1999

Can Money Buy Happiness—An Examination of the Coverage of Infertility Services under HMO Contracts?

Lisa M. Kerr

Follow this and additional works at: https://scholarlycommons.law.case.edu/caselrev

Part of the Law Commons

Recommended Citation
Available at: https://scholarlycommons.law.case.edu/caselrev/vol49/iss3/6

This Note is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Case Western Reserve Law Review by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.
CAN MONEY BUY HAPPINESS? AN EXAMINATION OF THE COVERAGE OF INFERTILITY SERVICES UNDER HMO CONTRACTS

INTRODUCTION

“We just want the good old American dream with one or two kids, a good running car and a roof over our heads,” proclaims Kerry McCutchen.1 “We would like for our insurance company to help us. But that’s apparently too much to ask.”2 Ms. McCutchen, age thirty-four, suffers from infertility, and now, after three years of unsuccessful treatments, is dependent on advanced reproductive technologies to aid her in becoming pregnant.3

Ms. McCutchen is only one of the millions of infertile Americans who desperately want to have a baby. Like the great majority of such persons, Ms. McCutchen’s options are limited by the high costs of advanced infertility treatments and the insurance industry’s refusal to pay for these services.

Aetna U.S. Healthcare, the nation’s largest health insurer, recently announced that as of April 1, 1998, it will no longer offer coverage for in vitro fertilization and other advanced reproductive technologies in its basic benefits package.4 This decision is not surprising. Aetna cites the high cost of providing services for women who choose the health plan specifically for its coverage of infertility services, and then leave the plan once they have taken advantage of the benefits.5 While it is true that Aetna funded a disproportionate share of infertility services being one of only a few companies to offer such benefits, this decision is particularly disturbing because it epitomizes the dis-

---

2 Id.
3 See id.
4 See Judy Greenwald, Reproduction Help: Aetna May Spur Health Plans to Review Coverage, BUS. INS., Jan. 19, 1998, at 3. Aetna will continue to offer coverage of in vitro fertilization as an option for an additional cost. See id.
paraging attitudes toward infertility evident in both society and insurance companies.

There seems to be a presumption in today's society that childless couples have voluntarily chosen not to have offspring.\(^6\) They receive labels such as "DINK" (Dual Income, No Kids),\(^7\) and are the objects of scorn and contempt. Given the lack of serious attention society has given infertility, it follows that insurance companies have historically trivialized the problem as well. For example, one insurance company has deemed the inability to conceive or carry a child to term as "extraneous to health care,"\(^8\) and refused to cover costs associated with infertility treatments.\(^9\)

Despite these negative attitudes, infertility is in fact a serious health problem in the United States. It is believed that one in six American couples is infertile.\(^10\) Fortunately, new technologies are making infertility treatments more successful than ever before. Unfortunately, the high costs of some of these procedures and inconsistent insurance coverage make such infertility services largely inaccessible to all but the wealthiest Americans. Compounding this problem is the fact that the health care industry is currently in flux. With managed care organizations emerging as the leading health care providers, the likelihood of increased, or even continued, coverage for these procedures is dubious at best.

Part I of this Note examines the prevalence of infertility in American society, its causes and its various treatments. Part II discusses the current law mandating insurance coverage for infertility services and exposes its shortcomings. Part III examines the crises presently facing the health care industry and the various types of managed care organizations that are emerging to cope with these problems. The future of infertility services is considered in light of this change. Part IV analyzes arguments in favor of, and in opposition to, legislation mandating that health maintenance organizations provide coverage for infertility services. This analysis includes a discussion of the so-

---

\(^6\) In fact, only two percent of women who marry decide not to have children by their own volition. See Melissa O'Rourke, Comment, The Status of Infertility Treatments and Insurance Coverage: Some Hopes and Frustrations, 37 S.D. L. \textsc{Rev.} 343, 343 (1992).

\(^7\) Id.

\(^8\) Id. (citing figures from former Congresswoman Patricia Schroeder).

\(^9\) See William C. Cole, Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage, 27 San Diego \textsc{L. Rev.} 715, 715 (1990) (stating that some insurance companies cover only a portion of infertility treatments, while other insurance companies do not provide coverage for infertility services at all).

cial obligation to provide health care services, the increased costs of providing infertility services, adoption as an alternative option and free-market choice. It concludes that health maintenance organizations should offer infertility services. Part V offers a number of ways in which health maintenance organizations can be encouraged to offer infertility services, including state and federal legislation, the Americans with Disabilities Act and the benefits of voluntary provision by both providers and employers. This section concludes with a proposed infertility services clause that health maintenance organizations could voluntarily include in their contracts.

I. INFERTILITY: A BASIC OVERVIEW

The standard definition of infertility is the inability of a couple to reproduce after a year of regular sexual intercourse without contraceptives. Estimates of the number of infertile couples in the United States range from 2.4 million to 5 million and these numbers are increasing each year.

Infertility has a large impact on an individual’s overall health. Only two percent of married women are voluntarily childless. The personal disappointment and depression that accompany the failure to conceive a child is compounded by the negative attitudes of society toward childless couples and the costs of seeking diagnosis and treatment. Infertility also imposes a number of immeasurable costs on society. It is common for couples afflicted with infertility to “experience depression, anger, and helplessness.” They suffer from anxiety that is a permanent distraction and reduces productivity both at work and at home. Many couples put life “on hold,” and refuse to make realistic plans for the future because they cling to the slight hope they might one day have a baby. These devastating effects of infertility have a very real health impact.

13 See ROBERTSON, supra note 11, at 97-98 (discussing the increase in infertility due to an increase in the prevalence of gonorrhea, rising IUD use and environmental factors); Lisa A. Rinehart, Infertility: The Market, the Law, and the Impact, 35 JURIMETRICS J. 77, 77 (1994) (offering as a reason for the increased rate of infertility a generation of women who focused on their careers and delayed childbearing).
14 See O’Rourke, supra note 6, at 343.
15 See id. at 344 (explaining that infertile couples often feel cut off from family and friends).
16 Id. at 346 (quoting JANET STROUP FOX, SERONA SYMPOSIA, INFERTILITY INSURANCE 2 (1991)).
17 See id.
18 See id; see also Rinehart, supra note 13, at 78 (noting the “willingness to persevere” and “reluctance to surrender” in many infertile couples who desperately want a child).
The number of couples seeking treatment for infertility is increasing. An estimated two to three million couples seek infertility treatments each year. One reason this number is so large is that more women are pursuing careers and putting off starting a family. Moreover, it has become more socially acceptable to seek infertility treatments. In addition, new technology has provided improved treatments and success rates, offering increased hope to those suffering from infertility.

A. Causes

Infertility occurs in both males and females. There are many causes of infertility, including physical conditions, sexually transmitted diseases, environmental toxins, genetic disease, sterilization and age. The most common defects in men are spermatogenesis (defects in the production of viable sperm), defects in semen production, and obstruction of the ducts through which the sperm must travel. Common causes in women are hormonal disturbances, endometriosis, blocked or damaged fallopian tubes, and prenatal exposure to diethylstilbestrol (DES). Other causes include strenuous exercise and eating disorders (both of which can alter menstruation), poor nutrition, stress, smoking, and alcohol and drug use.

B. Treatments

The first step in treating infertility is a proper diagnosis of the problem. Diagnosing infertility is not inexpensive, usually costing between $500 and $2000. This diagnosis includes a thorough medical history as well as a physical examination. Common tests include semen analysis, basal body temperature charts, ovulation pre-
dictor kits, post-coital cervical mucus tests, hormone testing, laparoscopy, hysteroscopy and ultrasonography.31

Once the initial diagnosis has been made, the typical couple will employ standard infertility treatments, including hormones, fertility drugs and tubal surgery.32 If these treatments are unsuccessful, artificial insemination (“AI”) is the next best alternative.33 This procedure is timed to coincide with the woman’s ovulation.34 There are two types of artificial insemination: artificial insemination by husband (“AIH”) and artificial insemination by donor (“AID”).35 AIH is used when the husband has a low sperm count or low sperm mobility or the woman has hostile cervical mucus.36 AID is used when the husband’s sperm count or quality is too low, when the husband carries a genetic disease or when six months of AIH has been unsuccessful.37 The success rate of AI varies: AIH has a lower success rate than AID, probably due to inherent defects in the husband’s sperm.38 For AID, 54% of cycles initiated are successful.39

Other assisted reproductive technologies include in vitro fertilization (“IVF”), gamete intrafallopian transfer (“GIFT”), zygote intrafallopian transfer (“ZIFT”), pro-nuclear stage transfer (“PROST”) and natural cycle ovum retrieval intravaginal fertilization (“NORIF”).40 In IVF, which literally translates to “fertilization in glass,”41 a woman’s ovaries are stimulated with hormones designed to promote the development of multiple eggs. She is monitored for estrogen levels and follicular growth to determine the best time to retrieve the eggs.43 Sperm is obtained from the man immediately upon retrieval and the eggs are then fertilized in a test tube.44 The embryos are transferred back into the uterine cavity forty-eight hours later and within two weeks, a pregnancy test is performed to determine whether the process has been successful.45 Only about one percent of all infertile couples actually use IVF.46

31 See O’Rourke, supra note 6, at 350-51.
32 See Leftin, supra note 12, at 663.
33 See id.
34 See O’Rourke, supra note 6, at 354.
35 See YEH & YEH, supra note 22, at 35.
36 See O’Rourke, supra note 6, at 354.
37 See YEH & YEH, supra note 22, at 35-37.
38 See id. at 38.
39 See id.
40 See O’Rourke, supra note 6, at 355-56 (describing other new reproductive technologies).
41 Id. at 354.
42 See YEH & YEH, supra note 22, at 62 (describing the time frame for IVF).
43 See id.
44 See id.
45 See id.
46 See O’Rourke, supra note 6, at 346.
GIFT is similar to IVF, except that in a GIFT treatment the retrieved eggs and sperm are immediately transferred into the fallopian tubes for fertilization. ZIFT is a combination of IVF and GIFT in that the zygote is immediately transferred back into the uterus. In PROST the eggs remain in the test tube until the sperm penetrates and fertilizes the eggs before being transferred to the fallopian tubes. NORIF is another variation of IVF. It is substantially less expensive because it does not use drug-induced ovulation or laboratory incubation. A woman's natural cycle is closely monitored and when she is close to ovulation, her eggs are retrieved through her vagina and placed in a small plastic vial with sperm supplied by her partner, and the entire vial is placed inside the woman's vagina to incubate for forty-eight hours. The fertilized egg is then implanted in the uterus.

