

BRIDGING THE GAP BETWEEN THE “HAVE” AND THE “HAVE-NOTS”: THE ACA PROHIBITS INSURANCE COVERAGE DISCRIMINATION BASED UPON INFERTILITY STATUS

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I. INTRODUCTION

Due to the high costs of infertility treatment, many infertile Americans find themselves without the means to procreate.¹ Compounding this issue, access to infertility treatment varies greatly from state-to-state largely due to the differences in state insurance coverage mandates.² The access to infertility treatment, such as artificial reproductive technology (“ART”), often correlates to factors like household income, marital status, education level, race, ethnicity, and age.³ Therefore, a dichotomy exists between the “haves,” those with the financial means to undergo infertility treatment, and the “have-nots,” those who lack such means.

In an effort to curb this preclusive effect, a total of fifteen states have passed legislation that requires insurers to provide coverage, or at least offer coverage, for infertility treatment.⁴ The infertile individuals living within the other thirty-five states and the District of Columbia, however, do not enjoy similar insurance coverage.⁵

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¹ See ANJANI CHANDRA ET AL., U.S. DEP’T OF HEALTH AND HUMAN SERVS., INFERTILITY SERVICE USE IN THE UNITED STATES: DATA FROM THE NATIONAL SURVEY OF FAMILY GROWTH, 1982–2010 2 (2014); Debra Spar & Anna M. Harrington, *Building a Better Baby Business*, 10 MINN. J.L. SCI. & TECH. 41, 49, 50 (2009).

² Spar & Harrington, *supra* note 1, at 51–53.

³ See CHANDRA ET AL., *supra* note 1, at 10.

⁴ *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx> (last updated June 2014) [hereinafter *State Laws Related to Insurance Coverage*]; Saswati Sunderam et al., *Assisted Reproductive Technology Surveillance – United States, 2011*, MORBIDITY AND MORTALITY WKLY. REP. (Nov. 21, 2014), at 9, <http://www.cdc.gov/mmwr/pdf/ss/ss6310.pdf>.

⁵ See *State Laws Related to Insurance Coverage*, *supra* note 4.

Even within the fifteen states that have passed infertility coverage mandates, the scope of the laws vary and may be significantly limited.⁶ Thus, individuals without the necessary financial means to pay out-of-pocket for infertility treatments are disadvantaged depending on the laws of the state in which they reside. Allowing the states to choose whether to provide infertility insurance coverage has proven to yield discriminatory effects upon infertile individuals. In fact, only about 25 percent of U.S. health insurance plans include infertility benefits.⁷

The lack of access to infertility treatment for the majority of Americans is not a new concern. For example, in 2001, a Michigan Federal District Court held that infertility is a disability under the Americans with Disabilities Act (“ADA”) and therefore, relevant federal protections apply to infertile individuals.⁸ Moreover, the National Women’s Law Center spearheaded a campaign called “Being a Woman Is Not a Preexisting Condition” that seeks to prevent insurers from raising insurance premiums based upon gender.⁹ Despite the court ruling and political efforts, there were no reforms made on the federal level to mandate health insurance coverage for infertility treatment.¹⁰

The advent of the Patient Protection and Affordable Care Act (“ACA”),¹¹ however, changed the landscape for the health insurance market and provides a new lens in which to view this issue. The ACA instituted large-scale health insurance reform at the federal level in an effort to control the steadily increasing cost of health care in the United States.¹² Specifically, health care spending in 2009 represented 17.6% of the United States’ GDP and was projected to increase to 19.8% of GDP by 2020.¹³ The most highly publicized provision of the ACA is the individual mandate requiring the vast majority of Americans to enroll in either private or public health

⁶ *See id.*

⁷ Kate Devine et al., *The Affordable Care Act: Early Implications for Fertility Medicine*, 101 FERTILITY & STERILITY 1224, 1224 (2014).

⁸ *See* LaPorta v. Wal-Mart Stores, Inc., 163 F. Supp. 2d 758, 763 (W.D. Mich. 2001).

⁹ Devine et al., *supra* note 7, at 1226.

¹⁰ Valarie Blake, *It’s an ART not a Science: State-Mandated Insurance Coverage of Assisted Reproductive Technologies and Legal Implications for Gay and Unmarried Persons*, 12 MINN. J.L. SCI. & TECH. 651, 661–62 (2011).

¹¹ Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–121 (2013) (effective Jan. 16, 2014).

¹² *See Trends in Health Care Cost Growth and the Role of the Affordable Care Act*, EXEC. OFFICE OF THE PRESIDENT OF THE U.S., 1, 24 (Nov. 2013), https://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf.

¹³ Paul R. Brezina et al., *How Obamacare Will Impact Reproductive Health*, 31 SEMINARS REPROD. MED. 189, 191 (2013).

insurance plans.¹⁴

More pertinent to this article, the ACA greatly affected the private insurance market and public health plans.¹⁵ First, the ACA created a generalized list of categories for minimum “essential health benefits” that all qualified health plans must offer to its beneficiaries.¹⁶ Significantly, there are several statutory provisions within the ACA regarding nondiscrimination.¹⁷ The Department of Health and Human Services (“DHHS”), the authoritative decision-maker on implementing the ACA, issued several regulations regarding nondiscrimination in the health insurance market.¹⁸ In particular, qualified health plans may “[n]ot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.”¹⁹ Therefore, the ACA and subsequent regulations represent a new legal framework in which to view discrimination in the national health insurance market.

The ACA’s statutory language is silent as to infertility treatment coverage, and its effect upon the fifteen states that have enacted state insurance mandates.²⁰ Additionally, DHHS has not included infertility coverage as an essential health benefit in any subsequent regulation.²¹ This is partly due to the fact that DHHS provided states with the authority to create their own essential health benefit standards.²² Specifically, DHHS proposed a policy in December 2011 that provided states with “the flexibility to select . . . ‘benchmark

¹⁴ See 26 U.S.C. § 5000A(a) (2013); Brezina et al., *supra* note 13, at 191.

¹⁵ See *infra* Part IV.A.

¹⁶ 42 U.S.C. § 18022(a)(1), (b)(1) (2013); see *infra* notes 160–67. This provision, however, does not affect “grandfathered” insurance plans that were in existence before the enactment of the ACA. See 42 U.S.C. § 18011 (2013). Moreover, the essential health benefit standard does not apply to self-insured groups and large group plans. See Kate Greenwood et al., *Implementing the Essential Health Benefits Requirement in New Jersey: Decision Points and Policy Issues* 1 (Seton Hall Univ. Sch. of Law, Ctr. for Health & Pharm. Law & Policy, Research Paper No. 08, 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2146806. It is important to note that Congress gave the Department of Health and Human Services (“DHHS”) the power to formalize essential health benefits after receiving input from the Department of Labor, Institute of Medicine, Congressional members, private citizens, and physician groups. See 42 U.S.C. § 18022(a)(1); Brezina et al., *supra* note 13, at 193.

¹⁷ See, e.g., 42 U.S.C. §§ 300gg-3, -4, -5, -16, 18116 (2013).

¹⁸ In enacting the ACA, Congress authorized DHHS to “issue regulations setting standards for meeting the requirements” under Title 1 of the ACA, which includes the relevant ACA provisions for the purposes of this article. 42 U.S.C. § 18041(a)(1) (2013).

¹⁹ 45 C.F.R. § 156.225(b) (2014).

²⁰ Brezina et al., *supra* note 13, at 194, 195; see also Devine et al., *supra* note 7, at 1224 (noting that the long-term effects of the ACA with respect to infertility treatment is unknown).

²¹ See Brezina et al., *supra* note 13, at 194.

²² Devine et al., *supra* note 7, at 1225.

plan[s]” based upon typical insurance coverage plans within the state.²³ On February 27, 2015, DHHS renewed this policy through 2017.²⁴ In accordance with this policy, the states with insurance mandates regarding infertility treatments adopted essential benefit standards that incorporated such laws.²⁵ Therefore, in this context, the status quo has been maintained, so far.

In light of the changes created by the ACA, the question arises: Does the fact that some infertile individuals in the United States lack access to insurance coverage for infertility treatment violate the ACA’s anti-discrimination framework? This article answers in the positive. Although medical practitioners and scholars have already addressed the problem of unequal access to infertility treatment,²⁶ this article will use the ACA as a new lens to view this inequality. Interestingly enough, congressional hearings regarding the passage of the ACA uncovered stories of women who were wholly “denied insurance coverage because their infertility [status] was treated as a preexisting condition.”²⁷ Due to financial restrictions, often no hope exists for many infertile individuals who live in states without insurance mandates to obtain the means to procreate.²⁸

This article will proceed as follows. Part II will discuss the various types of infertility treatment and the associated costs. This section will also discuss established demographic patterns in the type of

²³ *Id.*

²⁴ See CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS: LIST OF THE LARGEST THREE SMALL GROUP PRODUCTS BY STATE 3 (2015), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf>; see generally 45 C.F.R. § 156.100 (2015) (granting States the ability to select their own benchmark plan).

²⁵ Devine et al., *supra* note 7, at 1225.

²⁶ See, e.g., CHANDRA ET AL., *supra* note 1, at 1–2 (“[W]omen who use infertility services are significantly more likely to be married, non-Hispanic white, older, more highly educated, and more affluent than nonusers.”); Blake, *supra* note 10, at 660–61 (arguing that the necessity to pay out-of-pocket for fertility treatment is a deterrent for infertile women); Anne Fidler & Judith Bernstein, *Infertility: From a Personal Public Health*, 114 PUB. HEALTH REP. 494, 497 (1999) (discussing statistics which indicate that race and wealth are directly correlated to women’s use of fertility treatment); Marianne P. Bitler & Lucie Schmidt, *Utilization of Infertility Treatments: The Effects of Insurance Mandates* 12–13 (Nat’l Bureau of Econ. Research, Working Paper No. 17668, 2011), <http://www.nber.org/papers/w17668.pdf> (noting that statistics from the National Survey of Family Growth demonstrate that older and more educated women have greater access to infertility treatment as a result of State infertility insurance mandates allowed for by the ACA).

