, sexually transmitted disease, and the use of alcohol, tobacco, or illegal drugs may impair both men's and women's fertility.<sup>25</sup>

#### *A. Treatment of Infertility*

While there are many ways to treat infertility, conventional treatments, such as medication to return male and female hormones to normal levels and surgery to repair reproductive organs, are successful for 85% to 90% of infertile couples.<sup>26</sup> More sophisticated procedures are available for couples who are unable to conceive using conventional therapies. Intrauterine insemination (also called artificial insemination) is a non-surgical procedure in which a woman is injected with prepared sperm during ovulation.<sup>27</sup> “[A]ll fertility

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20. See ARONSON, *supra* note 2, at 89–174.

21. See American Society for Reproductive Medicine, *supra* note 14.

22. ARONSON, *supra* note 2, at 89.

23. American Society for Reproductive Medicine, *supra* note 14.

24. See generally AM. SOC'Y FOR REPROD. MED., AGE AND FERTILITY: A GUIDE FOR PATIENTS (2003), available at <http://www.asrm.org/Literature/patient.html> (follow “Age and Fertility” hyperlink) [hereinafter ASRM GUIDE]. A healthy thirty-year-old woman has about a 20% chance of becoming pregnant each month. *Id.* at 3. However, after age forty, her chance drops to 5% per month. *Id.* This decline is due to a combination of factors. As a woman ages the number, quality, and fertility of her eggs decline. Byers, *supra* note 5, at 269. Furthermore, older women experience increased rates of ovarian dysfunction, uterine dysfunction, and chromosomal abnormalities in their eggs. See ASRM GUIDE, *supra*, at 1–7. Although the decrease is not as dramatic as it is for women, men also experience changes in their fertility as they age. *Id.* at 7.

25. See ARONSON, *supra* note 2, at 234, 242–46. Occupational and environmental risks, such as mental stress and exposure to radiation, can also impact one's fertility. See *id.*; see also RESOLVE, THE IMPACT OF ENVIRONMENTAL FACTORS, BODY WEIGHT & EXERCISE ON FERTILITY, <http://www.resolve.org/site/DocServer/EnvironmentalFactors.pdf> (discussing the effects of environmental toxins on fertility).

26. American Society for Reproductive Medicine, *supra* note 14; see also Bonny Gilbert, Note, *Infertility and the ADA: Health Insurance Coverage for Infertility Treatment*, 63 DEF. COUNS. J. 42, 42–43 (1996) (discussing the use of drug therapy and surgery to treat infertility).

27. RESOLVE, Understanding Infertility Treatment Options: IUI, <http://www.resolve.org/>

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treatments in which both eggs and sperm are handled”<sup>28</sup> are assisted reproductive technologies. The most widely used ART,<sup>29</sup> in vitro fertilization (IVF), “[i]nvolves extracting a woman’s eggs, fertilizing the eggs in the laboratory, and then transferring the resulting embryos into the woman’s uterus . . . .”<sup>30</sup>

The cost of infertility treatment varies, depending on the cause of the infertility and the therapy. One month of prescription medications to stimulate ovulation in a woman can cost anywhere from \$40 to \$5000, excluding the costs of monitoring the effects of these drugs and other medications often taken in conjunction with these drugs.<sup>31</sup> ARTs, however, are much more expensive—often costing more than \$10,000 per cycle.<sup>32</sup> In addition, patients who choose ovulation-stimulating drugs or an ART procedure typically undergo numerous cycles before becoming pregnant and carrying a child to term.<sup>33</sup> Few couples have to resort to ART and therefore, “[w]hile IVF and other assisted reproductive technologies are not inexpensive, they account for only three hundredths of one percent (0.03%) of U.S. health care costs.”<sup>34</sup>

The use and success of infertility treatments are steadily increasing. Between 1996 and 2003, the number of ART cycles performed each year doubled.<sup>35</sup> One in every one hundred infants

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site/PageServer?pagename=lm\_wamo\_IUI (last visited Oct. 22, 2006). Intrauterine insemination (IUI) is often an appropriate treatment for couples with “unexplained infertility, minimal male factor infertility, and women with cervical mucus problems. . . . [It] is often done in conjunction with ovulation-stimulating drugs.” *Id.* IUI should not be used if a woman’s infertility is caused by a structural problem that has not been corrected with surgery. ARONSON, *supra* note 2, at 145.

28. CDC SUCCESS RATES, *supra* note 7, at 3. During IUI, only sperm is handled. ARONSON, *supra* note 2, at 145.

29. Other types of ART include gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). *Id.* During GIFT, unfertilized eggs and sperm are transferred to a woman’s fallopian tubes. *Id.* ZIFT involves fertilizing a woman’s eggs in the laboratory then transferring the eggs into her fallopian tubes. *Id.*

30. *Id.* Through the end of 2002, IVF accounted for 99% of ART procedures. American Society for Reproductive Medicine, *supra* note 14.

31. See Pratt, *supra* note 5, at 1135; Michele St. Martin, *Fertility Drugs: Are They Right for You?*, PRECONCEPTION, n.d., <http://preconception.com/resources/articles/fertdrugs.htm>.

32. See Sonfield, *supra* note 10, at 4.

33. In 2000 the average live delivery rate for IVF was 29.9% per cycle. American Society for Reproductive Medicine, *supra* note 14; see also ARONSON, *supra* note 2, at 303.

34. American Society for Reproductive Medicine, *supra* note 14.

35. See CDC SUCCESS RATES, *supra* note 7, at 55. In 2003 122,872 ART cycles were performed, compared to 64,681 cycles in 1996. *Id.*

born in the United States in 2002 was conceived with the use of ART.<sup>36</sup> In fact, IVF has a higher success rate than natural conception. In 2000 IVF's average of live birth deliveries per cycle was 29.9%, while a reproductively healthy couple has a 20% chance in any given month of becoming pregnant and carrying the baby to term.<sup>37</sup>

## II. APPLICATION OF THE ADA AND PDA TO INSURANCE BENEFITS

### *A. Insurance Coverage of Infertility Treatment and the ADA*

The ADA<sup>38</sup> prohibits an employer<sup>39</sup> from discriminating against “a qualified individual with a disability,”<sup>40</sup> in the “terms, conditions, and privileges of employment,”<sup>41</sup> including employee fringe benefits such as employer-provided health insurance.<sup>42</sup> Under the ADA, employers can be liable for any disability-based discrimination that results from benefits they provide themselves or that a third party (such as insurance companies, health maintenance organizations (HMOs), or plan administrators) provides through a contract entered into with the employer.<sup>43</sup>

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36. American Society for Reproductive Medicine, *supra* note 14.

37. *Id.*

38. Americans with Disabilities Act, 42 U.S.C. §§ 12101–12300 (2000).

39. The term “employer” includes any business having more than fifteen employees. *Id.* § 12111(5)(A).

40. *Id.* § 12112(a). A “disability” is defined as “a physical or mental impairment that substantially limits one or more of the major life activities . . .” *Id.* § 12102(2)(A). The ADA was enacted to “provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities . . .” *Id.* § 12101(b)(2).

41. *Id.* § 12112(a).