In the last decade, infertility services have become increasingly successful. Fifty percent of all couples who undergo infertility treatments successfully conceive and have babies. When the treatment methods are used together, including counseling, the combined success rate is seventy and eight-five percent. IVF alone has a much lower success rate (only about twenty percent), but it has provided a powerful new alternative to infertile couples. More than 30,000 children have been born throughout the world from IVF. The overall success rate of GIFT is twenty-nine percent, and of completed ZIFT procedures, seventeen percent resulted in a live birth. When compared to the actual rate that normal fertile couples have of conceiving in any given month, some procedures, such as GIFT, actually have a higher success rate.

On the other hand, because of the high costs associated with some infertility procedures, not all people have access to these services. As

47 See id. at 355.
48 See YEH & YEH, supra note 22, at 64.
49 See O'Rourke, supra note 6, at 355.
50 See id. at 356.
51 See id.
52 See id.
53 See Leftin, supra note 12, at 663.
54 See Cole, supra note 9, at 716-17 (excluding IVF statistics).
55 See id. While this figure looks discouraging, it is actually quite misleading because IVF is used only by a few couples and only after all other treatment options have failed. See YEH & YEH, supra note 22, at 61. The overall success rate of IVF is difficult to measure because of the many ways in which success can be defined. For example, it may be the birth of a live baby, the number of babies born divided by the number of ovulation cycles induced, or the number of clinical pregnancies. See id. at 63.
56 See ROBERTSON, supra note 11, at 9.
57 See Leftin, supra note 12, at 663.
58 See O'Rourke, supra note 6, at 381.
59 See id. The conception rate for fertile couples is estimated to be 15-20%. See id.
stated above, the cost of diagnosing infertility ranges from $500 to $2000.\textsuperscript{60} Drug therapies alone cost approximately $3000.\textsuperscript{61} AI costs approximately $400 per cycle.\textsuperscript{62} The average cost of an IVF cycle is $10,000.\textsuperscript{63} Diagnosis and treatment for couples using high-tech procedures have been estimated to cost up to $100,000.\textsuperscript{64} These expensive, high-tech procedures are so rarely utilized, however, that the actual average cost of infertility treatment is estimated to be only about $200 per couple.\textsuperscript{65}

Currently, infertility treatments are typically used by better-educated, upper-middle class white professional women.\textsuperscript{66} This is a direct result of the high costs and lack of insurance coverage for these procedures. For example, seventy-five percent of low-income women in need of infertility services, a disproportionate number of whom are African-American, do not have access to those services.\textsuperscript{67} Infertility is more prevalent among lower income persons because of greater exposure to environmental toxins and sexually transmitted diseases.\textsuperscript{68} Many lower income people also suffer from poor nutrition and health care,\textsuperscript{69} making them more likely to suffer infertility. While infertility services are covered under Medicaid and Title X,\textsuperscript{70} there is little information available on the amount of public funds actually spent on infertility services.\textsuperscript{71}

\begin{itemize}
  \item See Millsap, supra note 10, at 56.
  \item See Cole, supra note 9, at 717.
  \item See id.
  \item See Sharon Begley, The Baby Myth, NEWSWEEK, Sept. 4, 1995, at 38, 40. However, figures such as these are very misleading because these expensive procedures are not always required and often the problems can be corrected fairly easily with counseling or preliminary testing of the sperm, costing only $2500-$3000. See Cole, supra note 9, at 717.
  \item See Cole, supra note 9, at 717.
  \item See Rinchart, supra note 13, at 78 (describing the typical infertility patient).
  \item See Vernellia R. Randall, Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African-American Perspective on Bioethics, 15 ST. LOUIS U. PUB. L. REV. 191, 225 (1996) (noting that the risk of infertility for African-Americans is 1.5 times higher than that of whites).
  \item See ROBERTSON, supra note 11, at 225-26 (arguing that reproductive technology resources should be fairly allocated to all social classes).
  \item See id.
\end{itemize}
II. INSURANCE COVERAGE OF INFERTILITY TREATMENTS UNDER CURRENT LAW

Currently, insurance coverage for infertility services is inconsistent. Consumers purchase health insurance for peace of mind, with the belief that it will protect them from any health risks that may materialize in the future. When it comes to infertility, however, insurance policies fall short. In the United States, individuals or their health care providers spend more than one billion dollars on infertility services.72 Private health insurance typically covers pregnancy, childbirth and abortion, but not infertility services.73 In fact, over thirty percent of private insurance companies do not cover most infertility treatments and over eighty percent do not cover IVF.74

This section examines both judicial decisions and state statutes dealing with the provision of infertility services under health insurance policies. A number of courts have considered whether health insurance policies should cover treatments for infertility. In many of these cases, the insureds have prevailed, particularly where there was no specific exclusion for infertility procedures. In addition, thirteen states have enacted legislation that mandates the provision of infertility services in health insurance policies. Although these are positive steps, they remain inadequate to comprehensively meet the needs of the millions of infertile Americans.

A. Case Law

Courts have dealt with the question of whether insurance companies will be required to cover infertility services in four main contexts: 1) as reversal of sterilization, 2) as an illness, 3) as “medically necessary,” and 4) as experimental. Each of these arguments as to the nature of infertility treatments is examined in turn. The case law is conclusive on some issues—e.g., that insurance companies do not have to pay for the reversal of voluntary sterilization and that most infertility procedures are no longer experimental. Frustratingly, however, decisions dealing with infertility as an illness and infertility services as medically necessary do not offer any definite answers.

1. Reversal of Voluntary Sterilization

Insurers consistently refuse to cover expenses related to reversal of voluntary sterilization and the courts have supported this position. In

72 See Leftin, supra note 12, at 663.
73 See Millsap, supra note 10, at 51.
74 See id. at 57.
**Reuss v. Time Insurance Co.,** the court held that expenses for a procedure designed to reverse a vasectomy were not covered under the policy language. Similarly, in **Marsh v. Reserve Life Insurance Co.,** the court held that the insurer was not obligated to pay for surgery to reverse tubal ligation that the Plaintiff had elected to have some years earlier. The reasoning behind these exclusions is that voluntary sterilization procedures, which have infertility as their purpose, do not constitute a "sickness" under the policy for which the insurer is obliged to pay. Viewed in this light, the exclusion makes sense: If a person purposefully undergoes a procedure designed to produce sterility, it seems illogical that the person's infertility is a result of an illness. Rather, the infertility is a result of a conscious decision not to have children.

2. **Infertility as a Disease**

Insurance companies also deny coverage for infertility treatments under the rationale that infertility is not a "disease." This argument has had less success in the courts. A number of definitions of disease have been advanced by courts, such as "[a] deviation from the healthy or normal condition of any of the functions . . . of the body" or "[a] disturbance in function or structure of any . . . part of the body." Infertility fits into both these definitions. When an otherwise healthy couple can not reproduce because of a physical or genetic impairment, there is obviously a deviation from the normal reproductive function of the body.

Two decisions which have adopted this type of reasoning are **Witcraft v. Sundstrand Health and Disability Group Benefit Plan** and **Egert v. Connecticut General Life Insurance Co.** In **Witcraft,** the court considered whether infertility was an "illness" within the meaning of the Plaintiffs' insurance policy. Physical examinations of the Plaintiffs revealed that the husband had a low sperm count and the wife experienced irregular ovulation. The couple received infertility

---

76 See id. at 626 (finding vasectomy reversal not "usual, customary and necessary" as defined by the policy).
78 See id. at 1314-15 (stating this procedure was "excluded by clear and unambiguous language").
79 See id. at 1315.
81 Blalock v. City of Portland, 291 F.2d 218, 221 (Or. 1955).
82 420 N.W.2d 785 (Iowa 1988).
83 900 F.2d 1032 (7th Cir. 1990).
84 See Witcraft, 420 N.W.2d at 786.
treatments and eventually conceived a child. They then underwent a second set of treatments in order to have another child, but this course of AI was unsuccessful. This second AI procedure, as well as all prior treatments had been paid for by the insurance company, but when the Plaintiffs submitted a claim for an additional treatment to the husband's sperm, their third overall, it was denied.

Their health care insurance policy stated that all "expenses relating to injury or illness" would be covered, and provided no exclusion for infertility. The plan defined "illness" as "any sickness occurring to a covered individual which does not arise out of or in the course of employment . . . ." The trial court found that "the dysfunctioning of the reproductive organs of both Mr. and Mrs. Witcraft came within the plan's definition of an 'illness.'" On appeal, the Supreme Court of Iowa affirmed the trial court's decision, stating that "the natural function of the reproductive organs is to procreate" and that the stated procedures did "help to reverse the dysfunction of the reproductive organs of both parties."

The insurance company was also required to pay for infertility services in Egert v. Connecticut General Life Insurance Co. The health insurance policy at issue stated therein that participants would be reimbursed for services "essential for the necessary care and treatment of an [i]njury or a [s]ickness." The Egert court ordered the insurance company to pay for the procedures because the Defendant's own internal memorandum referred to infertility as an illness.