²⁷ Devine et al., *supra* note 7, at 1226; see also RICHARD KIRSCH, FIGHTING FOR OUR HEALTH: THE EPIC BATTLE TO MAKE HEALTH CARE A RIGHT IN THE UNITED STATES 271 (2011) (describing a woman whose children were approved for coverage, but who was denied coverage because her infertility was considered to be a preexisting condition).

²⁸ See Fidler & Bernstein, *supra* note 26, at 504 (arguing that insurance coverage is required to make infertility treatment widely available).

individuals who undergo such treatment. Part III will address the different insurance mandates in the fifteen states that have enacted legislation to provide coverage for infertility treatment. It will also argue that inherent inequalities arise from the fact that access to infertility treatment is, in part, based upon state residency. Part IV explains the relevant federal insurance law reforms instituted by the ACA and illustrates the ways in which the reform brought about more inclusive coverage standards. Finally, Part V argues why the inequality in access to infertility treatments amongst Americans violates the ACA's anti-discrimination framework.

II. INFERTILITY IN AMERICA AND THE ASSOCIATED HIGH COST FOR TREATMENT

Similar to many health issues, no single universal definition for infertility exists. The most common definition of infertility is a "disease of the reproductive system"²⁹ where an individual is unsuccessful in becoming pregnant after more than one year of unprotected sex.³⁰ The definitional variations for infertility produce different statistical findings on the number of infertile individuals and how they are treated.³¹ Moreover, defining infertility as the inability to do something is problematic for statistical purposes.³² For example, a physician treats two women who both have blocked fallopian tubes, but only one woman is trying to get pregnant. Despite both women having blocked fallopian tubes, only one of them would be diagnosed as infertile.³³ Therefore, the below statistics should be viewed in light of these difficulties in collecting adequate data.

According to the Centers for Disease Control and Prevention ("CDC"), approximately 6.7 million women between the ages of 15–44 suffer from an impaired ability to become pregnant.³⁴ Therefore, almost eleven percent of women in the United States suffer from this

²⁹ *Infertility is a Global Public Health Issue*, WORLD HEALTH ORG., <http://www.who.int/reproductivehealth/topics/infertility/perspective/en/> (last visited Nov. 15, 2014) (internal quotation marks omitted).

³⁰ Fidler & Bernstein, *supra* note 26, at 497; *State Laws Related to Insurance Coverage*, *supra* note 4.

³¹ Fidler & Bernstein, *supra* note 26, at 497.

³² *See id.*

³³ *See id.*

³⁴ *Infertility*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/infertility.htm> (last updated Feb. 6, 2015); *Quick Facts About Infertility*, AM. SOC'Y FOR REPROD. MED., <http://www.asrm.org/detail.aspx?id=2322> (last visited Nov. 15, 2015).

impaired ability.³⁵ Additionally, infertility affects men and women equally. For example, the male partner is either the sole cause or a contributing cause for infertility in approximately 40 percent of infertile couples.³⁶

In addition to the high financial costs associated with infertility treatment,³⁷ a diagnosis of infertility is associated with a significant emotional toll. Evidence shows that the psychological effects sustained by infertile individuals are similar to the effects on heart disease and cancer patients.³⁸ Further, an infertility diagnosis may contribute to a patient developing clinical depression, social isolation, and overall affect his or her quality of life.³⁹ Indeed, infertility affects a “major life activity” as determined by the United States Supreme Court in *Bragdon v. Abbott*.⁴⁰ These additional considerations, that are too personal to be monetarily valued, must not be overlooked.

Part A of this section will briefly discuss the types of infertility treatment and the associated financial costs. The impact that information has on the United States population will be examined in Part B.

A. Varying Types of Infertility Treatments and the Costs Associated with Such Treatment

Infertile individuals have several options for medical procedures to increase their chances to conceive a child. Defining infertility treatment can be undertaken in a broad or narrow sense. For example, some physicians may believe providing general advice to increase a couple’s chances of becoming pregnant fits within the infertility treatment umbrella and therefore, reflects a broad meaning of infertility treatment.⁴¹ For the purposes of this article, however, a more narrow perspective on infertility treatment is adopted that includes only the three levels of treatment described below.

As a preliminary matter, physicians will first run diagnostic exams of each partner’s reproductive organs if a couple is experiencing

³⁵ *Infertility*, *supra* note 34; *Quick Facts About Infertility*, *supra* note 34.

³⁶ *Quick Facts About Infertility*, *supra* note 34.

³⁷ *See infra* Part II.B.

³⁸ Fidler & Bernstein, *supra* note 26, at 497.

³⁹ *Id.*

⁴⁰ *Bragdon v. Abbott*, 524 U.S. 624, 639, 655 (1998) (holding that HIV infection is a disability under the Americans with Disabilities Act because it substantially limits a major life activity, reproduction).

⁴¹ *See* CHANDRA ET AL., *supra* note 1, at 2.

difficulty in getting pregnant.⁴² About fifty percent of patients who receive infertility evaluation decide to undergo some type of infertility treatment.⁴³ Depending upon these results, there are generally three categories of infertility treatment: (1) Level I; (2) Level II; and (3) Level III.⁴⁴ The treatment structure follows a pyramid-like scheme. Many infertile couples who choose to undergo Level III procedures have already unsuccessfully tried Level I and Level II.⁴⁵

Level I infertility treatment involves ovarian stimulation with clomiphene citrate (a medication) for up to six ovulation cycles.⁴⁶ Level II procedure involves another medication with exogenous gonadotrophins to stimulate ovulation with the option of using intrauterine insemination⁴⁷ for up to six cycles.⁴⁸ Finally, Level III infertility treatment encompasses the various ARTs for as many cycles the couple can pay for.⁴⁹ There are various types of ART, which include: (1) in vitro fertilization⁵⁰ (“IVF”); (2) zygote intrafallopian transfer⁵¹ (“ZIFT”); (3) gamete intrafallopian transfer⁵² (“GIFT”); and (4) intracytoplasmic sperm injection⁵³ (“ICSI”).⁵⁴

The infertility treatment variations discussed above inherently lead to varying levels of cost. For example, hormone therapy used in Level I and Level II can cost anywhere from \$200 to \$3,000 per

⁴² See Bitler & Schmidt, *supra* note 26, at 7.

⁴³ Devine et al., *supra* note 7, at 1224.

⁴⁴ See Bitler & Schmidt, *supra* note 26, at 7.

⁴⁵ *Id.* at 7–8.

⁴⁶ *Id.* at 7.

⁴⁷ See CTRS. FOR DISEASE CONTROL & PREVENTION, 2011 ASSISTED REPRODUCTIVE TECHNOLOGY: FERTILITY CLINIC SUCCESS RATES REPORT 513 (2013), http://www.cdc.gov/art/ART2011/PDFs/ART_2011_Clinic_Report-Full.pdf [hereinafter ASSISTED REPRODUCTIVE TECHNOLOGY] (providing a definition showing that this Level II procedure is generally not considered an artificial reproductive technology because the sperm is injected directly into a woman’s uterus to facilitate egg fertilization, and no manipulation of the egg itself is conducted); Bitler & Schmidt, *supra* note 26, at 7.

⁴⁸ See Bitler & Schmidt, *supra* note 26, at 7.

⁴⁹ See *id.*

⁵⁰ Eggs are removed from a woman’s ovaries and are fertilized outside of her body. ASSISTED REPRODUCTIVE TECHNOLOGY, *supra* note 47, at 514. The fertilized egg (embryo) is then “transferred [back] into a woman’s uterus through [her] cervix.” *Id.*

⁵¹ Similar to the IVF procedure in that the eggs collected from a woman’s ovaries are fertilized outside of her body. *Id.* at 515. It differs from IVF because a laparoscope is used to place the zygote “into the woman’s fallopian tube through a small incision in her abdomen.” *Id.*

⁵² Eggs are removed “from the woman’s ovary, combining them with sperm, and using a laparoscope to place the unfertilized eggs and sperm into the woman’s fallopian tube through small incisions in her abdomen.” *Id.* at 514.

⁵³ “A procedure in which a single sperm is injected directly into an egg; this procedure is commonly used to overcome male infertility problems.” *Id.*

⁵⁴ *Id.* at 513.

cycle.⁵⁵ Once you move into ART procedures that require tubal surgery, then the price can range from \$10,000 to \$15,000 per cycle and hospitalization costs are added on top of the price tag.⁵⁶ As with any type of surgery, there are associated complication risks that could lead to more financial cost. An average IVF cycle in the United States can cost between \$10,000 and \$15,000 with only a 25%–30% live birth success rate.⁵⁷ Therefore, many couples will need to undergo several IVF cycles to achieve their desired outcome.⁵⁸ The cost to conceive a child through IVF ranged from \$44,000 to \$211,940 in 1992 dollars.⁵⁹

Comparative analysis with other countries helps put these numbers into perspective. The average cost for one IVF cycle is about \$6,534 in the United Kingdom, \$5,645 in Australia, and \$3,956 in Japan.⁶⁰ Additionally, “the gross cost of a single IVF cycle as a percentage of annual disposable income was highest in the United States, at 50%, compared with, for example, 12% in Japan.”⁶¹ Thus, ART costs in the United States are more expensive than in many similarly developed countries.