42. *See id.* § 12112(b)(2); EQUAL EMPLOYMENT OPPORTUNITY COMM’N, NOTICE NO. 915.002, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE 2 (1993), available at <http://www.eeoc.gov/policy/docs/health.html> [hereinafter EEOC INTERIM GUIDANCE NOTICE] (“Employee benefit plans, including health insurance plans . . . are a fringe benefit available by virtue of employment. Generally speaking, therefore, the ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees.”); *see also* Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1014–15 (6th Cir. 1997) (recognizing that under the ADA employers are prohibited from discriminating on the basis of disability in their provision of health insurance).

Although not binding, agency interpretations of statutes, such as the EEOC’s Interim Guidance Notice, “are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.” *Chevron U.S.A. Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 844 (1984).

43. *See* 42 U.S.C. § 12112(b); EEOC INTERIM GUIDANCE NOTICE, *supra* note 42, at 2.

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1. Reproduction as a Disability: *Bragdon v. Abbott*

In claims for discrimination in violation of the ADA courts have disagreed over whether reproductive activities constitute a “major life activity,”<sup>44</sup> thus invoking protection under the ADA.<sup>45</sup> In its five-to-four decision in *Bragdon v. Abbott*,<sup>46</sup> the Supreme Court resolved the question by recognizing reproduction as a major life activity.<sup>47</sup> In

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Employers are prohibited from “participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity’s qualified applicant or employee with a disability to the discrimination prohibited by this subchapter . . . .” 42 U.S.C. § 12112(b)(2).

Under the ADA, all employees with disabilities must have equal access to benefits. *See id.* § 12112(b)(4); EEOC INTERIM GUIDANCE NOTICE, *supra* note 42, at 3. The EEOC has set forth a two-step analysis for determining when a distinction in a benefits plan violates the ADA. *See* EEOC INTERIM GUIDANCE NOTICE, *supra* note 42, at 3–4. First, the challenged distinction in benefits must be based on a disability. *Id.* According to the EEOC, a disability-based distinction is one that “singles out a particular disability . . . , a discrete group of disabilities . . . , or disability in general” for different treatment. *Id.* at 7.

Second, if a distinction is disability-based, the respondent must prove that it falls within the ADA’s exception. *Id.* at 4. This “safe harbor” exception provides:

[The ADA] shall not be construed to prohibit or restrict . . . [health insurance providers] from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or are not inconsistent with State law; or . . . that [are] not subject to State laws that regulate insurance.

42 U.S.C. § 12201(c). This exception, however, cannot be used as a “subterfuge to evade the purposes of” the ADA. *Id.* This exception creates a safe harbor only for insurance plans which classify risks in a bona fide manner. *Id.* § 12201(c). If an employer “can show that the distinction is . . . based on permissible classification of risks,” then the employer will be protected by the ADA’s safe harbor clause. Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 307 (2004).

44. Under the ADA, a major life activity is “substantially limit[ed]” if the individual is “[u]nable to perform a major life activity that the average person in the general population can perform; or [s]ignificantly restricted as to the condition, manner or duration under which an individual can perform” the activity as compared to the general population. 29 C.F.R. § 1630.2(j) (2006).

45. 42 U.S.C. § 12102(2)(a). *Compare* Pacourek v. Inland Steel Co., 916 F. Supp. 797, 801–02 (N.D. Ill. 1996) (finding that infertility impairs reproduction, a major life activity; thus, an infertile employee was disabled under the ADA), *and* Erickson v. Bd. of Governors, 911 F. Supp. 316, 323 (N.D. Ill. 1995) (holding that reproduction is a major life activity for purposes of the ADA), *rev’d*, 207 F.3d 945 (7th Cir. 2000), *with* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (holding that reproduction is not a major life activity), *and* Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995) (ruling that reproduction was not a major life activity because it “is not an activity engaged in with the same degree of frequency as . . . walking, seeing, speaking, breathing, learning, and working”).

46. 524 U.S. 624 (1998).

47. *Id.* at 638.

*Bragdon*, an HIV-positive patient brought suit against her dentist under the ADA for his refusal to treat her in his office.<sup>48</sup> The Court maintained that reproduction was a major life activity within the meaning of the ADA because “[r]eproduction and the sexual dynamics surrounding it are central to the life process itself.”<sup>49</sup> The Court found that the HIV infection substantially limited her ability to reproduce and bear children, thus drawing protection under the ADA.<sup>50</sup>

## 2. Infertility as a Disability: *Saks v. Franklin Covey Co.*

After the Supreme Court’s decision in *Bragdon* recognizing reproduction as a major life activity many lawyers, activists, and scholars thought that insurance coverage of infertility treatment would follow.<sup>51</sup> *Saks v. Franklin Covey Co.*<sup>52</sup> was the first case to test how the *Bragdon* decision applied to an infertile person’s standing as a disabled person under the ADA. Saks, a store manager at Franklin Covey, was a member of her employer’s self-insured health benefits plan.<sup>53</sup> During her employment, Saks and her husband used several infertility treatments in their attempt to conceive a child.<sup>54</sup> Her

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48. *Id.* at 628–29.

49. *Id.* at 638. The Court also noted that “reproduction could not be regarded as any less important than working and learning.” *Id.* at 639.

50. *Id.* at 641. The Court reasoned that a woman infected with HIV posed a significant risk to her partner and child. *Id.* at 639–40. Rejecting the petitioner’s argument that medication can lower the risk of transmission at birth to about 8%, the Court stated “[i]t cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one’s child does not represent a substantial limitation on reproduction. The Act addresses substantial limitations on major life activities, not utter inabilities.” *Id.* at 641.

51. *See, e.g.,* Jane Gross, *The Fight to Cover Infertility*, N.Y. TIMES, Dec. 7, 1998, at B1 (reporting opinions of Mrs. Saks’ attorney and an EEOC official regarding *Bragdon*’s impact on insurance coverage of infertility); *see also* Sato, *supra* note 9, at 189–90 (purporting that many thought mandatory insurance coverage for infertility was a “slam dunk” after *Bragdon* held that reproduction was a major life activity as defined by the ADA (citation omitted)).

52. 316 F.3d 337 (2d Cir. 2003).

53. *Id.* at 341. Under the insurance plan, a number of infertility products and procedures were covered. These included “ovulation kits, oral fertility drugs, penile prosthetic implants . . . , and nearly all surgical infertility treatments.” *Id.* However, the plan expressly excluded coverage of “[s]urgical impregnation procedures, including artificial insemination, in-vitro fertilization or embryo and fetal implants, even if medically necessary.” *Id.* (citation omitted) (alteration in original).