3. Medical Necessity of Infertility Services

Medical necessity is another consideration traditionally affecting whether insurance companies will pay for infertility treatment. In

---

85 See id.
86 See id.
87 See id.
88 Id.
89 Id.
90 Id. at 787.
91 Id. at 788 (quoting the trial court's findings of fact).
92 Id. at 789.
93 900 F.2d 1032 (7th Cir. 1990).
94 Id. at 1037.
95 See id. at 1038.
96 See Norman Daniels, Technology and Resource Allocation: Old Problems in New Clothes, 65 S. Cal. L. Rev. 225, 232 (1991) (discussing how scarce resources are allocated). Historically, practitioners have been given a lot of leeway in deciding what treatments are medically necessary, based upon their efficaciously and risk/benefit analysis. See id. at 233. These decisions are more frequently being made by insurance company representatives with little or no medical training. See id. at 233-35.
Kinzie v. Physician's Liability Insurance Co., the court held that "in vitro fertilization [is] not a medically necessary service because it [is] elective and [is] not required to cure or preserve Mrs. Kinzie's health." The court reasoned that "[t]he infertile condition of Mrs. Kinzie's body was not corrected by in vitro fertilization. Although Mrs. Kinzie and her husband did indeed become parents, Mrs. Kinzie's infertile medical condition was in no way reversed or cured." Finally, the court stated that "[t]he conception of a child, although certainly important to married couples who have a problem conceiving, was not 'medically necessary' to the physical health of the insured." This decision is inconsistent with the Witcraft analysis, which held that infertility procedures did help cure the dysfunction of the Plaintiff's reproductive organs.

The insurer in Egert employed the same line of reasoning to argue that IVF was not medically necessary. It asserted that the IVF treatment at issue would not cure the infertility. The insurer argued that IVF was "not essential because it cannot make [the Plaintiff] fertile again unlike microsurgery [which was covered by the policy] which might repair her fallopian tubes." This argument is frequently used to deny coverage for assisted reproduction procedures, such as IVF, GIFT or ZIFT, because these procedures do not permanently correct an underlying physical problem, but rather circumvent the problem area. Insurance companies continue to embrace the notion that if a treatment does not cure a condition it should not be covered. One insurance representative stated that IVF should not be covered because "[i]t doesn't treat a disease, it bypasses the condition." The Egert court did not, unfortunately, come to a conclusion on this issue.

4. Assisted Reproductive Technologies Excluded as Experimental

A final method employed by insurance companies to deny coverage for infertility services is to label such services as "experimental."
Insurers regularly seek to exclude such experimental services in order to keep their costs down. There are, however, other more socially responsible reasons for denying coverage of experimental treatments. Exclusion of experimental treatments promotes elimination of worthless procedures from the medical field. Before insurers agree to pay for a treatment they want to make sure that it is safe and efficacious, thereby protecting the public from quackery.

A number of factors must be considered in deciding whether a treatment is experimental. These include cost, expert testimony, the patient's condition, the possibility of alternative treatments, professional consensus regarding the treatment's effectiveness and the extent to which the treatment is prescribed. In Reilly v. Blue Cross & Blue Shield United, the insurance company claimed that IVF was excluded under the policy's general exclusion of experimental treatments because it had a success rate of less than fifty percent. The court suggested that the insurance company's success ratio of fifty percent was arbitrary and unrealistic, pointing out that the insurance company did not use a success ratio in determining whether other diseases should be covered by the policy.

Despite the decision in Reilly, many insurers are still excluding coverage for IVF by continuing to consider it experimental, with one insurer recently announcing a lifetime limit on payments for infertility services of $5000. In reality, most advanced technologies carry high price tags, and thus, this limit is barely adequate to cover one attempt. On the other hand, $5000 is adequate to pay for a number of more traditional services, such as drug therapy and artificial insemination. In short, this amount reinforces the belief that the assisted reproductive technologies are still experimental and therefore undeserving of coverage from insurance companies.

Once a procedure has gained widespread acceptance in the medical community, it should no longer be considered experimental.

\(^{105}\) See Barbara A. Fisfis, Who Should Rightfully Decide Whether a Medical Treatment Necessarily Incurred Should Be Excluded from Coverage Under a Health Insurance Policy Provision Which Excludes from Coverage "Experimental" Medical Treatments?, 31 DUQ. L. REV. 777, 780 (1993) (explaining that, until recently, the primary purpose of exclusions for experimental treatments was to protect third-party payors from odd-ball or maverick therapies).

\(^{106}\) For a complete list of factors, see id. at 789-90.

\(^{107}\) 846 F.2d 416 (7th Cir. 1988).

\(^{108}\) See id. at 418.

\(^{109}\) See id. at 423-24 (remanding the case for further evidence on this issue); see also O'Rourke, supra note 6, at 380 (analogizing that if such a success ratio were applied to all treatments there would be no coverage for treatments of the terminally ill because they realistically have a success rate of zero percent).

\(^{110}\) See Leftin, supra note 12, at 664.
surance policies should recognize as acceptable and useful treatments, and in turn should provide coverage for, those procedures that have been deemed safe and effective by either the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

The number of babies born through IVF, GIFT and ZIFT approaches and sometimes surpasses the rates of natural pregnancies and therefore can not reasonably be considered experimental.\textsuperscript{112} IVF has proven to be an especially satisfactory means of achieving pregnancy.\textsuperscript{113} For example, in 1989, 4,284 babies born were conceived through IVF, GIFT or ZIFT.\textsuperscript{114} Perhaps it was this data which influenced the insurer in the class action suit, Thiebaud v. Kaiser Foundation Health Plan to concede that IVF is not an experimental procedure and settle a claim for payment of IVF procedures.\textsuperscript{115}

5. Traditional Contract Principles

Courts have also applied traditional principles of contract and insurance law to decide if an insurance policy covers infertility treatments. Courts examine what both parties intended the contract to mean and the contract is construed against the insurer as the drafter of the document.\textsuperscript{116} All ambiguities must be resolved in favor of the insured and the insurance company bears the burden of proving that the disputed treatment is not covered by the policy.\textsuperscript{117}

One important reason behind this jurisprudence is it takes into account the reasonable expectations of the insured.\textsuperscript{118} This is an important factor because when the insured signs a contract he or she has a present expectation about what will and will not be covered. If the contract is misleading it will prevent the insured from seeking out another contract which may cover the desired type of treatment. By

\textsuperscript{112} See supra notes 57-59 and accompanying text (comparing the statistics for assisted reproduction births and natural births).

\textsuperscript{113} See Dresser, supra note 25, at 164; see also supra notes 53-59 and accompanying text (discussing the success rates of assisted reproductive technologies).

\textsuperscript{114} See O'Rourke, supra note 6, at 380. There were 2,876 babies born through IVF, 1,202 through GIFT and 206 through ZIFT. See id.


\textsuperscript{116} For a general discussion of the rules of construction of insurance contracts, see Fisfis, supra note 105, at 781-82.

\textsuperscript{117} See Wicraft v. Sundstrand Health and Disability Group Benefit Plan, 420 N.W.2d 785, 789 (Iowa 1988) (holding that infertility is a disease and thus, the insurance company was obligated to pay for treatment).

\textsuperscript{118} See Fisfis, supra note 105, at 779 (arguing that the insured's expectations are an important factor to be considered).
the time the insured gets sick and needs the insurance, it is too late to look for another policy, and therefore the insured’s reasonable expectations must be taken into account in any judicial determination of the meaning of a contract. After courts began interpreting insurance contracts to include coverage for infertility treatments, insurers began to specifically exclude infertility services from the plans.\textsuperscript{119}

\textbf{B. Statutory Law}

As a result of the insurance industry’s specific exclusion of infertility treatments, many state legislatures have passed laws mandating coverage for infertility services. However, due to the fact that each state has the power to regulate insurance within that state,\textsuperscript{120} there is a great deal of inconsistency in coverage. Whether or not a person will have access to insurance funds for infertility services depends largely upon the state in which a person lives.

\textit{1. State Legislation}

Massachusetts and Rhode Island have the most comprehensive statutes dealing with the obligation of insurance companies to pay for infertility treatments. The Rhode Island legislation applies to any accident-and-sickness health insurance plan, any non-profit hospital service contract, any non-profit medical service contract and any health maintenance organization plan that includes pregnancy-related benefits.\textsuperscript{121} The scope is all “medically necessary expenses of diagnosis and treatment.”\textsuperscript{122} The legislation allows for co-payments up to twenty percent.\textsuperscript{123}

\textsuperscript{119} See Cole, supra note 9, at 718; Cox, supra note 115, at 14 (quoting a Kaiser insurance contract rewritten to specifically exclude IVF because it is “not a customary procedure required to save a life or cure a disease”).


\textsuperscript{121} See R.I. GEN. LAWS § 27-18-30 (1998). The statute provides, in part:

Any health insurance contract, plan or policy delivered or issued for delivery or renewed in this state on or after December 1, 1989, except contracts providing supplemental coverage to Medicare or other governmental programs, which includes pregnancy related benefits, shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility.

\textsuperscript{122} Id. at § 27-18-30(a). This section of the Rhode Island code applies to accident-and-sickness insurance policies. The language is substantially identical for nonprofit hospital service corporations, see id. § 27-19-23(a), nonprofit medical service corporations, see id. § 27-20-20(a), and health maintenance organizations, see id. § 27-41-33(a).

\textsuperscript{123} Id. § 27-18-30.