There are other financial costs to ART procedures due to an increased risk of multiple-order births.⁶² Specifically, the high cost of ART and the relatively low success rates influence people to maximize their investment by implanting more than one egg into the woman’s ovaries in any given cycle.⁶³ Infertile individuals choose to do this in an effort to save money on ART cycles. The logic being, pregnancy chances are increased because there is more than one egg

⁵⁵ See Bitler & Schmidt, *supra* note 26, at 8.

⁵⁶ See *id.*

⁵⁷ Barton H. Hamilton & Brain McManus, *The Effects of Insurance Mandates on Choices and Outcomes in Infertility Treatment Markets*, 21 HEALTH ECON. 994, 994 (2012); Bitler & Schmidt, *supra* note 26, at 8 (discussing how the average cost for one IVF cycle in the United States is \$12,400).

⁵⁸ See Hamilton & McManus, *supra* note 57, at 944 (discussing how there is only a 25%–30% success rate for IVF, and as a result, those who choose to undergo such treatments oftentimes do so more than once).

⁵⁹ Bitler & Schmidt, *supra* note 26, at 8.

⁶⁰ See Georgina M. Chambers et al., *The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries*, 91 FERTILITY & STERILITY 2281, 2288 (2009).

⁶¹ Bitler & Schmidt, *supra* note 26, at 15 n.12.

⁶² See CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL PUBLIC HEALTH ACTION PLAN FOR THE DETECTION, PREVENTION, AND MANAGEMENT OF INFERTILITY 13 (2014) [hereinafter NATIONAL PUBLIC HEALTH ACTION PLAN], http://www.cdc.gov/reproductivehealth/Infertility/PDF/DRH_NAP_Final_508.pdf.

⁶³ M. Kate Bundorf et al., *Mandated Health Insurance Benefits and the Utilization and Outcomes of Infertility Treatments* 3–4 (Nat’l Bureau of Econ. Research, Working Paper No. 12820, 2007), <http://www.nber.org/papers/w17668.pdf>.

implanted into the ovary, thereby improving the chance that only one ART cycle is needed.⁶⁴ Implanting more than one egg, however, has its trade-offs. Since more than one fertilized egg is implanted into the woman's ovaries, the risk of having multiple-order births as a result of ART is relatively high.⁶⁵ About 30% of ART deliveries involve multiple births while only 3% of the general population experiences multiple birth deliveries.⁶⁶ The multiple birth rates increased from 1.93% in 1980 to 3.3% in 2002.⁶⁷ This increase represented 65% more twin deliveries and 397% more higher-order deliveries.⁶⁸ In a study that compared ART usage data in the United States, Canada, United Kingdom, Scandinavia, Japan, and Australia, the United States had the highest multiple birth rates per ART cycle at 34.2%.⁶⁹ The CDC estimated that 80% of the multiple birth rate increase could be ascribed to ART and ovulation stimulating drugs.⁷⁰

Multiple births are associated with higher health risks for both the mother and children, which leads to more expensive health care.⁷¹ Generally speaking, multiple order infants have lower birth weight, which is positively correlated within infant mortality and serious health conditions.⁷² Indeed, perinatal costs of multiple births are more costly than ART procedures themselves.⁷³ A study concluded in the early 1990s found the average cost for the delivery of one baby was \$9,845 compared to \$18,974 per baby for twin deliveries.⁷⁴ Although insurers cover these costs after birth, it is important to discuss in the context of infertility treatment cost. In essence, if infertility treatment was not so expensive, there would be fewer multiple births overall because people would be less inclined to accept the aforementioned health risks in exchange for potentially saving money on ART cycles.

⁶⁴ See Hamilton & McManus, *supra* note 57, at 995.

⁶⁵ Bundorf et al., *supra* note 63, at 3.

⁶⁶ *Id.*

⁶⁷ Melinda B. Henne & M. Kate Bundorf, *Insurance Mandates and Trends in Infertility Treatments*, 89 FERTILITY & STERILITY 66, 66 (2008).

⁶⁸ *Id.*

⁶⁹ Chambers et al., *supra* note 60, at 2285. Compare this with Japan's multiple birth rate of 17.1% per ART cycle. *Id.*

⁷⁰ Henne & Bundorf, *supra* note 67, at 66.

⁷¹ NATIONAL PUBLIC HEALTH ACTION PLAN, *supra* note 62, at 13.

⁷² Laura A. Schieve et al., *Low and Very Low Birth Weight in Infants Conceived with Use of Assisted Reproductive Technology*, 346 NEW ENG. J. MED. 731, 731 (2002).

⁷³ Chambers et al., *supra* note 60, at 2292.

⁷⁴ Tamara L. Callahan et al., *The Economic Impact of Multiple-Gestation Pregnancies and the Contribution of Assisted Reproduction Techniques to Their Incidence*, 331 NEW ENG. J. MED. 244, 244 (1994).

B. The National Impact of the High Cost for Infertility Treatment

The cost for infertility treatment impacts how accessible the procedures are to the infertile population within the United States. Studies show that approximately 12% of childbearing-aged women in the United States received some sort of assistance for infertility.⁷⁵ In 2008, more than 61,600 children were born in connection with ART.⁷⁶ According to the CDC, ART accounts for approximately 1% of total births within the United States.⁷⁷ Below the surface of these statistics, patterns emerge as to infertility treatment accessibility and the resulting inequality of individuals receiving treatment.

In a 2014 report on infertility treatment usage within the United States, data was collected from women ranging from fifteen to forty-four years of age from a period between 1982 and 2010.⁷⁸ This study is helpful in illuminating accessibility patterns to infertility treatment, but it must be introduced with one caveat—the study encompasses a broad definition of infertility treatment.⁷⁹ Specifically, the study not only considers the three levels of infertility treatment described above, but also includes services like general advice, infertility testing, and medication to prevent miscarriage.⁸⁰ Therefore, the statistics will reflect greater usage of infertility treatment because these additional services come at a significantly lower cost than the types of infertility treatment this article is based upon.⁸¹

The type of person who receives infertility treatment fits a general profile. An infertile woman that uses infertility treatment is “significantly more likely to be married, non-Hispanic white, older, more highly educated, and more affluent than nonusers.”⁸² In fact, 19% of women between twenty-five and forty-four who obtained a master’s degree or higher have received medical help in getting

⁷⁵ *State Laws Related to Insurance Coverage*, *supra* note 4.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ CHANDRA ET AL., *supra* note 1, at 1.

⁷⁹ *See id.* at 1, 2–3.

⁸⁰ *Id.* at 2–3; *see also supra* notes 46–54 and accompanying text (describing the three levels of infertility treatment).

⁸¹ *See supra* note 55 and accompanying text.

⁸² CHANDRA ET AL., *supra* note 1, at 2; Marilyn B. Hirsch & William D. Mosher, *Characteristics of Infertile Women in the United States and Their Use of Infertility Services*, 47 FERTILITY & STERILITY 618, 623–24 (1987). *But see*, Anjani Chandra & Elizabeth Hervey Stephen, *Infertility Service Use Among U.S. Women: 1995 and 2002*, 93 FERTILITY & STERILITY 725, 733 (2010) (finding that older age, formal marital status, and higher socioeconomic status are associated with the use of infertility services, but also asserting that race and Hispanic origin does not have any significant association).

pregnant, while only 6.4% of similarly-aged women without a high school diploma received such help.⁸³ Moreover, there is a positive correlation between household income and the use of infertility services.⁸⁴ “[I]n 2006–2010, 21% of women whose household incomes were 400% of the poverty level or higher had ever used infertility services, compared with 13% of women whose household incomes were below the poverty level.”⁸⁵ In regards to ART usage rates during 2006–2010, ART was, by far, the least common infertility treatment used with only 0.7% of women between the ages of twenty-five and forty-four using such services.⁸⁶

This data is problematic for several reasons. First, an apparent unmet need for infertility treatment exists based upon the statistics.⁸⁷ As discussed in Part II above, the CDC found about 6.7 million women in the United States between the ages of fifteen and forty-four suffer from an impaired ability to become pregnant.⁸⁸ In 2008, however, only 61,600 births resulted from ART.⁸⁹ Although other treatment besides ART exists to aid infertile individuals to procreate, one would imagine that the total number of children conceived through ART would be higher since approximately 11% of American women suffered from an impaired ability to conceive.⁹⁰ In fact, as this section illuminated, ART usage rates by women between twenty-five and forty-four years-old was only 0.7%.⁹¹ Comparative studies further support the argument that there is an unmet need for infertility treatment within the United States. For example, in Denmark, ART was associated with about 4.2% of births in 2004, while in the same year only 1.2% of births in the United States resulted from ART.⁹² The ART utilization rate in the United States, which is approximately 373 cycles per million persons, is dwarfed in comparison to the rates in other developed countries.⁹³ The rates in

⁸³ CHANDRA ET AL., *supra* note 1, at 7; *see also* Hamilton & McManus, *supra* note 57, at 1009 (“IVF penetration is significantly greater in markets with a large percentage of women with graduate degrees, which may indicate that infertility treatments are relative[ly] common among women who have delayed childbearing in favor of additional schooling . . .”).

⁸⁴ *See* CHANDRA ET AL., *supra* note 1, at 10.

⁸⁵ *Id.* at 5–6.

⁸⁶ *Id.* at 7.

⁸⁷ Bitler & Schmidt, *supra* note 26, at 26.

⁸⁸ *See Infertility*, *supra* note 34.

⁸⁹ *State Laws Related to Insurance Coverage*, *supra* note 4.