54. *Id.* Saks’ treatments included: ovulation kits, medication to stimulate ovulation, IUIs, IVFs, injectable fertility drugs, and blood tests and ultrasounds to monitor the side effects of these drugs. *Id.* Saks became pregnant three times during the course of her infertility treatment,

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insurance company refused to reimburse her for most of the costs based on the plan's exclusion of coverage for surgical impregnation techniques.<sup>55</sup>

The district court held that infertility is a disability within the meaning of the ADA.<sup>56</sup> The court, however, also held that the insurance plan did not violate the ADA because it offered the same insurance coverage to all its employees, both fertile and infertile.<sup>57</sup>

### B. Title VII and the PDA

Title VII of the Civil Rights Act of 1964 prohibits employment practices that “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex . . . .”<sup>58</sup> In 1978 Congress passed the PDA, which amended Title VII's definition of the phrase “because of sex” to include discrimination “because of or on the basis of pregnancy, childbirth, or related medical conditions . . . .”<sup>59</sup> In *Newport News Shipbuilding & Dry Dock Co. v. Equal Employment Opportunity Commission*,<sup>60</sup> the Supreme Court held that the PDA applied to health insurance benefits.<sup>61</sup> Therefore, under the PDA, an otherwise comprehensive insurance plan that singles out pregnancy-related benefits for exclusion is discriminatory.<sup>62</sup>

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but all three pregnancies ended in miscarriage. *See id.*

55. *Id.* at 342. Specifically, the plan refused to cover the costs of the IUIs, IVF cycles, injectable fertility drugs, and the tests used to monitor the side effects of the drugs. *Id.*

56. *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 326 (S.D.N.Y. 2000). Franklin Covey argued that Saks lacked standing under the ADA as a disabled person, which Judge Colleen McMahon found “simply silly” and unworkable in light of *Bragdon*. *Id.* at 324.

57. *Id.* at 326–27. Furthermore, the court found that the self-insured plan was within the ADA's safe harbor provision. *Id.* at 327. Because the plan's exclusion of surgical impregnation procedures predated the passage of the ADA, the court held that it could not have been adopted as a subterfuge. *Id.* at 328. The court reasoned that “[t]he only self-insured plans that fall outside the ADA Safe Harbor are those that are used as a subterfuge to evade the purposes of the statute.” *Id.*

58. 42 U.S.C. § 2000e-2(a)(1) (2000).

59. *Id.* § 2000e(k). The PDA also requires that such women “shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs.” *Id.*

60. 462 U.S. 669 (1983).

61. *Id.* at 682.

62. *Id.* at 683–85. Relying upon this analysis, the court in *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001), held that an employer's exclusion of prescription contraceptives from its otherwise comprehensive health plan constituted sex discrimination

Although the Supreme Court has yet to rule on whether infertility is included in the PDA's definition of "related medical conditions," a number of courts across the country have addressed the scope of the PDA as applied to infertility treatments.<sup>63</sup> In *Pacourek v. Inland Steel Co.*<sup>64</sup> the court held that a woman's medical condition which prevents her from becoming pregnant naturally is a "related medical condition" under the PDA.<sup>65</sup> Noting the expansive language of the PDA, the court stated that the term "related" was a "generous choice of wording, suggesting that interpretation should favor inclusion rather than exclusion in the close cases."<sup>66</sup>

Unlike the *Pacourek* court, the United States Court of Appeals for the Eighth Circuit held in *Krauel v. Iowa Methodist Medical Center*<sup>67</sup> that the phrase "related medical conditions" in the PDA referred only to pregnancy and childbirth.<sup>68</sup> The court distinguished pregnancy and

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under Title VII. *Id.* at 1271. In granting the plaintiff's motion for summary judgment, the court held that Title VII requires employers to provide equally comprehensive coverage of both women's and men's prescription needs. *Id.* at 1277. While the plan covered "almost all drugs and devices used by men," the court reasoned that "the exclusion of prescription contraceptives creates a gaping hole in the coverage offered to female employees, leaving a fundamental and immediate healthcare need uncovered." *Id.*

63. See *Saks v. Franklin Covey Co.*, 316 F.3d 337 (2d Cir. 2003); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996); *Pacourek v. Inland Steel Co.*, 858 F. Supp. 1393 (N.D. Ill. 1994); *Alexander v. Am. Airlines, Inc.*, No. 4:02-CV-0252-A, 2002 U.S. Dist. LEXIS 7089, at \*9 (N.D. Tex. Apr. 23, 2002) (holding that the failure to provide health insurance coverage for infertility treatment did not violate the PDA); *Niemeier v. Tri-State Fire Prot. Dist.*, No. 99 C 7391, 2000 U.S. Dist. LEXIS 12621, at \*17-19 (N.D. Ill. Aug. 24, 2000) (reviewing the split in the circuits regarding whether the PDA includes insurance coverage for infertility treatments and noting that it "currently remain[s] unconvinced" that infertility was a related medical condition under the PDA).

64. 858 F. Supp. 1393. *Pacourek* suffered from esophofical reflux which prevented her from conceiving naturally. *Id.* at 1396.

65. *Id.* at 1402-04. "In ordinary terms, a medical condition related to the ability of a woman to have a child is related to pregnancy and childbirth." *Id.* at 1403.

66. *Id.* at 1402. The court considered the plain language of the statute, its legislative history, and the Supreme Court's decision in *International Union v. Johnson Controls, Inc.* *Id.* at 1402-03 (citing 499 U.S. 187 (1991)). The court concluded: "The basic theory of the PDA may be simply stated: Only women can become pregnant; stereotypes based on pregnancy and related medical conditions have been a barrier to women's economic advancement; and classifications based on pregnancy and related medical conditions are never gender-neutral." *Id.* at 1401.

67. 95 F.3d 674. After being diagnosed with endometriosis, *Krauel* underwent tubal surgery to eliminate the condition. *Id.* at 675-76. However, after the surgery *Krauel* continued to have difficulty conceiving a child. *Id.* at 676. *Krauel* received IUI and three GIFT treatments. *Id.* After the birth of her child, *Krauel's* insurance company paid for the tubal surgery, pregnancy, and delivery, but refused to pay for the IUI and GIFT treatments. *Id.*

68. *Id.* at 679-80. In interpreting the statute, the court acknowledged that "when a general

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childbirth, which occur after conception, from infertility, which prevents conception.<sup>69</sup> Based on this distinction, the court concluded that infertility is not a medical condition protected by the PDA.<sup>70</sup>

On appeal to the Second Circuit the court in *Saks v. Franklin Covey Co.*<sup>71</sup> held that infertility was not a sex-based classification because infertility affects both men and women. Therefore, infertility was not within the purview of the PDA.<sup>72</sup> Even though surgical impregnation procedures can only be performed on women, the court found that their exclusion from the insurance policy did not result in a less comprehensive benefits package for female employees.<sup>73</sup> According to the court, the exclusion equally disadvantaged infertile male and female employees because the need for surgery could be caused by either the male's or female's infertility.<sup>74</sup> Because the exclusion was gender neutral, the court concluded that it did not violate the PDA.<sup>75</sup>

Although a court may hold that infertility is a disability within the meaning of the ADA, so long as insurers and employers offer the same insurance coverage to all its employees, they do not violate the ADA by refusing to cover infertility treatments.<sup>76</sup> Similarly, courts disagree on whether infertility is a 'related medical condition' under

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term follows a specific one, the general term should be understood as a reference to subjects akin to the one with specific enumeration." *Id.* at 679 (quoting *Norfolk & W. Ry. Co. v. Am. Train Dispatchers' Ass'n*, 499 U.S. 117, 129 (1991)).

69. *Id.* Krauel argued that the causal connection between infertility and pregnancy made infertility a medical condition related to pregnancy. *Id.*

70. *Id.* at 679–80. The court also noted that infertility is not a sex-related medical condition because it affects both men and women, whereas only women can become pregnant. *Id.* at 680.