\textsuperscript{122} See, e.g., id. § 27-18-30 (a) (“[A] subscriber copayment not to exceed twenty percent (20\%) may be required for those programs and/or procedures the sole purpose of which is treatment for infertility.”).
of insurance contracts, including HMOs, and places no controls, restrictions or limits on the number of attempts at becoming pregnant. It covers all medically necessary expenses of diagnosis and treatment.\textsuperscript{124} Important aspects shared by both of these statutes are specific application to HMOs and a requirement of coverage for diagnosis and treatment of infertility services. Massachusetts actually provides wider coverage than Rhode Island because the Rhode Island statute is limited to married individuals.\textsuperscript{125}

Illinois also requires coverage for IVF, GIFT and ZIFT, but not until less expensive treatments have failed.\textsuperscript{126} It limits the number of attempts to four retrievals; however, if there is a live birth of one

\textsuperscript{124} See \textit{Mass. Gen. Laws Ann.} ch.175, § 47H (West 1998). The statute provides:
Any blanket or general policy of insurance . . . shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth. For purposes of this section, “infertility” shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

\textit{Id.}

\textsuperscript{125} See \textit{R.I. Gen. Laws} § 27-18-30(b) (1998) ("For the purpose of this section, “infertility” shall mean the condition of an otherwise presumably healthy \textit{married} individual who is unable to conceive or produce conception during a period of one year.") (emphasis added).


(a) No group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits may be issued, amended, delivered, or renewed in this State after the effective date of this amendatory Act of 1991 unless the policy contains coverage for the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.

(b) The coverage required under subsection (1) is subject to the following conditions:

(1) Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

(A) the covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract;

(B) the covered individual has not undergone 4 completed oocyte retrievals, except if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered; and

(C) the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for in vitro fertilization

(c) For purpose of this section, “infertility” means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

\textit{Id.}
child, the patient is allowed two more oocyte retrievals to attempt to have a second child.\textsuperscript{127}

Some states have enacted statutes that pertain only to IVF treatments. For example, Texas law requires insurers to offer coverage for IVF-related expenses.\textsuperscript{128} This statute also requires that a rejection of the offer to provide coverage for infertility services be “in writing.”\textsuperscript{129} This mandated offer applies only to employers who are choosing which plans to offer their employees; it does not extend to the actual insured. In addition, this law does not require coverage for other infertility treatments, although some may be implicit in the IVF coverage, such as stimulation of the ovaries and egg retrieval. Several requirements must be met before a person is eligible for coverage under the policy, including a continuous five-year period of infertility and a requirement that the sperm come from the patient’s spouse.\textsuperscript{130}

Other states with legislation limiting coverage to IVF services are Arkansas,\textsuperscript{131} Maryland\textsuperscript{132} and Hawaii.\textsuperscript{133} Arkansas permits the insur-

\textsuperscript{127} See id.  
\textsuperscript{128} See TEX. INS. CODE ANN. art. 3.51-6 § 3A (West 1991 & Supp. 1998). The statute provides: 
All insurers . . . self-insured welfare or benefit plans . . . shall offer and make available to each group policyholder, contract holder, employer, . . . union, association, or trustee under a group policy, contract, plan, program or arrangement that provides hospital, surgical, and medical benefits, coverage for services and benefits on an expenses incurred, service, or prepaid basis for out-patient expense that may arise from in vitro fertilization procedures, if the group insurance policy . . . otherwise provides pregnancy related benefits . . . .

\textsuperscript{129} Id. § 3A(a).  
\textsuperscript{130} Id. § 3A(c) (stating that "[a] rejection of an offer to provide coverage for the services or benefits provided by Subsection (a) of this section must be in writing").

\textsuperscript{131} See ARK. CODE ANN. §§ 23-85-137, -86-118 (Michie 1992). The statute reads: “All disability insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization.” Id. § 23-85-137(a). In Arkansas, “disability” insurance refers to any health problems. See O’Rourke, supra note 6, at 370 n.279.

\textsuperscript{132} See MD. CODE ANN., INS. § 15-810 (1997). This section applies to hospitals and major medical insurance policies, group or blanket health insurance policies, and nonprofit health service plans. See id. §15-810(a). The statute provides:
A policy, contract or certificate subject to this section that provides pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures performed on the policyholder . . . or the [policyholder’s] dependent spouse . . . .

\textsuperscript{133} Id. §15-810(b).  
\textsuperscript{134} See HAW. REV. STAT. § 431:10A-116.5 (1993). The statute provides:
All individual and group health insurance policies which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or the insured’s dependent spouse . . . .
ance commissioner to establish minimum and maximum levels of coverage to be provided by the insurance companies. In Maryland, not only must the oocytes be fertilized with the spouse’s sperm, but the patient also must have unsuccessfully tried other means of achieving pregnancy before undergoing IVF, have a five year history of infertility or have her infertility associated with one of the enumerated causes. The legislation in Hawaii only requires insurers to pay for one IVF attempt and also imposes several conditions precedent to coverage.

In other states, legislation has been enacted to require coverage for other infertility services, but does not include IVF. The law in California applies to health maintenance organizations, as well as other types of policies, and includes treatments for infertility, except IVF. This law requires insurance companies to offer treatment for infertility services, and includes coverage for GIFT. Because the exclusion applies only to “the actual in vitro fertilization process,” expenses for stimulation of the ovaries and egg retrieval would presumably be covered. Connecticut also has a mandate to offer infertility treatment coverage. This legislation is broader than California’s in that it includes IVF.

Id.

134 See ARK. CODE ANN. §§ 23-85-137(c), 23-86-118(c).
135 See MD. CODE ANN., INS. § 15-810.
136 See HAW. REV. STAT. § 431:10A-116.5(3)-(4). These conditions include fertilization “with the patient’s spouse’s sperm.” Id. § 431:10A-116.5(3). It also lists a number of qualifying medical conditions for coverage of in vitro fertilization. This list includes: “[a]bnormal male factors contributing to the infertility.” Id. § 431:10A-116.5(4)(B)(iv). This statute, like the Texas statute, which permits in vitro fertilization when the male has oligospermia (a low sperm count), see TEX. INS. CODE ANN. art. 3.51-6 § 3A(e)(3)(D), requires that in vitro fertilization be done with the husband’s sperm; but, if the husband has a low sperm count or other physical problem making this impossible, it may be necessary to use donor sperm, an option not permitted under either statute. See e.g., HAW. REV. STAT. § 431:10A-116.5(3); TEX. INS. CODE ANN. § 3A(e)(2)-(3).
137 CAL. INS. CODE § 10119.6 (West 1993). The statute provides:
On and after January 1, 1990, every insurer issuing, renewing, or amending a policy of disability insurance which covers hospital, medical or surgical expenses on a group basis shall offer coverage of infertility treatment, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group policyholder and the insurer.
Id. § 10119.6(c).
138 See id.
139 Id. § 10119.6(2); see also O’Rourke, supra note 6, at 368 n.266 (explaining that since the ovaries are frequently stimulated with hormones to encourage the ovulation of multiple eggs in other assisted reproductive techniques, such as GIFT, which are covered by the statute, then these expenses would also be covered when used in preparation for IVF).
140 See CONN. GEN. STAT. ANN. § 38a-536 (West 1992). The statute provides:
Any insurance company, hospital service organization or medical service corporation authorized to do the business of health insurance in this state shall offer to any individual, partnership, corporation or unincorporated association providing group hos-
In Montana, Ohio and West Virginia, statutes have been enacted which specifically require HMOs to cover "preventative health care services, including . . . infertility services." The scope of these statutes is not clear. Since they explicitly require coverage of "preventative services" they may be limited to procedures consistent with prevention of infertility, such as examination, diagnosis and minimal treatment. Because these statutes do not specifically require coverage for more expensive or high-tech procedures, a provider is likely to argue that IVF was not intended to be included. In West Virginia, the granting of a license to HMOs is conditional upon the provision of "basic health care services." In light of such language, it is difficult to argue that the legislature intended to include advanced procedures such as IVF and GIFT within the category of basic health care services.

2. The ERISA Problem

While these statutes are clearly a step in the right direction, they do not provide a complete solution for the infertility problem. The majority of American workers rely on health insurance provided in the workplace. There are several types of group insurance options available to employers who want to provide health insurance for their employees. One of these options, chosen by many large employers, is to self-insure. These employers cover the costs of their employees’ health care directly, taking on the financial risk involved. Such an employer will typically contract with an insurance company that manages the program and pays claims from the employer’s funds.

---

1. See id.


4. See Millsap, supra note 10, at 51. Approximately 4 out of 5 workers in the United States obtain their health insurance from their employer. See id.

5. See Mary Anne Bobinski, Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured, 24 U.C. Davis L. Rev. 255, 260 (1990) (stating that up to 81% of insured individuals are covered by employer-sponsored health insurance). There is, however, a growing trend toward self-insuring. In 1981, 22% of medium and large employers self-insured, with that percentage rising to 42% by 1985. See id. at 296 n.134.


7. See id.
These self-insured plans are attractive to employers because the plans are regulated by the Employee Retirement Income Security Act (ERISA) and are thereby exempt from state laws regulating insurance. This enables employers to offer insurance that does not meet the minimum state requirements, thereby significantly reducing costs. On the other hand, this also means that the majority of the American public is not able to take advantage of state legislation mandating insurance coverage for infertility services. This problem will be compounded by the shift to managed care, which focuses on lowering costs and eliminating unnecessary services. A number of the cost-control techniques used by managed care organizations will most likely discourage the provision of infertility services.

III. THE CHANGING FACE OF HEALTH CARE

Already inadequate coverage for infertility will likely be reduced even further in the near future. The United States is undergoing a major transformation from traditional fee-for-service plans to managed care organizations. This section examines the way infertility services are likely to be impacted by this shift. It begins by analyzing the growth of different types of managed care organizations. It then discusses the different techniques used by health maintenance organizations (HMOs) to control costs.