⁹⁰ *See Infertility*, *supra* note 34; *Infertility: Treatments and Drugs*, MAYO CLINIC (July 2, 2014), <http://www.mayoclinic.org/diseases-conditions/infertility/basics/treatment/con-2003-4770>.

⁹¹ CHANDRA ET AL., *supra* note 1, at 7.

⁹² Bitler & Schmidt, *supra* note 26, at 26.

⁹³ Chambers et al., *supra* note 60, at 2285.

Australia and Scandinavia were 1,574 and 1,465 cycles per million persons, respectively.⁹⁴ In fact, the authors of this comparative study found that the ART utilization rates in the United States and Canada resulted “in an unmet demand of 365,000 cycles per annum; that is to say, only 24% of demand for ART treatment cycles in North America was met in 2003.”⁹⁵

Secondly, the patient “profile” for individuals seeking infertility treatment is worrisome, especially because the right to procreate is a fundamental right recognized by the United States Supreme Court.⁹⁶ The statistics show a positive correlation of infertility treatment usage with higher household income and higher education levels.⁹⁷ According to one study, “[t]here is an 11 percent chance that low-income women will pursue ART, while high-income women are almost twice as likely to do so.”⁹⁸ Thus, a divide between the “haves” and the “have-nots” based upon these socioeconomic factors is suspect to say the least.

III. STATES WITH INSURANCE MANDATES REQUIRING COVERAGE FOR INFERTILITY TREATMENT

The decision whether to require insurance coverage for infertility treatment has traditionally been left up to the states.⁹⁹ Although there are advantages in leaving this in the state legislatures’ hands, there are marked disadvantages. Presently, there are fifteen total states that have passed legislation to require insurance companies to either offer coverage or cover infertility treatment.¹⁰⁰ These states include: Arkansas, California, Connecticut, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Montana, New Jersey, New

⁹⁴ *Id.*

⁹⁵ *Id.* at 2288.

⁹⁶ See *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (identifying the right to procreate as a basic civil right); see also *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“If 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.” (citing *Stanley v. Georgia*, 394 U.S. 557, 564 (1969))); *Griswold v. Connecticut*, 381 U.S. 479, 480 (1965) (invalidating a state law that prohibited the distribution of medical advice and information regarding contraception to married individuals).

⁹⁷ See *supra* notes 82–85 and accompanying text. It is also troubling that race and ethnicity serves as another indicator as to whether the infertile individual will receive infertility treatment. See *supra* notes 82–85 and accompanying text.

⁹⁸ Katie Falloon and Philip M. Rosoff, *Who Pays? Mandated Insurance Coverage for Assisted Reproductive Technology*, 16 VIRTUAL MENTOR 63, 64 (2014) (citing Mark P. Connolly et al., *Economics of Assisted Reproduction: Access to Fertility Treatments and Valuing Live Births in Economic Terms*, 13 HUM. FERTILITY 13, 14 (2010)).

⁹⁹ See *State Laws Related to Insurance Coverage*, *supra* note 4.

¹⁰⁰ *Id.*

York, Ohio, Rhode Island, Texas, and West Virginia.¹⁰¹ Approximately 25 percent of insurance plans within the United States include some infertility benefits.¹⁰²

Part A of this section will briefly describe the different types of insurance mandates enacted in the fifteen states listed above. It will illuminate significant degrees of mandate variations from state-to-state. Part B will identify the inequality that arises from the fact that no uniform federal standard exists. Specifically, infertile individuals within the fifteen states with insurance mandates enjoy greater access to the means to procreate than other similarly situated individuals in the thirty-five states within the United States and the District of Columbia that have not passed similar legislation. As explained below, the increased access residents enjoy in the fifteen states with insurance mandates, however, must be tempered with the differences in coverage requirements that exist within the fifteen state mandates themselves.¹⁰³ Overall, this section argues that the accessibility to infertility treatment is, in part, dependent upon state residency status.

A. *State-to-State Differences in Infertility Treatment Coverage Mandates*

West Virginia was the first state to enact an insurance mandate for infertility treatment in 1977, and since then, fourteen more states have followed.¹⁰⁴ As mentioned above, the insurance mandates among the fifteen states that provide for infertility treatment coverage vary greatly. Putting aside the divide between the fifteen states with insurance mandates and the thirty-five states without such mandates, additional division exists amongst the fifteen states because of differences in the mandates themselves.¹⁰⁵ There are generally three types of insurance mandates amongst the fifteen states that have already enacted legislation: (1) universal mandates that cover IVF treatment;¹⁰⁶ (2) restricted mandates that cover only specified types of ART;¹⁰⁷ and (3) other laws¹⁰⁸ requiring insurers to

¹⁰¹ *Id.*

¹⁰² Devine et al., *supra* note 7, at 1224.

¹⁰³ *See infra* Part III.A.

¹⁰⁴ Bitler & Schmidt, *supra* note 26, at 8.

¹⁰⁵ Hamilton & McManus, *supra* note 57, at 1000.

¹⁰⁶ These states include Illinois, Massachusetts, and Rhode Island. *Id.* at 999–1000.

¹⁰⁷ Arkansas, Hawaii, Maryland, Montana, New Jersey, Ohio, and West Virginia fall into this category. *See id.*

¹⁰⁸ *See id.*

offer insurance for IVF or coverage mandates for non-IVF infertility treatments.¹⁰⁹ The reasoning adopted by some states for passing more generous mandates is twofold: (1) expand access to infertility treatment for patients who otherwise do not have the financial means to pay for the procedures out-of-pocket, and (2) the reduction in financial pressure on patients to conceive during the first cycle of treatment may reduce the multiple birth rates associated with ART.¹¹⁰

Significant differences exist relating to the type of insurance coverage itself. As a preliminary matter, only thirteen of the fifteen states with mandates require insurers to cover infertility treatment.¹¹¹ The two outlier states, Texas and California, merely require insurers to offer infertility treatment coverage.¹¹² Another divide amongst the state legislation is how IVF, the most expensive ART, is treated. For example, California, Louisiana, and New York explicitly exclude IVF from insurance coverage.¹¹³ Additionally, coverage mandates differ in scope as to what types of insurers are required to provide coverage.¹¹⁴ Some states require all insurance companies to provide coverage and other laws only apply to certain types of insurers like health management organizations.¹¹⁵

Moreover, insurance mandates from each of the fifteen states differ as to personal qualifications an infertile individual must meet in order to receive coverage. For example, Illinois, California, and New Jersey statutes require individuals engage in unprotected sex for a

¹⁰⁹ Connecticut, Texas, California, Louisiana, and New York fit within this category. *See id.*; Henne & Bundorf, *supra* note 67, at 66. Non-IVF infertility treatments include the three levels of treatment discussed in Part II, except for IVF. *See supra* Part II.A.

¹¹⁰ Hamilton & McManus, *supra* note 57, at 995; *see also* Bundorf et al., *supra* note 63, at 11 (stating that due to the high cost of IVF treatments, those who are not covered by insurance feel a need to get the most out of each cycle paid for, regardless of the risk of multiple births, whereas those who are provided with insurance coverage tend to be more conservative when making decisions regarding embryo transfer).

¹¹¹ *State Laws Related to Insurance Coverage*, *supra* note 4; Sunderam et al., *supra* note 4, at 9.

¹¹² *State Laws Related to Insurance Coverage*, *supra* note 4; *see also* CAL. HEALTH & SAFETY CODE § 1374.55(a) (West 2015) (“[E]very health care service plan . . . shall offer coverage for the treatment of infertility, except in vitro fertilization.”); TEX. INS. CODE ANN. § 1366.003(a) (West 2015) (“[A]n 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.”).

¹¹³ *State Laws Related to Insurance Coverage*, *supra* note 4; *see, e.g.*, LA. STAT. ANN. § 22:1036(A)(2) (2014) (“This Section shall not be construed to require coverage of the following: (a) Fertility drugs. (b) In vitro fertilization or any other assisted reproductive technique.”); N.Y. INS. LAW § 3221(k)(6)(C)(v) (McKinney 2015) (“Coverage shall not be required to include . . . in vitro fertilization.”).

¹¹⁴ *See* Hamilton & McManus, *supra* note 57, at 1000.

¹¹⁵ *Id.*

certain time period to qualify for mandated insurance coverage.¹¹⁶ Furthermore, some states impose a condition on the number of years an individual goes without becoming pregnant in order to qualify for insurance coverage.¹¹⁷ Spousal language is included in some state statutes that exclude any possibility that single or gay infertile individuals receive insurance coverage.¹¹⁸ This represents a significant hurdle for many infertile individuals living within those states.¹¹⁹ In addition, Hawaii, Maryland, and Texas require the infertility to either be unexplained or associated with specified medical conditions resulting in infertility.¹²⁰ Finally, another distinction among states is that some insurance mandates require the infertility treatment to be medically necessary.¹²¹ These states include: Connecticut, Massachusetts, Ohio, and Rhode Island.¹²² Requiring medical necessity can be especially discriminatory against gay and single individuals.¹²³ From the numerous differences among

¹¹⁶ Blake, *supra* note 10, at 667; *see also* CAL. HEALTH & SAFETY CODE § 1374.55(b) (“[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.”); 215 ILL. COMP. STAT. § 5/356m(c) (2015) (“[I]nfertility’ means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.”); N.J. STAT. ANN. § 17:48-6x(a) (West 2015) (“[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 . . . 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.”).

¹¹⁷ *See, e.g.*, N.J. STAT. ANN. § 17:48-6x(a) (imposing a two year requirement for female partners under the age of 35); R.I. GEN. LAWS § 27-18-30(b) (2015) (“[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.”).