71. 316 F.3d 337 (2d Cir. 2003). For a discussion of the facts of this case and Saks's claim under the ADA see *supra* notes 52–57 and accompanying text.

72. 316 F.3d at 346. Rejecting the equal access test used by the district court, the circuit court held that "[u]nder Title VII the proper inquiry in reviewing a sex discrimination challenge to a health benefits plan is whether sex-specific conditions exist, and if so, whether exclusion of benefits for those conditions results in a plan that provides inferior coverage to one sex." *Id.* at 344. "Because reproductive capacity is common to both men and women, we do not read the PDA as introducing a completely new classification of prohibited discrimination based solely on reproductive capacity. Rather, the PDA requires that pregnancy, and related conditions, be properly recognized as sex-based characteristics of women." *Id.* at 345.

73. *Id.* at 347.

74. *Id.*

75. *Id.* at 346.

76. See *supra* notes 38–57 and accompanying text.

the PDA.<sup>77</sup> Thus, neither the ADA nor the PDA are useful in compelling insurance companies to cover the costs of infertility treatments.

### III. STATE MANDATES FOR INSURANCE COVERAGE OF INFERTILITY TREATMENTS

Fifteen state legislatures have passed laws mandating coverage for infertility treatments.<sup>78</sup> However, each state's mandate differs. Some states require coverage of select treatments while others provide more comprehensive coverage.<sup>79</sup> There are two types of mandates addressing infertility treatments: a mandate to offer coverage and a mandate to cover.<sup>80</sup> A mandate to offer is a law requiring insurers to offer coverage of infertility treatments; however, employers are not required to include coverage in their benefit plans.<sup>81</sup> A mandate to cover requires health insurance companies to include coverage of infertility treatments as a benefit in every policy.<sup>82</sup> Legislation in California and Texas can be categorized as mandates to offer, while the remaining thirteen states' laws are mandates to cover.<sup>83</sup>

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77. See *supra* notes 58–75 and accompanying text.

78. ARK. CODE ANN. §§ 23-85-137, 23-86-118 (2004); CAL. HEALTH & SAFETY CODE § 1374.55 (West 2000); CAL. INS. CODE § 10119.6 (West 2005); CONN. GEN. STAT. § 38a-536 (2005); HAW. REV. STAT. §§ 431:10A-116.5 (2004); 215 ILL. COMP. STAT. 5/356m, 125/5-3 (2004); LA. REV. STAT. ANN. § 22:215.23 (2004); MD. CODE ANN., HEALTH-GEN. § 19-701 (LexisNexis 2005); MD. CODE ANN., INS. § 15-810 (LexisNexis 2006); MASS. GEN. LAWS ch. 175, § 47H; ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (West 2004); MONT. CODE ANN. §§ 33-22-1521, 33-31-102 (2001); N.J. STAT. ANN. §§ 17:48-6x, 17:48A-7W, 17:48E-35.22, 17B:27-46.1x, 26-2J-4.23 (West Supp. 2006); N.Y. INS. LAW §§ 3216, 3221 (McKinney 2006), 4303 (McKinney 2000 & Supp. 2006); OHIO REV. CODE ANN. § 1751.01(A)(7) (West Supp. 2006); R.I. GEN. LAWS §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (2002); TEX. INS. CODE ANN. § 1366 (Vernon 2006); W. VA. CODE § 33-25A-2 (West 2003).

79. See *infra* notes 82–111 and accompanying text.

80. See ARONSON, *supra* note 2, at 301.

81. See *id.* Employees who choose to include infertility treatments in their health insurance coverage may have to pay higher premiums. Leslie King & Madonna Harrington Meyer, *The Politics of Reproductive Benefits: U.S. Insurance Coverage of Contraceptive and Infertility Treatments*, 11 GENDER & SOC'Y 8, 15–17 (1997).

82. See ARONSON, *supra* note 2, at 301. In states with mandates to cover, premiums are often lower because the cost of infertility treatments is spread across all covered individuals. See King & Meyer, *supra* note 81, at 17.

83. *Id.* In 2005 Connecticut revised its statute to mandate coverage of infertility treatments. Jane Gordon, *Infertility Treatments Now Covered, to a Point*, N.Y. TIMES, Oct. 2, 2005, at 14CN-2.

### A. IVF Coverage Only

A number of states have enacted statutes that pertain only to IVF. For example, Arkansas requires group health insurance companies—exempting HMOs—to cover the cost of IVF.<sup>84</sup> Coverage, however, is limited to procedures in which the woman’s eggs are fertilized with her spouse’s sperm.<sup>85</sup> Similarly, legislation in Maryland only mandates coverage of IVF and specifies that a spouse’s sperm be used for fertilization.<sup>86</sup> In addition, Maryland allows insurance companies to limit their coverage to three IVF attempts per live birth and to set a maximum level of coverage of \$100,000.<sup>87</sup>

Applying to insurance plans which provide pregnancy-related benefits, Hawaii’s statute mandates coverage of only one IVF cycle and imposes a number of preconditions to receiving coverage.<sup>88</sup> Insurance companies in Texas that offer IVF coverage must provide the same amount of coverage for IVF as they do for other pregnancy-related procedures.<sup>89</sup> Furthermore, patients must have a continuous five-year history of infertility,<sup>90</sup> have tried other treatments, and the sperm used for fertilization must be from the patient’s spouse.<sup>91</sup>

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84. ARK. CODE ANN. § 23-85-137 (2004).

85. ARK. INS. DEP’T, RULE AND REGULATION 1, § 1(5)(B) (2006), <http://www.insurance.arkansas.gov/Legal%20DataServices/mrpage.htm> (follow “In Vitro Fertilization” hyperlink). This qualification indicates that individuals must be married to receive coverage and IVF procedures using donor sperm are not covered. *Id.* Furthermore, a couple must have a two-year history of unexplained infertility or infertility associated with a listed medical condition before they are eligible for coverage. *Id.* § 1(5)(C)(1)-(2). Arkansas’ statute also allows the insurance commissioner to establish minimum and maximum levels of coverage the insurance companies must provide. *See* ARK. CODE ANN. § 23-85-137(c).

86. MD. CODE ANN., INS. §§ 15-810(b), (c)(2) (LexisNexis 2006). Under Maryland’s statute, a two-year history of infertility or infertility associated with one of four listed medical conditions is required. *Id.* § 15-810(c)(3). A couple must also have been unable to achieve pregnancy through the use of less expensive treatments. *Id.* § 15-810(c)(4).

87. *Id.* § 15-810(d).

88. HAW. REV. STAT. § 431:10A-116.5 (2004). Couples in Hawaii must have a five-year history of infertility, prior unsuccessful attempts with other treatments, and the woman’s eggs must be fertilized with her spouse’s sperm. *Id.* §§ 431:10A-116.5(a)(3)-(5).

89. TEX. INS. CODE ANN. § 1366.003(b) (Vernon 2006).

90. *Id.* § 1366.005(3). If infertility is associated with endometriosis, exposure to diethylstilbestrol (DES), blockage or surgical removal of fallopian tubes, or low sperm count then a five-year history of infertility is unnecessary. *Id.*

91. *Id.* § 1366.005(2), (4).