A. The Rise of HMOs

The United States spends more on health care than any other developed nation. In response to growing costs, the health care industry is undergoing a dynamic change, with health care being increasingly provided by for-profit providers. During the 1970s, ninety percent of Americans were enrolled in traditional indemnity health care plans; by 1991, that figure had dropped to only ten to fif-

---

149 ERISA is a federal statute regulating employee benefit plans. The preemption clause is the most significant aspect of this act. It provides that any state law "relating to any employee benefit plan" is preempted by ERISA. Id. § 1144(a). There is, however, a savings clause which saves "any law of any State which regulates insurance" from preemption. Id. § 1144(b)(2)(A). The statute, however, also states that "an employee benefit plan . . . shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts . . ." Id. § 1144(b)(2)(B). This clause has been interpreted to mean that laws relating to employee benefit plans, which would otherwise be exempt from preemption by the savings clause, are preempted as applied to self-insured plans. See Millsap, supra note 10, at 54 n.26.
150 See John D. Rockefeller IV, Health and the Underserved: Policy- Decisions, 3 STAN. L. & POL'Y REV. 27, 27 (1991) (comparing the amount of money spent on health care by the United States to that of other nations).
Americans are now seeking insurance from managed care organizations that promise to provide affordable insurance to more people through lower operating costs. Approximately 15% of the U.S. population are enrolled in HMOs, and another 19.5% are enrolled in preferred provider organizations (PPOs). For-profit HMOs are currently the fastest growing type of managed care organization.

HMOs attempt to reduce costs and maintain quality by both controlling the medical decisions of patients and minimizing provider payments. This is accomplished by eliminating unnecessary care, providing necessary care more efficiently and preventing the need for acute care. The first two objectives are particularly important to coverage for infertility services because they deal with the tenuous concept of "necessary care." The argument that infertility services are not medically necessary has long been used by insurance companies to deny coverage. If HMOs adopt this position, coverage for infertility services is likely to be one of the first areas cut from the typical insured's health care policy.

B. Techniques Used to Control Costs

Many of the techniques used to control costs in HMOs would permit, and even encourage, reduced coverage for infertility services. These include utilization review, patient management programs and financial risk shifting. Utilization review requires that a procedure be approved by the third party payor before payment is made. In other words, the insurer determines whether or not the service will be

---

152 See Edward Hirschfeld, The Case for Physician Direction in Health Plans, 3 ANNALS HEALTH L. 81, 84 (1994) (commenting on shift in decision-making for health plans from physicians to HMO managers).
153 See id.
155 See Hirschfeld, supra note 152, at 85 (discussing the primary goals of managed care as medical management of patients and cost containment).
156 See id. (explaining the three areas in which managed care organizations attempt to limit expenditures).
157 See supra notes 96-104 and accompanying text (discussing cases in which insurance companies refused to pay for infertility treatments on the theory that they are not "medically necessary").
158 Even if HMOs base their definition of "necessary care" on statistics, it is likely that the standards will be the result of studies based upon "a middle-class, European American, fairly healthy, male population." See Randall, supra note 67, at 218. Medical research has historically ignored the African-American population in general, and the low-income black females who suffer from the highest rates of infertility, leading some commentators to argue that these conclusions are based on faulty research. See id.
159 See id. (describing some of the techniques used by managed care organizations to control costs).
160 See id.
paid for prior to the performance of the procedure. If the payor denies the claim, the procedure is not performed unless the patient can demonstrate that he or she is personally able to pay for the service. By denying AI or IVF requests, HMOs can effectively cut those services out of their health plans.

Patient management programs are another means by which HMOs can eliminate infertility services from their plans. This technique requires patients to first see their general practitioner, commonly referred to as a “gatekeeper,” and to receive a referral prior to visiting a specialist. If a patient sees a specialist without receiving a referral from his or her primary physician, any services provided by the specialist will not be covered by the insurance plan. Primary physicians often have financial incentives not to make referrals. They may receive a cash bonus for keeping their number of referrals down, or may risk expulsion from the network if their number of referrals is too high. It is possible that HMOs will use this technique to increasingly deny claims made by patients who visited fertility specialists without first receiving a referral from their primary physician. Patient management may also achieve this end by encouraging HMOs to establish cash bonuses for physicians who keep their number of referrals to infertility specialists to a minimum.

Financial risk-shifting, another HMO strategy, also uses economic incentives to keep primary physicians from making referrals or performing high-cost procedures. Under a capitation program each doctor receives a certain fee per patient, regardless of what services are actually provided. If the doctor performs services that cost more than the standard fee paid by the HMO, the doctor becomes personally responsible for the additional expenses. This type of program may impact the provision of infertility services in many ways. First of all, it may discourage doctors from entering obstetrics. Furthermore, it may also induce obstetricians and gynecologists not to offer infertility services, or may even cause some doctors to postpone a proper diagnosis of infertility to protect themselves from the burden of bearing the high costs of some infertility procedures.

---

161 See id.
163 See id.
164 See Hirschfeld, supra note 152, at 85 (explaining a number of the tactics employed by managed care organizations to motivate physicians to change their practice methods).
165 See id.
C. HMO Contracts

As managed care plans draft their policies, they are faced with the ever increasing dilemma of trying to contain costs in the face of the many new medical technologies which are quickly being made available. This may lead to a very strict interpretation of what procedures qualify as medically necessary. In addition, many of the decisions about the "necessity" of a particular service are not even made by physicians, but rather by insurers, who traditionally have no medical training.

Many HMO contracts do not comprehensively cover infertility services. Kaiser Permanente, for example, does not cover "services to induce pregnancy, such as in-vitro fertilization and ovum transplants," but it will cover AI techniques performed with the husband’s sperm. Federal employees are covered by the Federal Employees Health Benefit program which is made up of 435 different health care plans nationwide, none of which cover IVF and many of which specifically exclude all treatments for infertility. Oxford Health Systems, Inc., a Norwalk, Connecticut-based company offers advanced infertility coverage as part of its basic coverage in New York, but imposes various monetary limits. HIP Health Plan of New York has not included coverage for IVF for several years, while Humana Inc. offers coverage for IVF as an optional rider. It is evident from

---

166 See Daniels, supra note 96, at 235 (suggesting that for a new treatment to be considered medically necessary it must be the most cost effective treatment within a class of acceptable procedures, not only when considered as a treatment option for a particular patient but also when evaluated across many patients and conditions). See also infra notes 219-23 and accompanying text for a discussion on the dangers of classifying "medically necessary" treatment too narrowly.

167 See Hirschfeld, supra note 152, at 86 (suggesting that if current practices continue insurance companies will be making the majority of treatment decisions).

168 See Leftin, supra note 12, at 664.

169 See O’Rourke, supra note 6, at 373 (demonstrating the need for federal legislation mandating coverage of infertility services). Examples of these plans include the Mail Handlers Benefit Plan, which is described as one of the "most comprehensive plans available." Id. at 357 n.150 (citing MAIL HANDLERS BENEFIT PLAN HIGH OPTION, PROMOTIONAL BROCHURE 3 (1991)). This plan excludes "[s]ervices for or related to artificial insemination or in vitro fertilization," "[t]reatment of infertility except for initial diagnostic testing" and "fertility drugs." Id. (citing MAIL HANDLERS BENEFIT PLAN, OFFICIAL STATEMENT OF BENEFITS 18, 23 (1992)). The Alliance Health Benefit Plan also lists exclusions for the "[t]reatment of infertility." Id. (citing ALLIANCE HEALTH BENEFIT PLAN, OFFICIAL STATEMENT OF BENEFITS 13 (1992)). It also excludes "[s]ervices related to conception by artificial means, including treatment and expenses related to in-vitro fertilization, embryo transfer or artificial insemination." Id. (citing ALLIANCE HEALTH BENEFIT PLAN, OFFICIAL STATEMENT OF BENEFITS 13 (1992)).

170 See Greenwald, supra note 4, at 3 (reporting coverage of infertility treatments by various managed care companies).

171 See id.

172 See id.
these examples that HMO coverage of infertility services is neither consistent nor complete.

According to one report, another HMO policy defines a treatment as “medically necessary” only if it is “an essential part of an active treatment” and “there is a defined medical goal that the [m]ember is expected to attain.” This definition would seem to include infertility treatments, even those that are considered more “high-tech.” These procedures, such as IVF, are part of an active treatment with the defined goal of achieving pregnancy and childbirth. However, the clause mentioned above, which pertains to home health care, has an additional requirement that the service not be provided for “custodial care.”

This last requirement effectively excludes many home health care services that would otherwise be incorporated in the definition. It demonstrates how narrowly HMO contracts are worded in order to keep costs down. Similarly restrictive clauses may be added to defeat infertility claims as well. These types of control mechanisms are resisted both by beneficiaries, who often can not obtain the services they require, and by health care professionals, who are prevented from prescribing the course of treatment they feel is appropriate or even necessary.

IV. THE DEBATE OVER HMO COVERAGE OF INFERTILITY SERVICES

To determine whether HMOs should provide infertility services, it is necessary to examine the strengths and weaknesses of several different arguments in favor of, and opposed to, coverage for infertility services. This section begins with a discussion of what constitutes an “adequate” package of health care services. It looks at philosophical notions, the concept of procreative liberty and what services are medically necessary. It concludes that because procreative liberty is a fundamental human right and infertility services are medically necessary for the infertile to successfully reproduce, an “adequate” package of health care services should include access to these services.

One of the strongest arguments in opposition to providing these services is increased cost. This is a valid concern, considering that controlling costs is one of the major priorities of HMOs. However, the discussion demonstrates that the costs of covering infertility services, including high-tech ones, is relatively small. In the long run,


174 See id.

175 See Hirschfeld, supra note 152, at 87 (explaining that both subscribers and providers feel that control mechanisms, such as utilization review, infringe on their control of medical decision-making).
comprehensive coverage of infertility services by HMO contracts may actually reduce costs. In any event, a more accurate picture of the true costs is provided.

A number of other arguments opposing infertility services coverage are also examined. These include the adoption alternative and the interference with free market choice. The weaknesses in these arguments is also exposed.