¹¹⁸ *See, e.g.*, HAW. REV. STAT. § 431:10A-116.5(a)(4) (2015); MD. CODE ANN., INS. § 15-810(d)(2) (LexisNexis 2015); R.I. GEN. LAWS § 27-18-30(b); Blake, *supra* note 10, at 670.

¹¹⁹ *See* Blake, *supra* note 10, at 670–71.

¹²⁰ *See* HAW. REV. STAT. ANN. § 431:10A-116.5(a)(4); MD. CODE ANN., INS. § 15-810(d)(3); TEX. INS. CODE ANN. §1366.005(3).

¹²¹ Blake, *supra* note 10, at 671–72.

¹²² *Id.*; *see also* CONN. GEN. STAT. ANN. § 38a-536(a) (West 2015) (“[E]ach group health insurance policy . . . shall provide coverage for the medically necessary expenses of the diagnosis and treatment of infertility”); MASS. GEN. LAWS ANN. ch. 175, § 47H (West 2015) (“Any blanket or general policy of insurance . . . shall provide . . . coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth.”); OHIO REV. CODE ANN. § 1751.01(A)(1) (LexisNexis 2015) (defining what “basic health care services” mean when something is determined to be medically necessary); R.I. GEN. LAWS §27-18-30(a) (“Any health insurance contract, plan, or policy . . . shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years.”).

¹²³ *E.g.*, 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, 175 (2000) (arguing that infertility treatment is not medically necessary for same sex couples because in a definitional sense, gays and lesbians are not medically infertile, but

state insurance mandates, it becomes evident that equal access to infertility treatment is still problematic in states that have enacted coverage laws. In essence, living in a state with more broadly written and interpreted insurance mandates will increase the likelihood an infertile individual will have access to infertility treatment.¹²⁴

B. Unequal Access to Infertility Treatments Due to the State Law Divide

The insurance mandates passed in the fifteen states requiring insurers to cover, or at least offer to cover, infertility treatment increased accessibility to such treatments to residents within those states who otherwise could not afford to pay the medical costs.¹²⁵ The infertile individuals residing in the other thirty-five states and District of Columbia, however, do not enjoy similar accessibility. In the absence of any federal coverage standard, the dichotomy between the “haves” and the “have-nots” remains the status quo. Further analyzing this division is beneficial to understand the repercussions from maintaining the present day system.

Generally, state insurance mandates are associated with higher ART utilization.¹²⁶ For example, ART usage more than doubled the national average in New Jersey, New York (excluding New York City), and Massachusetts.¹²⁷ Additionally, delivery rates for women between thirty-five and thirty-nine years old increased as a result of comprehensive insurance mandates.¹²⁸ Although comprehensive mandates had a lesser effect upon younger women, the effect is still similarly significant.¹²⁹ Moreover, ART usage rates are greater in states with insurance mandates to cover such treatment than in the

instead are constructively infertile).

¹²⁴ For example, in Illinois the coverage mandate provides for up to six egg retrievals (dependent on circumstances), which is a required procedure for IVF. See *Insurance Coverage in Your State*, RESOLVE, http://www.resolve.org/family-building-options/insurance_coverage/state-coverage.html (last visited Dec. 22, 2015). In Hawaii, however, an insured is covered for only one IVF cycle. *Id.*

¹²⁵ Hamilton & McManus, *supra* note 57, at 1014 (discussing how insurance mandates increase access to IVF); Henne & Bundorf, *supra* note 67, at 66, 70 (“[U]tilization of ART has been shown to be greater in states with insurance mandates than in those without. . . . [U]tilization rates were higher and increased most rapidly in states adopting comprehensive insurance mandates.”).

¹²⁶ See, e.g., Chambers et al., *supra* note 60, at 2292; Henne & Bundorf, *supra* note 67, at 66.

¹²⁷ See Sunderam et al., *supra* note 4, at 1. These three states adopted some version of insurance mandates for infertility treatment. See *supra* Part III.A.

¹²⁸ Bundorf et al., *supra* note 63, at 20.

¹²⁹ See *id.* at 26.

states without similar laws.¹³⁰ In states with universal mandates, IVF penetration expanded by approximately 90% for infertile women in all age groups.¹³¹ Since ART is the most expensive type of infertility treatment, it is natural for the insurance mandates to most significantly affect its usage rate. Even in studies dealing with several well-developed countries, “[h]igher levels of [ART] utilization were found in countries with low out-of-pocket expenses, either through low treatment costs . . . or generous public funding.”¹³²

It is important to note, however, that the state insurance mandates enacted to cover infertility treatment are not perfect solutions to the inequality problem discussed above. Some evidence suggests that the insurance mandates fail to bridge the gap in usage rates for infertility treatment based upon race, ethnicity, and socioeconomic status.¹³³ One potential reason for this finding is misconception over what infertility treatment entails. As stated above, infertility treatment can take many forms, such as reproductive organ testing, general advice, and medication to prevent miscarriage.¹³⁴ Another potential explanation for this evidence is the restrictions placed upon coverage within the state statutes themselves discussed above.¹³⁵ Residing in a state that explicitly excludes IVF treatments from insurance coverage, for example, could foreclose the infertile individual from seeking treatment and affect the statistics accordingly.¹³⁶ Thus, the jury is still out on the overall impact insurance mandates will have on all types of infertility treatments as a whole.

Statistics showing a correlation between states with insurance mandates and increased usage of infertility treatment are helpful in tangibly demonstrating how residents within those states are at an advantage compared to residents within the other thirty-five states without mandates.¹³⁷ In other words, the fact that infertility

¹³⁰ See Hamilton & McManus, *supra* note 57, at 1002; Henne & Bundorf, *supra* note 67, at 66; Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 NEW ENG. J. MED. 661, 664 (2002); Sunderam, *supra* note 4, at 9.

¹³¹ Hamilton & McManus, *supra* note 57, at 1009.

¹³² Chambers et al., *supra* note 60, at 2291.

¹³³ See CHANDRA ET AL., *supra* note 1, at 2. Moreover, one study concluded that insurance mandates have the largest effect on older, highly educated women, as they are at the highest risk for infertility, and more likely to carry private health insurance. See Bitler & Schmidt, *supra* note 26, at 21.

¹³⁴ See CHANDRA ET AL., *supra* note 1, at 6–7.

¹³⁵ See *supra* Part III.A.

¹³⁶ See Hamilton & McManus, *supra* note 57, at 1004 (discussing how characteristics of state insurance mandates drive patient decisions in seeking alternative forms of treatment).

¹³⁷ See Henne & Bundorf, *supra* note 67, at 66–67; Jain et al., *supra* note 130, at 664–65 (noting that in states requiring insurance, the rate of utilization was 277 percent of the rate when there was no coverage); *supra* note 6 and accompanying text.

treatment rates are higher in states where insurance coverage is required, demonstrates that the same would be true in the other thirty-five states if similar legislation were enacted. This statistical analysis, however, is not necessary to further the argument in this article, as the choice to undergo infertility treatment is a personal decision involving many factors besides financial cost. Instead, this article examines the *access*, or lack thereof, infertile individuals have to infertility treatment in the United States. This article merely sets forth that the access to infertility treatment within the United States is unequal and largely dependent upon financial status and state lines.

IV. FEDERALIZED INSURANCE REFORM AND THE ACA'S ANTI-DISCRIMINATION FRAMEWORK

Traditionally, state insurance mandates governed private health insurance reform.¹³⁸ The ACA effectuated large-scale reforms in the health care industry on the federal level.¹³⁹ Although the ACA is most widely known to provide insurance for millions of Americans who were originally without coverage, a majority of the ACA is dedicated to health insurance reform specifically.¹⁴⁰ Part A will briefly discuss the most significant changes made to the insurance market, drawing a trend for more inclusive health insurance coverage. Part B will set forth the ACA's anti-discrimination framework derived from both statutory language and DHHS regulations.

A. *The ACA's Major Insurance Reforms*

The need for some degree of standardization in the insurance market has long been recognized as integral in effectuating lasting reform.¹⁴¹ The ACA addressed several problems within the insurance market with the aim of decreasing costs for healthcare and making

¹³⁸ See SABRINA CORLETTE ET AL., CROSS-CUTTING ISSUES: MOVING TO HIGH QUALITY, ADEQUATE COVERAGE: STATE IMPLEMENTATION OF NEW ESSENTIAL HEALTH BENEFITS REQUIREMENTS 3 (2013).

¹³⁹ See, e.g., David Pratt, *Health Care Reform: Will it Succeed?*, 21 ALB. L.J. SCI. & TECH. 493, 509 (2011).

¹⁴⁰ See, e.g., Troy J. Oechsner & Magda Schaler-Haynes, *Keeping it Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 241 (2010/2011).

¹⁴¹ SARA ROSENBAUM ET AL., THE ESSENTIAL HEALTH BENEFITS PROVISIONS OF THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PEOPLE WITH DISABILITIES 2 (2011).

health insurance more accessible.¹⁴² What emerged from these changes is a more inclusive trend in health insurance coverage, with more Americans receiving health care with higher minimum standards.¹⁴³ “With implementation of the ACA, the market for health insurance in the United States is poised for dramatic change.”¹⁴⁴ Before enacting the ACA, Congress made several key findings pertinent to this article. First, national spending for health care and insurance represented 17.6% of the nation’s GDP.¹⁴⁵ Second, uninsured Americans were generally in poorer health than insured Americans and even had shorter lifespans.¹⁴⁶ Third, the high costs for medical care partly caused 62% of all personal bankruptcies.¹⁴⁷ Finally, the provision of health care for uninsured individuals cost approximately \$43 billion in 2008.¹⁴⁸

The first major reform the ACA sought to achieve was the expansion of health insurance to individuals who otherwise would not have had coverage.¹⁴⁹ There were two ways to achieve this: (1) the individual mandate¹⁵⁰ and (2) Medicaid expansion.¹⁵¹ The controversial individual mandate requires most Americans (with some exceptions) to obtain health insurance either through employers, Medicare or Medicaid, or individual health exchanges.¹⁵² The state-based health insurance exchanges created by the ACA have qualifying insurance policies available for individual purchase¹⁵³ and contain federal subsidies to Americans that make “up to four times the federal poverty level.”¹⁵⁴ If a state has chosen not to create its own exchange, a federally-facilitated marketplace will become operational instead.¹⁵⁵ The individual mandate cuts health care costs

¹⁴² See CORLETTE ET AL., *supra* note 138, at 2.