### B. Exemption of IVF

In other states, legislation has been enacted requiring coverage for infertility treatments, but specifically excludes IVF. California, for example, requires insurance companies to offer coverage of infertility treatments, including diagnostic tests and medication.<sup>92</sup> Although IVF is excluded from coverage, California's mandate does include gamete intrafallopian transfer (GIFT), a treatment similar to IVF.<sup>93</sup> Patients in California are eligible for treatment after one year of infertility or if their infertility is caused by a medically recognized condition.<sup>94</sup> California's mandate does not include age or marital status restrictions.<sup>95</sup>

Conversely, in New York infertility coverage is only available for patients between the ages of twenty-one and forty-four.<sup>96</sup> Insurance companies in New York are required to cover diagnostic tests and infertility procedures, such as tubal surgery and infertility drugs.<sup>97</sup> However, they do not have to provide coverage for IVF, GIFT, zygote intrafallopian transfer (ZIFT), or reversal of voluntary sterilization.<sup>98</sup>

In Louisiana insurers are prohibited from excluding "diagnosis and treatment of a correctable medical condition, otherwise covered by the policy" because the condition may lead to infertility.<sup>99</sup> Thus,

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92. CAL. HEALTH & SAFETY CODE § 1374.55(a)-(b) (West 2000). Covered infertility treatments include: "procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons." *Id.* § 1374.55(b). IVF is defined as "the laboratory medical procedures involving the actual in vitro fertilization process." *Id.* Under this definition of IVF, it is likely that expenses for stimulation of the ovaries and egg retrieval would be covered. Lisa M. Kerr, *Can Money Buy Happiness? An Examination of the Coverage of Infertility Services Under HMO Contracts*, 49 CASE W. RES. L. REV. 599, 615 (1999).

93. See CAL. HEALTH & SAFETY CODE § 1374.55(b). For a description of GIFT, see *supra* note 29.

94. *Id.* § 1374.55(b).

95. See *id.* § 1374.55.

96. N.Y. INS. LAW § 3221(k)(6)(C)(i) (McKinney 2006). New York's statute states that infertility is to be determined according to the guidelines established by ACOG and ASRM. *Id.* §§ 3221(k)(6)(I), 4303(s)(3)(F)(i).

97. *Id.* § 3221(k)(6)(A)(ii).

98. *Id.* § 3221(k)(6)(C)(v). For an explanation of GIFT and ZIFT, see *supra* note 29.

99. LA. REV. STAT. ANN. § 22:215.23(A)(1) (2004).

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coverage depends on conditions included in the plan and whether the condition is considered “correctable.”<sup>100</sup>

### C. Comprehensive Coverage

Illinois requires insurance policies that cover more than twenty-five people to provide coverage for the diagnosis and treatment of infertility after one year of infertility.<sup>101</sup> IVF, GIFT, and ZIFT are covered, but only after less expensive treatments have failed.<sup>102</sup> New Jersey also requires insurance policies<sup>103</sup> to cover the costs of IVF, GIFT, and ZIFT only if the patient has tried other less expensive treatments, is forty-five years of age or younger, and has not reached the maximum of four egg retrievals.<sup>104</sup>

Legislation in Rhode Island mandates that insurers and HMOs provide coverage for the “medically necessary expenses of diagnosis and treatment of infertility” and allows co-payments which do not exceed 20%.<sup>105</sup> Coverage in Rhode Island, however, is limited to married individuals.<sup>106</sup>

In Massachusetts insurance companies and HMOs must cover “the medically necessary expenses of diagnosis and treatment of infertility.”<sup>107</sup> The statute does not place any restrictions or limits on

100. *Id.* Louisiana’s mandate provides that insurers are not required to cover fertility drugs, ARTs, or reversal of voluntary sterilization. *Id.* § 22:215.23(A)(2).

101. 215 ILL. COMP. STAT. 5/356m(a)-(c) (2004).

102. *Id.* at 5/356m(b)(1)(A). ART coverage is limited to four egg retrievals; however, if a retrieval results in a live birth, then two additional retrievals are covered. *Id.* at 5/356m(b)(1)(B).

103. Health insurance policies that insure less than fifty people are exempt. N.J. STAT. ANN. § 17:48A-7w(a) (West Supp. 2006).

104. *Id.* The statute defines infertility as:

[T]he 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 or one of the partners is considered medically sterile; or carry a pregnancy to live birth.

*Id.*

105. R.I. GEN. LAWS §§ 27-18-30(a), 27-41-33(a) (2002).

106. *See id.* §§ 27-18-30(b), 27-19-23(b) (defining infertility as “the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one year”).

107. MASS. GEN. LAWS ch. 175, § 47H; ch. 176B, § 4J (West 2004). Massachusetts defines infertility as “the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.” *Id.* ch. 175, § 47H.

the number of IVF attempts covered, and it does not contain a lifetime maximum dollar amount.<sup>108</sup> On the other hand, Connecticut's coverage of infertility diagnosis and treatment is subject to a number of limitations.<sup>109</sup> For instance, a patient must be younger than forty years of age and have maintained coverage under the policy for at least one year.<sup>110</sup> In order to receive coverage for IVF, GIFT, or ZIFT a patient must have tried less expensive treatments.<sup>111</sup> Connecticut also limits the number of cycles of IVF, GIFT, ZIFT, and ovulation induction that insurance companies are required to cover.<sup>112</sup> Additionally, Connecticut is the only state to limit the number of embryos that can be transferred per cycle.<sup>113</sup>

#### *D. Preventative Services Only*

Montana, Ohio, and West Virginia have statutes that require HMOs to cover infertility services as part of a plan's "preventative health care services."<sup>114</sup> Due to the statutes' broad language, their scope is unclear. The statutes only mandate the coverage of "preventative" services and do not specify which services are to be included. Therefore, it is unlikely that ARTs are covered since they do not *prevent* infertility, but, rather, are designed to remedy the problem of infertility.<sup>115</sup>

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108. *See id.*

109. *See* CONN. GEN. STAT. § 38a-536 (2005). Infertility is defined in the Connecticut statute 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." *Id.* § 38a-536(a).

110. *Id.* § 38a-536(b)(1), (7).

111. *Id.* § 38a-536(b)(5).

112. *Id.* § 38a-536(b)(2)-(4). Specifically, coverage includes a lifetime maximum benefit of two cycles of IVF, GIFT, and ZIFT; three cycles of IUI; and four cycles of ovulation induction. *Id.*

113. *Id.* § 38a-536(b)(4).

114. MONT. CODE ANN. § 33-31-102(2)(h)(v) (2001); OHIO REV. CODE ANN. § 1751.01(A)(7) (West Supp. 2006); W. VA. CODE § 33-25A-2 (2003). None of these states' statutes define infertility. *See* MONT. CODE ANN. § 33-31-102; OHIO REV. CODE ANN. § 1751.01(A)(7); W. VA. CODE § 33-25A-2(1).

115. *See* Kerr, *supra* note 92, at 616 (suggesting that preventative care may be limited to examination, diagnosis, and minimal treatment of infertility).