A. Social Obligations to Meet Health Care Needs

Health insurance is a means of protecting choice by providing individuals access to a range of health care opportunities. Without health care insurance, many people could not afford expensive medical treatments, making medical technology a viable option only for the wealthy. Because of the potentially high costs of infertility treatments, such services are a prime example of those accessible only to people with deep pockets absent a comprehensive health care package. However, as one commentator argued, “we have a social obligation to protect equality of opportunity” in health care matters. But if only the rich can choose to have a child via medically assisted methods, then there is yet another gap between health care opportunities for the rich and poor.

To equalize the discrepancies between what services are available for the rich and the poor, an adequate package of health services must be made available to everyone. Unfortunately, defining an “adequate” package of health care is not an easy task. One option is a national health care standard, as opposed to fifty separate state standards. One way of implementing this standard would be to provide a uniform national health plan. However, given the United States’ history as a pluralistic society accustomed to free choice, a single plan is probably not a realistic solution to providing adequate health care. A more workable approach, suggested by many advocates of health care reform is to provide an “adequate package of health care benefits that is in some sense reasonable or sufficient.” These plans do not call for identical coverage for all members of society.

---

176 Daniels, supra note 96, at 232.
178 See Rockefeller, supra note 150, at 29 (describing research done by the Pepper Commission on means of providing access to affordable, quality health care for all Americans).
179 See id. (arguing that the American public is not yet ready for a single, uniform health plan).
180 Kalb, supra note 177, at 1992.
181 See id.
In fact, they recognize that some individuals will have the resources and desire to purchase supplemental insurance plans. However, these advocates argue that an adequate level of minimal care, or basic services, must be available to everyone.

What does an “adequate” package of health services include? A logical starting point is a workable definition of health. The World Health Organization has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” According to this broad definition, infertility should be considered a health problem for several reasons. First, in many cases it may be the result of disease. Second, the malfunction of the reproductive system, whether caused by disease or some other physical defect is nonetheless an infirmity. Finally, this definition incorporates “complete . . . mental and social well-being” into a person’s overall health. Individuals who are unable to have children are often depressed, feel worthless and inadequate, and definitely do not feel “complete.” Unfortunately, this definition, although appealing, is probably unworkable due to its broadness. Providing coverage for every “health” problem that meets this definition would encompass nearly every conceivable ailment and would be extremely expensive.

Another proposed definition of “adequate” package of health care services includes “physician services; inpatient and outpatient hospital services; . . . prescription drugs; institutional care for the elderly and the physically or mentally disabled; dental services; early and periodic screening, diagnosis and treatment services; family planning services . . . and other medically necessary professional services.” Under this definition, infertility treatments would qualify under the “family planning services” clause. While some may argue that this phrase should be interpreted narrowly to include only counseling and preventive measures, the definition does not preclude coverage for fertility drugs, AI, and even IVF and other assisted-reproductive technologies used in connection with family planning. In addition, the definition provides a catch-all provision for “medically necessary”

---

182 Dresser, supra note 25, at 163 (citations omitted).
183 One of the many causes of infertility is endometriosis. See Rinehart, supra note 13, at 80-86, for a thorough discussion of this disease and its treatments.
184 See WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 1159 (1988) (defining infirmity as an "unsound, unhealthy, or debilitated state of body").
185 Dresser, supra note 25, at 163.
186 See Infertile Couples Keep Trying Despite Odds, OMAHA WORLD-HERALD, Dec. 15, 1997, at 1 (reporting the results of a 1993 study that found that infertile women had the same levels of depression as those with cancer, heart disease or HIV).
187 Kalb, supra note 177, at 1993 (citing the Health Policy Agenda Ad Hoc Committee on Medicaid, defining what services should be covered by Medicaid after reform).
services, so that those services not specifically mentioned may be provided for when needed. This is perhaps the best type of definition, because what is “adequate” simply cannot be defined in the abstract. It is different for every individual depending on their specific health care needs. However, even with this expansive definition of “adequate” health care, the provision of infertility services still seems to rest upon the unsettled question of whether such services are “medically necessary.”

Norman Daniels, a professor of philosophy noted for his work on what constitutes “adequate” minimum health care, offers an even more favorable definition. Under Daniels’s analysis, such an adequate package includes all health care services that are “needed to maintain, restore, or compensate for the loss of normal species-typical functioning.” Reproduction is a normal species function. The court in *Pacourek v. Inland Steel Co.* summarized this point nicely: “At the risk of waxing philosophical, none of us, nor any living thing, would exist without reproduction.” Any infertility service that is needed to restore this function, such as drugs or surgery, would be included within Daniels’s formulation, along with assisted reproductive technologies, which compensate for physical problems that interfere with natural reproduction.

A final definition of an adequate minimum package of health care focuses on what health care services must be provided to individuals in order “to be considered just.” Must a health care package offer equal benefits to everyone in order to be considered just? A careful consideration of this question reveals that the answer may not be as simple as it first appears. The idealistic notion that an adequate package of health care provides everyone with equal health care benefits is actually quite unappealing in its practical results. If a just health care system is one that gives all people equal access to health services, then our limited financial resources would dictate which services are available. This

188 See supra notes 96-104 and accompanying text (discussing case law on what is “medically necessary”); infra notes 218-28 and accompanying text (arguing that infertility services are “medically necessary”).
189 Kalb, supra note 177, at 1996 (quoting NORMAN DANIELS, JUST HEALTH CARE 79 (1985)).
191 Id. at 804.
192 See Kalb, supra note 177, at 1995 (arguing that society need not provide all health services possible to all individuals in order to offer a satisfactory minimum package).
193 See Dresser, supra note 25, at 160 (noting that requiring equal benefits to all members of society may have two consequences: it may demand making all infertility services available to every infertile individual seeking to have a child or it may mandate foregoing such procedures and instead improving preventative and crisis medical care programs).
would “prohibit people with higher incomes . . . from purchasing more care than everyone else gets . . . and would probably result in a black market for health care.” Such an approach would discourage scientific and technological advances, lower the overall standard of health care in the United States, and encourage physicians and patients to seek illegal means of fulfilling their needs. Instead of controlling health care costs and equalizing the discrepancies between rich and poor, it would likely increase them.

A better approach is grounded in the idea of distributive justice. An adequate package of health care “distinguishes on some principled basis between those health care services that all must receive for a society to be considered ‘just’ and those services that can be distributed inequitably without causing any fundamental injustice.” This definition still raises difficult questions concerning what services can justifiably be distributed inequitably but, at a minimum, it recognizes that not all health services deserve the same protection. It seems evident that procedures such as rhinoplasties, liposuction and breast augmentation are not fundamental human rights. The question remains as to whether having a biological child falls into the class of “fundamental rights,” or, rather, is simply analogous to plastic surgery.

A survey conducted by the Oregon Health Services Commission, in order to prioritize different treatments for the purpose of deciding which would be covered under the state’s new Medicaid plan, rated infertility services as number fifteen out of a total of seventeen. This low ranking suggests that the majority of the public considers infertility treatments to be of a low priority when rationing health care.

Leading scholars, as well as the U.S. Supreme Court disagree. According to Daniels, a just society is one in which every individual can experience a “‘normal’ range of lifetime opportunities.” Reproduction is a typical species function and an essential component of the life-plans of many people; as such, the ability to reproduce is...
something to which all people should be entitled.\textsuperscript{198} Because infertility interferes with this normal lifetime experience, everyone should have access to treatments that combat infertility.\textsuperscript{199} There are several reasons why the right to bear a child should be considered a "fundamental human right," each of which is discussed in the following sections.

\textit{I. Procreative Liberty}

In deciding whether or not HMO contracts should provide for infertility services it is important to keep in mind that there is a constitutional right to procreative liberty. In \textit{Skinner v. Oklahoma},\textsuperscript{200} the Supreme Court held that a law that required mandatory sterilization of certain criminals was unconstitutional because it interfered with the "right to have offspring," which is "fundamental to the very existence and survival of the race."\textsuperscript{201} While this decision specifically prohibited state action that denied procreative liberty and therefore would not be applicable to private insurance contracts, it is significant because it demonstrates the Court's belief that there is a basic human right to bear children. By extension, access to assisted reproductive technologies should also be protected.

This is an important right because the inability to reproduce deprives individuals of an "experience that is central to... identity and meaning in life."\textsuperscript{202} For many people, having and raising a child is a central part of their life plan.\textsuperscript{203} It is also a symbol of a couple's unity, commitment and love.\textsuperscript{204} The fact that the desire to procreate is, in part, socially constructed does not defeat the significance of this right.\textsuperscript{205} Personal autonomy should govern the choice whether or not to have a family. When a couple is infertile, this choice is dependent upon access to reproductive services.

However, simply because a right is protected by the Constitution does not mean that there is an affirmative obligation for the state to provide individuals with the means necessary to exercise that right.\textsuperscript{206} Procreative liberty is a negative right that prohibits state interference
HMO INFERTILITY COVERAGE

with choices to reproduce. There is no guarantee against private interference with the right to procreate, such as insurance companies' exclusion of services that would allow infertile couples to reproduce. The right to utilize reproductive technologies can be compared to the right to have an abortion, which is also afforded protection by the Constitution. Although states may not totally proscribe abortion, they have no obligation to provide it for citizens either.

While there is no positive right to assisted reproductive technologies, important policy considerations support the availability of coverage for infertility services in HMO contracts. One of the reasons for affording constitutional protection to procreation is to prevent the government from employing intrusive measures to control the population.

It is a fact that lower-income people have a higher incidence of infertility than wealthy people. The typical infertility patient, however, is a highly-educated, upper-middle class, white woman. If infertility treatments continue to be excluded from HMO contracts this trend is likely to continue. This means that reproductive choice is really only an option for two groups: those who are physically capable of bearing children naturally, and those with the financial resources to pay for infertility services themselves. In a country which has historically controlled African-American reproduction through sterilization, abortion and contraception, excluding infertility services from HMO contracts may be the latest means of ridding society of certain minority groups.