¹⁴³ See *id.*; Oechsner & Schaler-Hayes, *supra* note 140, at 242–43

¹⁴⁴ Devine et al., *supra* note 7, at 1224.

¹⁴⁵ See *id.*

¹⁴⁶ See *id.*

¹⁴⁷ See *id.*

¹⁴⁸ See *id.*

¹⁴⁹ The principal aim was to enroll between 32 million and 50 million Americans in health plans beginning in 2014. *Id.* So far, over “16 million Americans have gained health [insurance].” See *Key Facts and Reports: The Fifth Anniversary of the Affordable Care Act*, THE WHITE HOUSE (Mar. 22, 2015), <https://www.whitehouse.gov/the-press-office/2015/03/22/key-facts-and-reports-fifth-anniversary-affordable-care-act>.

¹⁵⁰ See 26 U.S.C. § 5000A.

¹⁵¹ See 42 U.S.C. § 1396a (2013).

¹⁵² See Devine et al., *supra* note 7, at 1224.

¹⁵³ See Brezina et al., *supra* note 13, at 192; Devine, et al., *supra* note 7, at 1224. Additionally, small businesses with fewer than 100 employees can buy private insurance from the exchanges as well. Brezina et al., *supra* note 13, at 192.

¹⁵⁴ Devine et al., *supra* note 7, at 1224.

¹⁵⁵ *Federal Marketplace Progress Fact Sheet: Progress Continues in Building Marketplaces*,

in two ways. First, it is extremely costly to insure unhealthy individuals, so requiring all Americans to buy health insurance improves the ratio of healthy insureds to unhealthy insureds, lowering overall costs to insurance companies.¹⁵⁶ Second, the high costs to provide health care to uninsured individuals are ameliorated by requiring those individuals to obtain health insurance.¹⁵⁷ Furthermore, the ACA expands Medicaid eligibility to any American under age sixty-five with a family income at or below 133% of the federal poverty line.¹⁵⁸

Before the ACA, insurers cut benefits in an effort to lower premiums in what was popularly deemed “a race to the bottom.”¹⁵⁹ To reverse this trend, the ACA created a list of ten categories for minimum “essential health benefits” that all qualified health plans must offer to its beneficiaries.¹⁶⁰ This list includes: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services, laboratory services, pediatric services (including vision and oral care), and preventive and wellness services.¹⁶¹ Many insurance plans did not originally cover mental health and substance abuse services, rehabilitative and habilitative services, or oral and vision pediatric care.¹⁶² The ACA’s essential health benefits standard changed that, and expanded the scope of minimum health care overall.

This list was expressed in broad terms as the ACA left formalizing minimum essential health coverage standard to DHHS.¹⁶³ As discussed earlier,¹⁶⁴ DHHS initiated a policy in 2011 that provided states with the authority to select “benchmark plan[s]” based upon

CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ffe.html> (last updated May 31, 2013).

¹⁵⁶ See Brezina et al., *supra* note 13, at 193.

¹⁵⁷ See *id.* at 191.

¹⁵⁸ See *States Implement Health Reform: Medicaid and the Affordable Care Act*, NAT’L CONFERENCE OF STATE LEGISLATURES (June 2011), <http://www.ncsl.org/documents/health/hrmedicaid.pdf>.

¹⁵⁹ See Frank Lalli, *The Affordable Care Act and You: The New Health Law Ensures You Have Access to These 10 Essential Benefits*, AARP MAG., Aug.–Sept. 2013, at 23.

¹⁶⁰ See 42 U.S.C. § 18022(b)(1); see ROSENBAUM ET AL., *supra* note 141, at 3 (noting that grandfathered health plans, large group health plans and self-insured ERISA plans are exempted from the essential health benefits requirement); Greenwood et al., *supra* note 16, at 1.

¹⁶¹ See 42 U.S.C. § 18022(b)(1)(A)–(J).

¹⁶² See CORLETTE ET AL., *supra* note 138, at 3; Greenwood et al., *supra* note 16, at 7–8.

¹⁶³ See 42 U.S.C. § 18022(a)(1); Brezina et al., *supra* note 13, at 193.

¹⁶⁴ See *supra* note 23 and accompanying text.

typical insurance plans found within the state.¹⁶⁵ DHHS renewed this policy on February 27, 2015.¹⁶⁶ In accordance with this policy, states have the option to include more essential health benefit standards than the general categories listed in the ACA. For example, states with pre-existing infertility treatment mandates have incorporated those laws into their benchmark plans.¹⁶⁷ Therefore, the ACA instituted significant reforms in both the public and private health insurance markets that resulted in more inclusive health insurance for everyday Americans.

B. *The ACA's Anti-Discrimination Framework*

Following this trend of more inclusive health care, the ACA effectuated an anti-discrimination framework to combat against unfair insurance practices.¹⁶⁸ This framework includes both the ACA's statutory language and the related DHHS regulations.¹⁶⁹ DHHS regulations hold equal legal weight to the ACA statute itself because Congress authorized DHHS to "issue regulations settings standards for meeting the requirements" under Title 1 of the ACA, which includes the relevant ACA provisions for the purposes of this article.¹⁷⁰ The ACA, coupled with DHHS regulations, constitute a comprehensive anti-discrimination framework for insurance practices.¹⁷¹

Many common practices exist in the private health insurance market that lower insurer costs, but also result in discriminatory practice. Generally, insurers attempt to manage risks through benefit design for health plans and plan implementation.¹⁷² Benefit design techniques may limit or fully exclude particular health services and apply to all members enrolled in the plan, regardless of the individual's characteristics.¹⁷³ On the other hand, plan implementation often refers to management techniques where "claim

¹⁶⁵ Devine et al., *supra* note 7, at 1225.

¹⁶⁶ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

¹⁶⁷ Devine et al., *supra* note 7, at 1225. States that choose to incorporate preexisting mandate benefits as essential health benefits suffer the price because the ACA requires the states to defray the cost for these additional benefits. See 42 U.S.C. § 18031(d)(3)(B) (2013); CORLETTE ET AL., *supra* note 138, at 4; Devine et al., *supra* note 7, at 1225.

¹⁶⁸ See 42 U.S.C. § 18022(b)(4); 45 C.F.R. § 156.125 (2014).

¹⁶⁹ See 42 U.S.C. § 18022(a)(1), (b)(4); 45 C.F.R. § 156.125.

¹⁷⁰ 42 U.S.C. § 18041(a)(1).

¹⁷¹ See 42 U.S.C. § 18022(a), (b); 45 C.F.R. § 156.125.

¹⁷² ROSENBAUM ET AL., *supra* note 141, at 5.

¹⁷³ *Id.*

denial rests on a determination that a particular benefit is not necessary for a particular patient.”¹⁷⁴

Insurers are constantly faced with the problem of adverse selection. Essentially, adverse selection refers to “strategic behavior by the more informed partner in a contract, against the interest of the less informed partner(s).”¹⁷⁵ In the health insurance market context, individuals choose a particular health plan based upon the expected probability he or she will be using covered health services.¹⁷⁶ The individuals who are in poorer health and foresee significant use of these services will purchase more expansive insurance plans than those who do not expect as much use.¹⁷⁷ Insurers want to avoid this because these individuals cost more money than the premiums they pay, and result in an overall net loss for the company.¹⁷⁸ Therefore, insurers use underwriting practices to analyze an individual’s expected health care costs typically based upon gender, age, and health status.¹⁷⁹ Depending upon the outcome of the underwriting evaluation, insurers may decline to provide any coverage whatsoever, refuse to cover specific treatments and/or impose treatment limits, require higher premiums, or impose more restrictive health management procedures.¹⁸⁰

“‘Discrimination’ refers to the ways that insurers differentiate among individuals in designing and implementing private health insurance coverage.”¹⁸¹ The ACA’s anti-discrimination framework is unparalleled because it applies to all of these cost-cutting practices by addressing the actual insurance coverage content; whereas, state insurance laws tend only to mandate specific treatments that otherwise may not be covered by insurers.¹⁸² Furthermore, the ACA represents unprecedented change because the anti-discrimination framework applies to both intentional discrimination and de facto discrimination.¹⁸³ De facto discrimination refers to facially neutral practices with a discriminatory impact.¹⁸⁴ The relevant ACA provisions and related DHHS regulations will be discussed in turn

¹⁷⁴ *Id.* at 6.

¹⁷⁵ Paolo Belli, *How Adverse Selection Affects the Health Insurance Market 1* (World Bank Dev. Research Grp., Working Paper No. 2574, 2001).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *See id.*

¹⁷⁹ KATIE KEITH ET AL., NONDISCRIMINATION UNDER THE AFFORDABLE CARE ACT 6 (2013).

¹⁸⁰ *See id.*

¹⁸¹ *Id.*

¹⁸² *See* ROSENBAUM ET AL., *supra* note 141, at 9, 11.

¹⁸³ *Id.* at 11.

¹⁸⁴ *See id.*

below.