## IV. ERISA PREEMPTION

While these state laws are an important step in providing insurance coverage for infertility treatments, they are unlikely to lead to uniform results because of the Employee Retirement Income Security Act (ERISA).<sup>116</sup> ERISA regulates employee benefit plans, such as employer-sponsored health benefits.<sup>117</sup> In 2002 more than 65% of Americans—approximately 160 million workers under the age of sixty-five and their family members—relied upon private health insurance provided through the workplace.<sup>118</sup>

ERISA distinguishes between insured and self-insured private health care plans.<sup>119</sup> Under an insured plan, health care benefits are provided to employees through an insurance plan that is purchased by their employers,<sup>120</sup> while employers with a self-insured plan cover the costs of their employees' health care directly.<sup>121</sup> Self-insured employee benefit plans are preempted by ERISA.<sup>122</sup> Therefore, they

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116. 29 U.S.C. §§ 1001–1461 (2000).

117. 29 U.S.C. § 1002(1).

118. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2004 WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 346 tbl.129 (2004) [hereinafter CDC CHARTBOOK], available at <http://www.cdc.gov/nchs/data/hus/04.pdf>. “Private health insurance” includes private health insurance plans, single-service hospital plans, and HMOs. *Id.* at 457. It does not include: Medicare, Medicaid, public assistance, a state- or government-sponsored plan, or a military health plan. *Id.*

119. See Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 491–92 (1998).

120. See *id.*

121. Colleen E. Medill et al., *Coverage of Reproductive Technologies Under Employer-Sponsored Health Care Plans*, 8 EMP. RTS. & EMP. POL'Y J. 523, 541 (2004). The employer may contract with an insurance company or other third party to administer the plan. *Id.*

122. ERISA preempts any state law “relat[ing] to any employee benefit plan.” 29 U.S.C. § 1144(a). In *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Supreme Court held that a state law relates to an ERISA plan if it refers to ERISA plans, mandates employee benefit structures or their administration, or provides alternative enforcement mechanisms for ERISA rights. *Id.* at 654–58. Thus, state mandates requiring insurance companies to cover or offer coverage of infertility treatments would be preempted by ERISA because they relate to a benefit plan.

ERISA's savings clause exempts specific state laws regulating insurance from preemption. See 29 U.S.C. § 1144(b)(2)(B). The statute, however, also provides that self-insured benefit plans, which would otherwise be exempt from preemption by the savings clause, are preempted. See *id.*; *FMC Corp. v. Holliday*, 498 U.S. 52, 63–65 (1990) (concluding that self-funded plans are regulated by ERISA).

are not subject to state laws regulating insurance.<sup>123</sup>

Because self-insured plans do not have to meet the minimum state requirements for insurance policies, they are attractive to many employers.<sup>124</sup> In 2005 the majority of covered workers were in a plan that was completely or partially self-insured.<sup>125</sup> This means that the majority of covered workers are unable to benefit from state laws mandating insurance coverage for infertility treatments.

## V. THE DEBATE OVER INSURANCE MANDATES FOR INFERTILITY

### A. High Costs

Insurance companies have argued that mandated coverage for infertility treatments would greatly increase health care costs and health insurance premiums.<sup>126</sup> However, evidence shows that this belief is unfounded.<sup>127</sup> Massachusetts, which has the most

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123. Due to this preemption, states are limited in creating health care policies that benefit their citizens. See James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 443 (1994). One study found that ERISA preemption "deterred states from implementing health reforms because they could not enforce insurance mandates on self-insured plans." Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. & REV. 340, 342 (2000) (citations omitted).

Subsequent amendments to ERISA have attempted to remedy some of the inconsistencies in self-insured plans by requiring coverage for post-delivery hospital stays for new mothers and infants, and post-mastectomy treatment, including reconstructive surgery. See 29 U.S.C. §§ 1185, 1185b. Likewise, ERISA could be amended to provide coverage for infertility treatments.

124. See Kerr, *supra* note 92, at 617. For an in-depth discussion of the relationship between employers and self-insured plans, see generally Park, *supra* note 123.

125. Kaiser Family Foundation, *Employer Health Benefits 2005 Annual Survey*, <http://www.kff.org/insurance/7315/sections/ehbs05-sec10-1.cfm> (last visited Jan. 20, 2007) (reporting that "54% of covered workers in 2005 [were] in a plan that [was] completely or partially self-funded").

Large companies are more likely to have self-insured plans than are smaller companies. See *id.* Seventy-eight percent of covered workers employed by large companies (meaning those that have 1000–4999 employees) are in a self-funded plan, compared to 13% of covered workers employed by small companies (meaning those that have 3–199 employees). *Id.*

126. Tim Bonfield, *Couples Struggle with Price of Conceiving*, CINCINNATI ENQUIRER, Apr. 17, 2005, at A1.

127. According to John McDonough, executive director of the advocacy group Health Care for All, "The maternity and the mental health mandates are the two big-ticket items. . . . Everything else is nickels and dimes, including in vitro." Tom Benner, *Infertility Treatment Could Lose Insurance in Mass.*, PATRIOT LEDGER (Quincy, Mass.), Dec. 5, 2005, at 1.

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comprehensive infertility treatment mandate, found that the monthly cost of providing such coverage was \$0.26, which amounted to “less than 0.1% of the total health care premium in the typical family health care benefits plan.”<sup>128</sup> Thus, by increasing premiums by less than 1%, 6.1 million Americans who experience infertility could have insurance coverage for this condition.

While expanding coverage to include infertility treatments may increase demand for such treatments because of the lower cost to patients, these increases would be small considering the limited number of people diagnosed with infertility and the low percentage of patients who utilize expensive procedures.<sup>129</sup> One 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.<sup>130</sup> Furthermore, the cost of providing coverage may actually decrease because couples will select treatments based on the appropriateness of the treatment for their particular infertility problems, rather than whether the procedure is covered by insurance.<sup>131</sup> For example, most insurance companies cover tubal surgeries, leading many couples to undergo numerous tubal surgeries simply because the tubal surgery is covered.<sup>132</sup> Yet, tubal surgery can be twice as expensive as one cycle of IVF<sup>133</sup> and is not an effective treatment for certain types of infertility.<sup>134</sup>

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128. Martha Griffin & William F. Panak, *The Economic Cost of Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate*, 70 FERTILITY & STERILITY 22, 22–23 (1998). The study examined the costs of coverage for nine large group insurance plans between 1986 and 1993 and cost data from the state insurance agency. *Id.* at 22. Massachusetts enacted its mandate in 1989. *Id.* Susan Leahy, spokeswoman for Blue Cross Blue Shield of Massachusetts, admitted, “[Infertility treatment is] ‘not the most expensive mandate, it’s not the least expensive mandate.’” Benner, *supra* note 127.

129. Eighty-five percent to 90% of patients conceive using conventional treatments. *See supra* note 26 and accompanying text.

130. *See* John A. Collins et al., *An Estimate of the Cost of In Vitro Fertilization Services in the United States in 1995*, 64 FERTILITY & STERILITY 538, 542 tbl.3 (1995).

131. *See* Gilbert, *supra* note 26, at 52. “Comprehensive coverage ‘enables companies to monitor infertility treatments and manage the true cost by eliminating unnecessary, repetitive, costly and ultimately unsuccessful treatments by replacing them with well-managed, cost-effective treatments that are more likely to result in positive outcomes’ . . . .” Virginia Linn, *Filling a Gap: Legislator’s Bill Would Require Insurance Coverage for Infertility Treatments*, PITTSBURGH POST-GAZETTE, Dec. 30, 1997, at G2 (quoting a report conducted by William M. Mercer, an employee benefits consultant).