---

207 See ROBERTSON, supra note 11, at 23 (defining the concept of procreative liberty).
208 See Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992) (holding that states may not restrict abortion in such a way as to place an undue burden on a woman's right to choose); Roe v. Wade, 410 U.S. 113, 163 (1973) (holding that a state may not completely proscribe abortion).
209 See Casey, 505 U.S. at 899 (permitting states to regulate abortion in ways that do not constitute an undue burden on the woman's right to choose, such as requiring informed consent and requiring parental consent for minors).
210 See Millsap, supra note 10, at 53 (discussing the Hyde Amendment, passed by Congress every year since 1980 with slightly varying terms, which usually restricts federal funding of abortions to cases where the mother's life is in danger, or in cases of rape and incest).
211 See ROBERTSON, supra note 11, at 24-25 (highlighting government action in the United States and abroad that interfered with reproductive choice).
212 See supra note 67 and accompanying text.
213 See Rinehart, supra note 13, at 78 (describing these women as "better educated" and "better off financially").
214 Approximately 433,000 of the women who become pregnant each year do not have health insurance. See Rockefeller, supra note 150, at 28 (demonstrating that a lack of insurance coverage is not an obstacle to having a child for the fertile population).
215 See Rutherford, supra note 71, at 273 (describing the use of various techniques employed to eliminate "human weeds"); see also Randall, supra note 67, at 218, 222, 225 (discussing the lack of available infertility services for African-American women and a mistrust of managed care organizations).
2. Medical Necessity

Reproductive choice is an important human right: "To deny procreative choice is to deny . . . a crucial self-defining experience."\(^{216}\) But in a country that has limited resources and which is increasingly becoming reliant on HMOs for health insurance, should we be spending our health care dollars on expensive infertility treatments?\(^{217}\) A key issue to consider is whether these treatments are medically necessary. In the view of many insurance companies, they are not.\(^{218}\) There are several problems with this assertion. "Medical necessity" is an arbitrary concept.\(^{219}\) It has different meanings for different people and even for the same people at different times in their life. It is simply impossible for one person to judge what is a necessary or unnecessary treatment for another. For an insurance company employee who has a family of her own, bearing a child may not seem to be necessary to the physical health of the patient. But for a woman suffering from depression who has been desperately trying to conceive and now finds there are options available to help her achieve her goal, IVF may indeed be medically necessary. Deciding what is or is not medically necessary requires a value judgment about one's quality of life and, as such, it does not seem fair to place these decisions solely in the hands of insurers.

Insurance companies have attempted to distinguish medically necessary treatments from non-necessary ones by focusing on whether or not the treatment results in a "cure."\(^{220}\) This, however, is a faulty distinction because insurance is intended to protect the insured from the possibility of illness; it is not designed to be a cure for anything.\(^{221}\) Furthermore, this distinction is undermined by the insurance companies themselves. If bypassing a condition rather than treating it directly is a valid reason for denying coverage, then many of the currently covered procedures would have to be eliminated from insurance plans. For example, coronary bypass surgery, pacemakers, corrective vision lenses, artificial limbs and kidney dialysis all could be denied coverage following this line of reasoning because none of these treatments "cures" the underlying health problem.\(^{222}\) Rather, they merely offer individuals afflicted with the disease a more com-

\(^{216}\) See Robertson, supra note 11, at 4.
\(^{217}\) See Dresser, supra note 25, at 160.
\(^{218}\) See supra notes 96-104 and accompanying text (detailing the resolution of this issue reached by insurance companies and the courts).
\(^{219}\) See Yeh & Yeh, supra note 22, at 162 (defining "medically necessary" as needed to preserve or cure the health of the patient).
\(^{221}\) See O'Rourke, supra note 6, at 379.
\(^{222}\) See id. at 380.
fortable life. Another set of treatments that would necessarily be de-
nied coverage under the not "medically necessary" argument are ex-
spenses involved with treating a terminal illness. The costs of hos-
pital stays and pain medication for a patient in the final stages of ter-
minal cancer could not be covered as costs of "curing" the disease. 
Finally, some diseases, such as alcoholism, are never "cured." Suf-
ferers are deemed to be "in recovery" but are never considered 
"cured" because they can suffer a relapse at any time. However, 
treatments for alcoholism are routinely covered in insurance policies. 
Procedures aimed at treating infertility should be afforded at least the 
same coverage.

While infertility is not life-threatening, it is recognized by most 
doctors as a medical condition that should be treated like any other 
disease. Infertility treatments have been proven to successfully 
achieve pregnancy, and they make reproduction possible for infertile 
people, who are unable to naturally bear children. Furthermore, preg-
nancy and child birth are routinely covered in insurance policies. If it 
is not necessary to a woman's health to give birth, then why do such 
services receive preferential treatment? Insurance policies seem to 
determine what is necessary based on whether a person has a natu-
really functioning reproductive system. If insurance policies are 
willing to cover childbirth expenses for those who can naturally con-
ceive, they should provide the same coverage for infertility services 
that are medically necessary for an infertile couple to have a child.

The concepts of cost-control, procreative liberty and medical ne-
necessity must be considered together in determining whether HMO 
contracts should cover infertility services as part of an adequate pack-
age of health care coverage. Common sense dictates that we must 
"give priority to the services that do the most good." The right to 
equal access to infertility services is a controversial issue in a society 
currently trying to ration health care. Wealth and access to health 
insurance are the predominant means of rationing health care. Even 
those who can afford health insurance are subject to limits im-
posed by providers who decide which procedures they will pay for, 
how much they will pay and how many attempts they will cover.

223 See id. at 379.
224 See id.
225 See Cole, supra note 9, at 733 ("[I]nfertility is a medical illness or condition similar to 
other illnesses or conditions that is created by the malfunction of other bodily organs, and thus is 
no different than other illnesses or conditions and should be treated for purposes of insurance 
the same as any other body dysfunction.").
226 See O'Rourke, supra note 6, at 378-79.
227 Peters, supra note 196, at 492.
228 See id. at 518.
When the service in question is an infertility treatment, decision-makers are faced with balancing the heartfelt desires of the millions of infertile people in this country with the costs and effectiveness of a service that is of "questionable rank in the hierarchy of urgently needed health-care interventions." Given the importance of procreative liberty and the medical necessity of these treatments if the infertile are to reproduce, infertility treatments are not among the services that can be left out of an "adequate" package of health services.

B. Increased Costs

One of the major concerns about including infertility services in HMO contracts is the risk of skyrocketing costs, a prospect that is in direct conflict with one of the primary objectives of managed care: curbing costs. This fear, however, is unfounded. In states that have mandated insurance coverage of infertility services, the costs have been lower than expected. One study reported that the cost of adding IVF to a standard benefits package would be about $2.79 per member, per year. This is not a substantial increase. It is unlikely that individuals purchasing their own policies would be deterred by a less-than-$3.00 differential. For employers who provide insurance for their employees, this cost could be passed on to the employees or consumers without a noticeable impact.

There are a number of other economic incentives for supporting HMO coverage of infertility services. Better coverage of infertility services would reduce the financial cost of infertility and alleviate some of the stress involved. Proper coverage of infertility treatments would also permit a more accurate measure of what these treatments actually cost. Many doctors, for example, mislabel tests and drugs as treatments for other conditions in order to receive insurance coverage for them. Infertility also has long-term effects. As people become older they often rely on their children for support. The costs of caring for infertile individuals who were never able to have children will thus fall on society. Instead of increasing costs, better coverage of

229 Dresser, supra note 25, at 160.
230 See O'Rourke, supra note 6, at 383.
231 See id. In Massachusetts there was a $1.70, per family per month increase and in Maryland the increase was projected to be only $1.02, per family per month. See id. at 383 n.394.
232 See Ornstein, supra note 1, at D6 (citing the results of a study by William M. Mercer, a benefits consulting firm).
233 See infra notes 281-83 and accompanying text (discussing why employers should offer infertility services as part of their standard benefits packages).
234 See O'Rourke, supra note 6, at 385.
235 See id. at 386 (discussing the lifelong legacy of infertility).
infertility treatments may actually reduce costs by providing coverage, which will lead to more procedures, eventually leading to advances in technology that may improve success rates and reduce costs.236

From an economic standpoint HMO coverage of infertility services is justified because infertility affects 6% of the population, while spending on infertility services only comprises 1/10 of 1% of the U.S. health care budget.237 These numbers alone make it clear that more money should be spent on infertility services.

Another economic argument is that any immediate increases in cost would not only be minimal, they would also be limited. Any increase in the utilization of infertility services that occurs as the result of HMO coverage would be finite due to the limited number of people who would actually undertake the procedures.238 In Massachusetts, which has mandated coverage, only 0.2% of infertility patients received advanced treatments and nine out of ten people required no treatment.239 Accordingly, any increases in costs would be proportionally low. Infertility treatments are no more, and often less, risky than other procedures that are routinely covered by insurance.240

Opponents of HMO coverage argue that including these services increases the cost of insurance policies to those who are fertile and will never need the services. This argument, however, can be turned on its head. Couples who will never have children are forced to pay for childbirth and abortion services they will never need.241 In addition, many couples who purchase insurance may not know they are infertile, or may suffer from infertility later in life. Excluding coverage of infertility is actually contrary to the idea of group insurance policies in which people pay for services they hope they will never need.242 The notion is to make health services more affordable by spreading the risk across the population.