In order to limit discrimination at the point of enrollment, the ACA instituted several main provisions. The ACA extended several Health Insurance Portability and Accessibility Act of 1966 (“HIPAA”) protections in the small group market, such as eligibility rules based on health status-related factors, to the individual market.¹⁸⁵ For example, the ACA requires that “each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”¹⁸⁶ Additionally, insurers may not create eligibility rules based on any health status factors, including medical condition, medical history, disability, and claims experience.¹⁸⁷ Second, the ACA prohibits exclusion based upon preexisting condition.¹⁸⁸ Third, the ACA aims to protect those who suffer from life-threatening illnesses by requiring coverage for approved clinical trials and the associated routine patient costs.¹⁸⁹

Several anti-discrimination provisions and regulations directly apply to the essential health benefit requirement in an effort to combat discriminatory benefit design. First, insurers may not impose lifetime limits on essential health benefits.¹⁹⁰ Second, essential health benefits may not be denied “on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”¹⁹¹ Insurers providing essential health benefits are prohibited from discriminating on the basis of race, color, disability, national origin, sex, age, gender identity, or sexual orientation.¹⁹² Moreover, insurance plans will not comport with essential health benefit standards if the benefit design or plan implementation discriminates on these grounds.¹⁹³

Finally, the ACA and subsequent DHHS regulations prohibit

¹⁸⁵ See 42 U.S.C. §§ 300gg-1(a), 300gg-2(a), 300gg-4(a), (d)(1), (j)(1)(C) (2013).

¹⁸⁶ 42 U.S.C. § 300gg-1(a).

¹⁸⁷ See 42 U.S.C. § 300gg-4(a).

¹⁸⁸ 42 U.S.C. § 300gg-3(b)(1)(A) (“[P]reexisting condition exclusion’ means . . . a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.”).

¹⁸⁹ See 42 U.S.C. § 300gg-8(a)(1) (2013).

¹⁹⁰ See 42 U.S.C. §§ 300gg-11(a)(1), (b), 18022(b)(1), (4) (2013).

¹⁹¹ 42 U.S.C. § 18022(b)(4)(D).

¹⁹² 45 C.F.R. § 156.125(b); 45 C.F.R. § 156.200(e) (2014); see also CORLETTE ET AL., *supra* note 138, at 4 (claiming the secretary cannot make decisions about coverage that discriminate based on age, disability, or life expectancy).

¹⁹³ 45 C.F.R. § 156.125(a); see also CORLETTE ET AL., *supra* note 138, at 4 (explaining that the benchmark plan cannot be discriminatory).

discrimination in a more general sense. Section 1557 of the ACA prohibits discrimination based upon race, color, national origin, age, sex, sex stereotypes, disability, or gender identity.¹⁹⁴ In fact, by virtue of this provision, the ACA is the first federal law prohibiting sex discrimination in the health care industry.¹⁹⁵ Pursuant to DHHS regulation, insurers are prohibited from: “1) adopting benefit designs that discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation; or 2) utilizing discriminatory marketing practices or benefit designs that discourage the enrollment of individuals with significant health needs.”¹⁹⁶ The prohibition on market practices and benefit designs with a negative effect upon enrollment of individuals with significant health needs in insurance plans applies to insurance companies broadly.¹⁹⁷ Specifically, this prohibition applies to both insurers offering qualified health plans through the health exchanges and insurance company employees, officials, representatives, and agents.¹⁹⁸

The main enforcers of the ACA are the states, which can require insurance companies operating within their state to comport with federal standards.¹⁹⁹ Additionally, the Centers for Medicare and Medicaid Services (“CMS”), an operating division within DHHS, has been the main federal body providing informal guidance to insurers to effectively participate in the post-ACA insurance market.²⁰⁰ If a state fails to enforce any part of the ACA, CMS steps in to do so.²⁰¹ CMS also produces letters to issuers in the federally-facilitated

¹⁹⁴ See 42 U.S.C. § 18116. This section applies to insurance companies that receive federal money, Medicare, Medicaid, and any plan offered on the health exchanges. See *Nondiscrimination Protection in the Affordable Care Act: Section 1557*, NAT'L WOMEN'S L. CTR. (Sept. 3, 2015), http://www.nwlc.org/sites/default/files/pdfs/general_1557_factsheet_9-3-15.pdf.

¹⁹⁵ See *Nondiscrimination Protection in the Affordable Care Act: Section 1557*, *supra* note 194.

¹⁹⁶ KEITH ET AL., *supra* note 179, at 9. Section 156.125(b) of the DHHS regulation requires that insurers offering qualified health plans through the health exchanges comply with 45 C.F.R. § 156.200(e), which prohibits discrimination based upon color, race, national origin, disability, sex, age, sexual orientation, and gender identity. 45 C.F.R. § 156.125(b); 45 C.F.R. § 156.200(e).

¹⁹⁷ See KEITH ET AL., *supra* note 179, at 9.

¹⁹⁸ See 45 C.F.R. § 147.104(e) (2014); 45 C.F.R. § 156.225 (2014).

¹⁹⁹ Katie Keith & Kevin Lucia, *New Guidance: Federal Regulators Allow “Collaborative Arrangements” for ACA Enforcement*, COMMONWEALTH FUND BLOG (Apr. 5, 2013), <http://www.commonwealthfund.org/publications/blog/2013/apr/federal-regulators-allow-collaborative-arrangements>.

²⁰⁰ See CTRS. FOR MEDICARE & MEDICAID SERVS., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, FINAL 2016 LETTER TO ISSUERS IN THE FEDERALLY-FACILITATED MARKETPLACES 1 (2015); Keith & Lucia, *supra* note 199.

²⁰¹ Keith & Lucia, *supra* note 199.

marketplaces that provide technical guidance.²⁰² In its recent letter for guidance in 2016, CMS announced it would be conducting outlier analyses in connection with preventing discriminatory qualified health plan design.²⁰³ One analysis “will compare benefit packages with comparable cost-sharing structures to identify cost-sharing outliers with respect to specific benefits.”²⁰⁴ Moreover, “CMS is considering conducting a review of each [qualified health plan] to identify outliers based upon estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally-recognized clinical guidelines.”²⁰⁵ Thus, CMS will play a role in ensuring health plans fit within the anti-discrimination framework.²⁰⁶ Although it remains unclear how the ACA’s anti-discrimination framework will be enforced in the future, systems have been put in place to ensure the anti-discrimination provisions do not become dead letter law.

V. ACCESS INEQUALITY TO INFERTILITY TREATMENTS VIOLATES THE ACA’S ANTI-DISCRIMINATION FRAMEWORK

A dual-leveled dichotomy exists between the “haves” and the “have-nots” in infertility treatment accessibility. The first level is the divide between rich and poor.²⁰⁷ As discussed in Part II, the costs for infertility treatment and ART in particular, can be extremely high.²⁰⁸ As an average, a single IVF cycle represents approximately 50% of annual disposable income in the United States.²⁰⁹ The second level is state residency.²¹⁰ Part III explained how 15 states passed legislation to provide insurance coverage for some form of infertility treatment.²¹¹ Since 2003, 47.2% of the United States population resides in one of these states.²¹² Thus, access is largely limited to two groups: financially well-off individuals and people who live within states with insurance mandates.²¹³

²⁰² See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 200, at 1.

²⁰³ See *id.* at 38.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Id.*

²⁰⁷ Ann V. Bell, *Beyond (Financial) Accessibility: Inequalities within the Medicalisation of Infertility*, 32 SOC. OF HEALTH & ILLNESS 631, 631–32 (2010).

²⁰⁸ See *supra* notes 55–74 and accompanying text.

²⁰⁹ Bitler & Schmidt, *supra* note 26, at 15 n.12.

²¹⁰ Hamilton & McManus, *supra* note 57, at 1000.

²¹¹ See *supra* note 100 and accompanying text.

²¹² Bitler & Schmidt, *supra* note 26, at 9.

²¹³ See Devine et al., *supra* note 7, at 1224.

The limited access to infertility treatment based upon wealth and state residency is suspect to say the least. As the previous section discussed, the ACA represents unprecedented health insurance reform at the federal level.²¹⁴ What was once left up to the states to regulate is now subject to the ACA, and the associated DHHS regulations.²¹⁵ The ACA's anti-discrimination framework was created to curb unfair insurance practices.²¹⁶ Although access to infertility treatment has been limited for years according to wealth and state residency, the ACA provides a new legal lens in which to view this problem. In short, the fact that some infertile Americans have access to treatment (either because of their own wealth or state insurance mandates), and others do not, violates the ACA's anti-discrimination framework.

Before discussing the applicable anti-discrimination provisions, it is necessary to identify what type of discrimination is actually prohibited under the ACA. As indicated above, "[d]iscrimination' refers to the ways that insurers differentiate among individuals in designing and implementing private health insurance coverage."²¹⁷ The ACA applies to both intentional and de facto discrimination in the actual content of health insurance policies.²¹⁸ Thus, an insurer need not intentionally discriminate against infertile individuals in crafting insurance policies, but a discriminatory impact of those policies may nevertheless violate the ACA. Typically, as long as insurance policies impose across-the-board exclusions on the whole benefit class the effect is not discriminatory as it applies to every individual within the class.²¹⁹ However, "exclusions that single out specific treatments used only for specific disabling conditions should be considered a form of discrimination."²²⁰ The application of this to the infertility context is apparent. In states without insurance mandates, infertility treatment is excluded from coverage for the entire benefit class.²²¹ This exclusion, however, singles out infertility treatment, which is used to specifically treat infertility.²²² Therefore, the exclusion truly only affects infertile individuals, not the entire benefit class. Moreover, almost 50 percent of the national population

²¹⁴ See *supra* notes 138–40 and accompanying text.