132. *See* Gilbert, *supra* note 26, at 51; Pratt, *supra* note 5, at 1137.

133. The cost per delivery for ART is \$37,028, while tubal surgery costs approximately \$76,000 per delivery. Bradley J. Van Voorhis et al., *Cost-Effectiveness of Infertility Treatments:*

### B. Multiple Births

A federal mandate will also likely reduce the number of multiple births that result from infertility treatments, thereby reducing health risks to mothers and infants. In 2003 34% of all live births conceived through the use of ARTs were multiple births.<sup>135</sup> For the general population the rate of multiple births was 3%.<sup>136</sup> Multiple births increase the mother's risk of hypertension, gestational diabetes, uterine hemorrhage, and premature labor and delivery.<sup>137</sup> Infants are at risk for pre-maturity; physical, mental, and developmental disabilities; and death.<sup>138</sup>

In addition to reducing these health risks, fewer multiple births would also lower the cost of health insurance. In 1991 the cost of delivering twins was four times as high, and the cost of delivering triplets was eleven times as high, as the delivery costs of a single infant.<sup>139</sup> The occurrence of multiple births can be reduced by limiting the number of embryos transferred in one cycle of ART.<sup>140</sup>

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*A Cohort Study*, 67 FERTILITY & STERILITY 830, 832 tbl.1 (1997). In addition, tubal surgeries require a hospital stay of three to five days, compared to ARTs that are performed on an outpatient basis. Gilbert, *supra* note 26, at 43. After tubal surgery, it may take one to two years of trying to conceive before one can determine if the surgery was successful. *Id.* On the other hand, the success of ARTs can be determined two weeks after the procedure. *Id.*

134. *See id.* at 52. Studies show that the number of tubal surgeries performed declines by half when insurance companies cover IVF. *Id.* at 51–52. For women with blocked fallopian tubes, IVF is a more cost-effective procedure than tubal surgery. Van Voorhis et al., *supra* note 133, at 835.

135. CDC SUCCESS RATES, *supra* note 7, at 20. Three percent of multiple births involved triplets or more. *Id.*

136. *Id.* Multiple births are higher among ART patients because typically more than one embryo is transferred during a single cycle in hopes of increasing the chance of implantation. *See Multiple Pregnancy Associated with Infertility Therapy*, 82 FERTILITY & STERILITY S153, S154–55 (Supp. 1 2004).

137. Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 NEW ENG. J. MED. 661, 665 (2002).

138. *Id.* Premature infants may experience “respiratory distress syndrome, intracranial hemorrhage, cerebral palsy, and blindness . . .” *Id.*

139. *Id.*

140. *See* David Frankfurter, *To Insure or Not to Insure: That Is the Question*, 80 FERTILITY & STERILITY 24, 25 (2003); *see also Multiple Pregnancy*, *supra* note 136, at S155 (recommending limiting the number of embryos to three or fewer in order to reduce the risk of multiple gestation).

During an IVF procedure embryos are traditionally transferred three days after retrieval. *See ARONSON*, *supra* note 2, at 181. By allowing embryos to develop into a blastocyst (a five-day-old embryo) before implanting them into a woman's uterus, a physician can transfer fewer blastocysts. *Id.* Blastocysts have a higher implantation rate than three-day-old embryos;

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However, 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.<sup>141</sup> Additionally, doctors in states that do not mandate insurance coverage of infertility treatments often feel pressured to transfer a higher number of embryos due to the “[c]ompetition for patients, desire for high fertility rates, and the need for speedy results . . . .”<sup>142</sup>

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.<sup>143</sup> Consequently, the states with mandated coverage had a lower percentage of pregnancies of triplets

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therefore, blastocyst transfer reduces the need to transfer multiple embryos during one cycle of IVF. *Id.*

Currently, three or more embryos are usually transferred in a single cycle of IVF. William D. Schlaff, *Impact of Insurance Coverage on In Vitro Fertilization Practice Patterns: A Complex Relationship*, 80 *FERTILITY & STERILITY* 30, 31 (2003). A recent study found that transferring blastocysts rather than embryos decreases the number of multiple births without lowering pregnancy rates in women under the age of thirty-eight. See Amy Criniti et al., *Elective Single Blastocyst Transfer Reduces Twin Rates Without Compromising Pregnancy Rates*, 84 *FERTILITY & STERILITY* 1613, 1617 (2005) (finding that when one blastocyst of good quality was selected for transfer, pregnancy rates remained the same, while the rate of twin pregnancies was significantly reduced); see also Michael Henman et al., *Elective Transfer of Single Fresh Blastocysts and Later Transfer of Cryostored Blastocysts Reduces the Twin Pregnancy Rate and Can Improve the In Vitro Fertilization Live Birth Rate in Younger Women*, 84 *FERTILITY & STERILITY* 1620, 1620 (2005) (concluding that elective single embryo transfers can maintain the rate of pregnancy through IVF while reducing the rate of multiple births by more than 75%). These studies show that younger women can maintain current pregnancy rates of IVF while reducing the occurrence of multiple births, thus further lowering the costs associated with IVF.

141. See Meredith A. Reynolds et al., *Does Insurance Coverage Decrease the Risk for Multiple Births Associated with Assisted Reproductive Technology?*, 80 *FERTILITY & STERILITY* 16, 17 (2003); see also *Multiple Pregnancy*, *supra* note 136, at S155 (“Inadequate or absent health coverage may force couples to . . . limit the number of IVF cycles and request that more embryos be transferred.”).

142. Mary D’Alton, *Infertility and the Desire for Multiple Births*, 81 *FERTILITY & STERILITY* 523, 524 (2004); see also David S. Guzick, *Should Insurance Coverage for In Vitro Fertilization Be Mandated?*, 347 *NEW ENG. J. MED.* 686, 687 (2002) (“[I]n states that do not require insurance coverage for in vitro fertilization[] there may be greater competition among fertility clinics for a smaller pool of patients.”); Schlaff, *supra* note 140, at 31 (“[T]he availability of published ‘success rates’ has exacerbated already intense competition among infertility practices”).

143. Jain et al., *supra* note 137, at 663.

or more than in the other states.<sup>144</sup> When insurance covers part of the cost of IVF and allows for multiple cycles, the personal financial burden on infertile couples is reduced, thereby lessening the pressure to transfer more embryos.<sup>145</sup> If required to cover IVF, insurance companies would likely increase pressure over doctors and clinics to lower the number of multiple births,<sup>146</sup> which would decrease the costs associated with infertility treatments even more.

### C. Unfairness

Opponents of infertility coverage argue that it is unfair for those who will never need infertility treatments to have to pay for them.<sup>147</sup> Yet, the purpose of health insurance is to pool risks in order to provide affordable health care for all members.<sup>148</sup> Insured individuals pay into the insurance pool, hoping they will never have to use it.<sup>149</sup> Insurance companies refuse to cover treatments that are necessary for infertile couples to conceive; nevertheless, infertile couples must pay for others' maternity and childbirth expenses that they will never use.<sup>150</sup> Therefore, the argument of unfairness is illogical.

## VI. FEDERAL LEGISLATION IS NECESSARY

Some state and federal courts have addressed the issue of insurance coverage of infertility treatments. Infertile plaintiffs, however, have found that neither the ADA nor the PDA provide them

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144. *Id.* at 664.

145. Reynolds et al., *supra* note 141, at 22. However, the addition of insurance coverage in a state might have effects in different directions. *Id.*

146. *Id.*; see also Carson Strong, *Too Many Twins, Triplets, Quadruplets, and So On: A Call for New Priorities*, 31 J.L. MED. & ETHICS 272 (2003) (discussing the need to reduce the number of multiple births attributed to ARTs, including how the insurance industry could help by increasing pressure on doctors).

147. See James B. Roche, *After Bragdon v. Abbott: Why Legislation Is Still Needed to Mandate Infertility Insurance*, 11 B.U. PUB. INT. L.J. 215, 228 (2002).

148. John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 312 (1997).

149. See William C. Cole, Comment, *Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage*, 27 SAN DIEGO L. REV. 715, 736 (1990).

150. *Id.* Insurance companies consider the costs of "childbearing and potential fetal health problems" when calculating insurance premiums. *Id.* (footnote omitted). "We all pay for all those who can conceive and have children. Shouldn't they pay for us who want to have children?" says Patti Gellman, mother of twins conceived through IVF. Linn, *supra* note 131.

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with much protection.<sup>151</sup> A number of states have stepped in and enacted mandates requiring insurance companies to cover or offer coverage of infertility treatments.<sup>152</sup> While significant, state mandates are limited in their effectiveness because not all insurance plans must comply with them.<sup>153</sup> Moreover, enacted mandates lack uniformity<sup>154</sup> and only some states have pursued them.

Recognizing the importance of this issue and the need for a uniform policy, Representative Anthony Weiner introduced the Family Building Act of 2005 in February 2005 (the “Act”).<sup>155</sup> If enacted, the Act would amend ERISA<sup>156</sup> to require insurance companies to cover the costs of infertility treatments.<sup>157</sup>

The Act presents a balance between the need for coverage and the need to contain costs. For example, coverage under the Act is relatively comprehensive and includes the use of ARTs.<sup>158</sup> The Act

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151. *See supra* notes 38–75 and accompanying text. The argument that the denial of coverage for IVF was justified because IVF is not medically necessary had mixed results in the courts. *See Egert v. Conn. Gen. Life Ins. Co.*, 900 F.2d 1032, 1037–38 (7th Cir. 1990) (rejecting defendant’s argument that IVF is not “essential for the necessary care or treatment” of plaintiff’s infertility because the procedure will not cure her infertility); *Ralston v. Conn. Gen. Life Ins. Co.*, 625 So.2d 156, 157 (La. 1993) (remanding case to trial court because general issues of fact existed as to “whether in vitro fertilization is a treatment, and whether treatment was necessary or essential”); *Kinzie v. Physician’s Liab. Ins. Co.*, 750 P.2d 1140, 1141 (Okla. Civ. App. 1987) (affirming the trial court’s holding that “in vitro fertilization was not a medically necessary service because it was elective and was not required to cure or preserve Mrs. Kinzie’s health”).

152. *See supra* notes 78–115 and accompanying text.

153. *See supra* notes 116–25 and accompanying text.

154. *See supra* notes 78–125 and accompanying text.

155. The bill includes the following findings:

- (1) Infertility is a disease affecting more than 6,000,000 American women and men, about 10 percent of the reproductive age population.
- (2) Recent improvements in therapy make pregnancy possible for more couples than in past years.
- (3) The majority of group health plans do not provide coverage for infertility therapy.
- (4) A fundamental part of the human experience is fulfilling the desire to reproduce.

Family Building Act of 2005, H.R. 735, 109th Cong. § 1(b) (2005).

156. 29 U.S.C. §§ 1001–1461 (2000).

157. H.R. 735 § 2(a) (amending section 2707(h) of ERISA). The Act would not preempt state laws that provide greater infertility benefits; thereby setting the floor, not the ceiling for coverage. *See id.*

158. *See id.* The Act also does not require that only the sperm of the woman’s spouse be used for egg fertilization; therefore, single women and men with infertility due to problems with their sperm are not unfairly disadvantaged. *See id.* (amending section 2707(b)(2) of ERISA).

provides for the development of new technology and allows new procedures to be included in the coverage once the Secretary of Health and Human Services determines they are “non-experimental.”<sup>159</sup> By refusing to restrict coverage to certain treatments, these provisions allow infertile patients and their doctors to choose the procedure that best matches the patient’s particular medical needs.

The Act also eliminates costs resulting from unnecessary procedures which are attempted simply because an insurance policy covers them.<sup>160</sup> To further minimize costs, the Act requires that patients attempt “less costly medically appropriate” treatments before ARTs are covered<sup>161</sup> and limits the number of egg retrievals to four.<sup>162</sup> Therefore, the Family Building Act of 2005 would make the treatment of infertility more effective and economical for the millions of Americans who experience infertility.

#### CONCLUSION

The success rates for infertility treatments continue to improve, and more universal insurance coverage of infertility treatments is likely to lead to more effective treatments while lowering the risks of multiple births associated with ARTs. Moreover, coverage for infertility treatments can be added to health insurance policies without greatly increasing premiums.

For a couple who desires a child, receiving a diagnosis of infertility can be devastating.<sup>163</sup> The experience can become even

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159. *See id.* (amending section 2707(b)(1) of ERISA).

160. *See supra* notes 131–34 and accompanying text.

161. H.R. 735 § 2(a) (amending section 707(b)(2)(A)(i) of ERISA). In the majority of cases, hormonal therapy and surgery is successful and only a small percentage of infertile couples must resort to ART. *See supra* note 26 and accompanying text. The Act defines ART as “all treatments or procedures that involve the handling of human egg and sperm for the purpose of helping a woman become pregnant,” including IVF, GIFT, ZIFT, embryo cyropreservation, egg or embryo donation, and surrogate birth. *See* H.R. 735 § 2(a) (amending section 2707(b)(2)(B) of ERISA).

162. *Id.* (amending section 2707(b)(A)(ii) of ERISA). This is a reasonable limitation because studies show that the success of ARTs decline with each attempt. Peter J. Neumann et al., *The Cost of a Successful Delivery with In Vitro Fertilization*, 331 NEW ENG. J. MED. 239, 239 (1994). The Act also provides that if an ART cycle is successful (results in a live birth) two additional egg retrievals should be covered, with a lifetime maximum of six. H.R. 735 § 2(a) (amending section § 2707(b)(A)(ii) of ERISA).

163. *See supra* notes 3–5 and accompanying text.

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more heart-breaking for the couple upon discovering that the medical technology to enable them to conceive exists, but that their health insurance does not provide coverage for it. Although a number of states have attempted to fill this void by mandating such coverage it is not enough.

Ultimately, the Act would mandate a uniform policy of coverage while keeping costs to a minimum. More importantly, this Act would enable millions of Americans to fulfill one of the most basic human desires: raising a family.<sup>164</sup>

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164. "For many American families, the blessing of raising a family is one of the most basic human desires." 147 Cong. Rec. 7981 (2001) (statement of Sen. Torricelli).