²¹⁵ See *supra* notes 168–69 and accompanying text.

²¹⁶ See *supra* note 168 and accompanying text.

²¹⁷ KEITH ET AL., *supra* note 179, at 6.

²¹⁸ See *supra* notes 183–84 and accompanying text.

²¹⁹ ROSENBAUM ET AL., *supra*, note 141, at 12.

²²⁰ *Id.*

²²¹ See Brezina et al., *supra* note 13, at 195.

²²² See *id.*

enjoys greater access to infertility treatment due to state residency, which reflects how infertility treatment exclusions are not uniform across the nation.²²³ Therefore, insurers differentiate infertile individuals by designing insurance coverage when policies explicitly exclude infertility treatment.

As discussed in Part IV, there are many anti-discrimination provisions within the ACA itself, and DHHS also promulgated related regulations in the same vein.²²⁴ Two main provisions in the anti-discrimination framework are specifically applicable to the limited access of infertility treatment. First, the ACA prohibits exclusion based upon a preexisting condition.²²⁵ Second, DHHS issued a regulation on marketing and benefit design for qualified health plans.²²⁶ This regulation specifically states that a qualified health plan “[n]ot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.”²²⁷ Therefore, taking into account the ACA’s anti-discrimination framework as a whole and further examining these two provisions demonstrates how unequal access to infertility treatment across the country is illegal under the ACA.²²⁸

Prohibiting exclusion for a preexisting condition is broadly written within the ACA. The ACA defines “preexisting condition” as “a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.”²²⁹ Infertility fits within this definition. As long as a person was infertile before the enrollment date for coverage under a qualified health plan, insurers are prohibited from excluding infertility benefits based upon the fact that the individual suffered from infertility before he or she enrolled in the plan.²³⁰ In other words, an insurer cannot exclude infertility treatment for a particular enrollee just because the insurer knows the enrollee is infertile and is more likely to undergo such

²²³ See Bitler & Schmidt, *supra* note 26, at 8–9.

²²⁴ See *supra* notes 168–71, 194–96 and accompanying text.

²²⁵ 42 U.S.C. § 300gg-3(a).

²²⁶ 45 C.F.R. § 156.225.

²²⁷ 45 C.F.R. § 156.225(b).

²²⁸ See Devine et al., *supra* note 7, at 1226 (arguing that the ACA prohibits insurers from denying infertile couples healthy insurance based upon their infertility status).

²²⁹ 42 U.S.C. § 300gg-3(b)(1)(A).

²³⁰ See Brezina et al., *supra* note 13, at 195 (arguing that insurers within the states with insurance mandates are prohibited from using infertility as a preexisting condition to determine coverage eligibility).

treatment. Significantly, congressional hearings preceding the ACA uncovered stories of women who were wholly denied insurance coverage because their infertility status was treated as a preexisting condition.²³¹ In states without insurance mandates, however, insurers typically exclude infertility treatment for every enrollee without qualification.²³² Thus, this provision alone will not suffice in these situations.

The DHHS regulation fills in the gap as applied to all qualified health plans beyond the point of enrollment. As previously discussed, a qualified health plan may not create benefit designs or employ market practices that discourage enrollment of people with significant health needs.²³³ More particularly, benefit designs excluding infertility coverage will discourage the enrollment of infertile individuals. In order to support this argument, two points must be proven: (1) infertility is a “significant health need”;²³⁴ and (2) insurer benefit designs or market practices discourage enrollment of infertile individuals.²³⁵ First, infertility is commonly referred to as a “disease of the reproductive system.”²³⁶ This definition inherently gives rise to the conclusion that infertility is a significant health need. Moreover, people who suffer from infertility cannot procreate (or are significantly impaired in procreation), which the United States Supreme Court recognized as a “major life activity.”²³⁷ Thus, the average infertile individual would at the very least classify infertility as “significant.” As the Former Director of UNDP/UNICEF/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (“HRP”) once stated, “[t]he different needs in reproductive health are simultaneous and consecutive related needs. People cannot be healthy if they have one element of the Reproductive Health package but miss others.”²³⁸ Indeed, many countries view infertility as a medical condition, which is reflected in their national health policies providing for infertility treatment

²³¹ KIRSCH, *supra* note 27, at 271; Devine et al., *supra* note 7, at 1226.

²³² Devine et al., *supra* note 7, at 1225; Bitler & Schmidt, *supra* note 26, at 6.

²³³ See 45 C.F.R. 156.225(b).

²³⁴ See *infra* notes 236–38 and accompanying text. The ACA and DHHS have yet to specifically define the term “significant health need.” See 42 U.S.C. § 18021 (2013); 45 C.F.R. 156.20 (2014).

²³⁵ See *supra* notes 102, 176–77 and accompanying text.

²³⁶ *Infertility is a Global Public Health Issue*, *supra* note 29.

²³⁷ *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998).

²³⁸ *Infertility is a Global Public Health Issue*, *supra* note 29.

coverage.²³⁹ Second, an infertile individual shopping for insurance coverage will be less likely to enroll in a qualified health plan if he or she knows that treatment is not covered. Therefore, qualified health plans that do not provide coverage for infertility treatment violate this regulation.

This article's conclusion is in line with the general trend favoring more inclusive health insurance policies discussed in Part IV.²⁴⁰ It would be a different analysis if the ACA set the opposite trend in scaling back on both the scope and accessibility of health insurance. Setting aside the anti-discrimination framework, the ACA federalized minimum insurance standards under the essential health benefit provision that directly requires coverage for health services that previously were not typically covered by insurers.²⁴¹ Through the individual mandate and Medicaid expansion, the ACA increased accessibility to health insurance to millions of Americans that previously were uninsured.²⁴²

Apart from any legal analysis, it is plainly unfair that some infertile individuals in this country enjoy significantly greater access to infertility treatment than many others. The two-level divide between the "have" and the "have-nots" is largely based upon wealth and state residency. Access to necessary treatment for a disease should not depend upon how much money the patient makes or the state in which he or she resides. As discussed in Part II, infertility is a disease that takes a significant emotional toll out of the person suffering from the inability to procreate, and is also extremely costly to treat out-of-pocket.²⁴³ Furthermore, discrimination is evident across the fifteen states with insurance mandates. Part III of this article explained that there is a significant level of variation amongst these mandates.²⁴⁴ For example, some infertile individuals enjoy greater access in states whose mandates provide for IVF compared to the states which explicitly exclude IVF from insurance coverage.²⁴⁵

The implications of this article's conclusion are great. Since the unequal access to infertility treatment violates the ACA's anti-discrimination framework, something must be done to alleviate the problem. What should be done about this is beyond the scope of this

²³⁹ See Edward G. Hughes & Mita Giacomini, *Funding In Vitro Fertilization Treatment for Persistent Subfertility: The Pain and the Politics*, 76 FERTILITY & STERILITY 431, 432 (2001).

²⁴⁰ See *supra* Part IV.A.

²⁴¹ See *supra* note 160 and accompanying text.

²⁴² See *supra* note 149 and accompanying text.

²⁴³ See *supra* Part II.A.

²⁴⁴ See *supra* notes 105–09 and accompanying text.

²⁴⁵ See *supra* notes 105–09, 111–13 and accompanying text.

article, however, two options seem evident. Since wealth and state residency largely dictate the level of access an infertile individual has to treatment, any solution to make accessibility more equal across the country must involve one, or both, of these factors. An amendment could be passed to the ACA mandating some form of infertility treatment inclusion in health plans. Turning to the international community, “the trend seems to be toward providing some level of public financing” for infertility treatment and ART in particular.²⁴⁶ Thus, looking to other countries for guidance may be helpful. Moreover, the cost of covering infertility treatment is not as high as some may assume. A study was conducted in Massachusetts, a state which requires all insurers to cover infertility treatment, incorporating data from 1986 through 1993.²⁴⁷ The study concluded that coverage cost \$1.71 per contact month or 0.4% of the mean total monthly family health insurance premium.²⁴⁸ In light of political gridlock in Congress, the chances of any amendment being passed to broaden the scope of the ACA are slim. So, the more likely scenario would be DHHS issuing a regulation requiring states to fit infertility coverage within their benchmark plans as it relates to essential health benefits.²⁴⁹ Another way to alleviate unequal access to infertility treatment is to lower its cost. The average cost for one IVF cycle in Japan is a mere fraction of the cost in the United States.²⁵⁰ The problem with this solution, however, would also involve some form of government regulation or subsidy.

In conclusion, the expansive health insurance reforms in the ACA created a new lens through which to view this old problem. The fact that many infertile individuals in this country do not have access to infertility treatment is no surprise. The costs for treatment are extreme and many people without the financial means to pay out-of-pocket find themselves childless. Starting in 1977,²⁵¹ fifteen states have passed their own legislation in combatting this divide between rich and poor.²⁵² Although these mandates have expanded access to infertility treatment within the state boundaries themselves, over 50 percent of the American population does not reside in a state requiring coverage.²⁵³ The ACA’s anti-discrimination framework

²⁴⁶ Chambers et al., *supra* note 60, at 2292.

²⁴⁷ Fidler & Bernstein, *supra* note 26, at 504.

²⁴⁸ *Id.*

²⁴⁹ See *supra* notes 165–67 and accompanying text.

²⁵⁰ See *supra* notes 60–61 and accompanying text.

²⁵¹ Bitler & Schmidt, *supra* note 26, at 8.

²⁵² *State Laws Related to Insurance Coverage*, *supra* note 4.

²⁵³ Bitler & Schmidt, *supra* note 26, at 9.

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attempts to prevent this type of divide in many health contexts and the lack of equal access to infertility treatment is no different.