236 See Cole, supra note 9, at 735 (stating that new drugs are being, and have already been developed, to prevent some causes of infertility).
237 See id.
238 See YEH & YEH, supra note 22, at 162.
240 See Millsap, supra note 10, at 81-82. For example, 195,000 people have end-stage renal disease, a disease routinely covered by insurance, and 45,000 new cases are diagnosed each year with a cost of $43,000 per patient per year. See id. This is comparable in terms of numbers and costs to high-tech infertility procedures, but the infertility treatments are usually a one-time expense, while the end-stage renal disease patient may require care for several years. See id.
241 See Cole, supra note 9, at 736.
242 See id.
C. The Adoption Option

People who oppose coverage for infertility treatments often offer adoption as a solution for infertile couples who wish to have children. But this is not a reasonable alternative. One million American couples want to adopt an infant, but only one in thirty will actually do so. Adoption is not an inexpensive choice. The costs of adoption average $20,000, making it an option only for the financially well-off. In addition, adoption is a painstaking procedure. It requires a thorough examination of the couple’s background and “acceptance” by an agency, which only adds to the humiliation of infertility. Age may also be a problem for couples hoping to adopt, for many agencies will not “accept” a couple if either partner is over forty years of age. Ironically, these are often the very people who suffer from infertility. Finally, while there are older children with special needs available for adoption, the burden of giving these children homes should not fall solely on the infertile population. It takes a rare breed of family to raise a child with special needs, and to suggest that infertile couples should shoulder this responsibility alone is not fair to either the couple or the child.

D. Free-Market Choice

Another argument asserts that legislative mandates that require HMO coverage of infertility services interfere with free-market choice. As with the other arguments detailed above, this is also unpersuasive. There is no real interference with the free market, because without HMO coverage of infertility services, no real choice exists. HMOs are currently the fastest growing segment of health care services and the U.S. population is becoming dependent upon them to provide and finance health care. If these plans do not at least offer an option to purchase infertility services, consumers will not have the choice to select them. In states where insurance coverage of infertility services is mandated by law, the services will continue to be available. But because half of the nation’s insured population belongs to self-insured plans, which are controlled by federal and not state law, these laws will not protect them.
In addition, in those states that have a mandate to offer coverage for infertility services, the offer must be made to the employer who is purchasing the plan, not to the individual subscribers. Most people can not pick their employer based on whether or not they choose to cover infertility services, and so the concept of free-market choice fails. Furthermore, insurance policies are adhesion contracts; consumers can not be expected to have the power to bargain over what their insurance policies will cover.

A review of these arguments leads to the conclusion that excluding infertility services from coverage is not a reasonable or justified cost-cutting measure. There are strong philosophical arguments for protecting reproductive choice. For the infertile population, these services are the only way to exercise that choice. The costs involved with providing coverage for infertility treatments are relatively small given the limited number of people who are infertile and the low percentage of infertility patients that actually use expensive procedures. Adoption is not a substitute for infertility services, because often it is just as expensive and it can not substitute for giving birth to one's own biological offspring. Finally, given the large percentage of the population receiving their health insurance from managed care organizations, if these companies do not offer infertility services, there will be no choice to exercise. For these reasons HMO contracts should offer infertility services.

V. HOW HMO CONTRACTS COULD INCLUDE INFERTILITY SERVICES

Due to the fact that HMOs will soon be delivering health services to the majority of the population, it is important that these contracts include coverage of infertility treatments. This section discusses a number of ways in which this can be accomplished. State and federal legislation are two options, but there are inherent problems with both of these solutions. The American with Disabilities Act (ADA)²⁵⁰ may be another source of authority for mandating coverage, but the law in this area is unclear. In turn, the most realistic and practical alternative is to encourage HMOs to voluntarily write and incorporate into their health care policies clauses that provide for infertility services, while at the same time encouraging employers to choose insurance packages which provide these services.

A. State Legislation

Some states have already enacted statutes requiring HMOs to offer or provide coverage of infertility services. This is a step in the right direction, but because of the ERISA exemption, it is not enough. One solution to this problem would be to lift the ERISA exemption for self-funded employer insurance plans. This proposal would most likely be met with staunch opposition, both from the insurance companies providing the insurance to the employer as well as the employer itself, because most employers now use self-funded plans as a means of avoiding comprehensive state insurance laws and keeping costs down.

B. Federal Legislation

A more definite and complete solution would be to enact federal legislation mandating that HMOs offer coverage for infertility services; however, given the improbability of such federal legislation, this solution seems no more workable than those discussed above. The federal government is very reluctant to get involved in health care regulation, because it has viewed this type of regulation as primarily a state responsibility. Despite the recent enactment of the Health Insurance Portability and Accountability Act (HIPPA) and a bill banning drive-thru deliveries, it is unreasonable to place much stock in federal legislation as a viable solution to the problem.

C. Record-Keeping Requirements

Another possibility is to have states pass legislation requiring all HMOs to keep detailed records of their number of subscribers, the number of men and women they insure, the information presented to the public, and the number of subscribers who utilize each of the services they provide. Using this approach, HMOs could be efficiently regulated to protect consumer safety. It would also paint a much clearer picture of who actually uses infertility services, the

---

251 See supra notes 120-43 and accompanying text (discussing the various statutes states have enacted mandating infertility coverage).
252 See supra notes 144-49 and accompanying text (discussing the exemption of self-funded plans from state insurance regulations).
253 According to one report, the American Society for Reproductive Medicine in Washington will "seek legislation to be introduced this year in Congress mandating infertility coverage." Greenwald, supra note 4, at 4.
types of procedures they undergo and the true costs involved. Once access to these records is made available, HMOs would be able to make much more informed decisions about the true costs and benefits involved in providing infertility services, and they will see that the costs are minimal when compared to the benefits.

D. The ADA

The ADA, which prohibits disability-based discrimination in the workplace, may be another means of circumventing the ERISA problem. Several judicial decisions have held that infertility is a disability under the ADA.\textsuperscript{256} Federal law defines “disability” as a “physical or mental impairment that substantially limits one or more of the major life activities.”\textsuperscript{257} The Equal Employment Opportunity Commission (EEOC), which enforces the ADA, has issued regulations which define a “physical or mental impairment” as “[a]ny physiological disorder . . . or condition affecting one or more of [a number] of body systems.”\textsuperscript{258} Included in this list is the reproductive system.\textsuperscript{259} Interpreting these provisions, one court stated: “It defies common sense to say that infertility is not a physiological disorder or condition affecting the reproductive system. In fact, infertility is the ultimate impairment of the reproductive system.”\textsuperscript{260}

The division among courts concerns whether or not reproduction is a “major life activity” entitled to coverage under the ADA. In the typical ADA claim in this context, the employee-plaintiff argues that the major life activity that has been substantially limited is reproduction. Courts that have accepted this argument have held that infertility constitutes a disability protected by the ADA.\textsuperscript{261} Other courts have

\textsuperscript{256} See Erickson v. Board of Governors, No. 95 C 2541, 1997 WL 548030, at *3 (N.D. Ill. Sept. 2, 1997) (“Erickson’s infertility substantially limits the major life activity of reproduction, bringing her within the ADA’s scope.”); Bielicki v. City of Chicago, No. 97 C 1471, 1997 WL 260595, at *3 (N.D. Ill. May 8, 1997) ("Infertility, as a physiological disorder of the reproductive system, is a physical impairment under the ADA. Because infertility substantially limits the major life activity of reproduction, Bielicki states a cause of action under the ADA.”); Pacourek v. Inland Steel Co., 916 F. Supp. 797, 804 (N.D. Ill. 1996) (holding that because Pacourek’s physical impairment of infertility substantially limited the major life activity of reproduction, she was disabled under to the ADA). But see Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996) (holding that employee’s infertility is not an impairment that substantially affected a major life activity within the ADA); Zatarain v. WDSU Television, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995) (holding that reproduction was not a major life activity and therefore not subject to the protection of the ADA).


\textsuperscript{258} 29 C.F.R. § 1630.2(h)(1) (1998).

\textsuperscript{259} See id.

\textsuperscript{260} Pacourek, 916 F. Supp. at 801.

\textsuperscript{261} See id. at 801-04 (discussing why reproduction should be considered a “major life activity”).
concluded that reproduction is not a major life activity and, therefore, infertility is not entitled to protection under the ADA.\textsuperscript{262}

"Major life activity" is not explicitly defined by the ADA, but the EEOC regulations give context to the question by providing a series of examples. Specifically, the regulations state that "major life activities" means "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."\textsuperscript{263} The list is not exclusive; reproduction is not specifically included on the EEOC's list, but equally as important, it is not specifically excluded.

The courts that have held that infertility is not a disability under the ADA read this list very narrowly. In \textit{Krauel v. Iowa Methodist Medical Center},\textsuperscript{264} the court held that the Plaintiff's infertility was not a disability because it did not interfere with her ability to work.\textsuperscript{265} In \textit{Zatarain v. WDSU Television, Inc.},\textsuperscript{266} the court rejected the claim that infertility was a disability under the ADA because:

\begin{quotation}
[re]production is not an activity engaged in with the same degree of frequency as the listed activities . . . . A person is required to walk, see, learn, speak, breathe and work throughout the day, day in and day out. However, a person is not called upon to reproduce throughout the day, every day.\textsuperscript{267}
\end{quotation}

This logic, however, fails to answer a critical question: if reproduction was not meant to be included in the ADA's category of major life activities, then why was the reproductive system listed as one which could be impaired?

In \textit{Pacourek v. Inland Steel Co.},\textsuperscript{268} which concluded that reproduction was a "major life activity," the court emphasized the significance of the inclusion of the reproductive system in the EEOC guidelines as a body system that can be impaired.\textsuperscript{269} Since a physical defect affecting the reproductive system is considered an impairment under the ADA, "it logically follows from that instruction that reproduction is a covered major life activity. Otherwise, it would make no

\textsuperscript{262} See \textit{Krauel}, 95 F.3d at 677; \textit{Zatarain}, 881 F. Supp at 243.
\textsuperscript{263} 29 C.F.R. § 1630.2(i) (1998).
\textsuperscript{264} 95 F.3d 674 (8th Cir. 1996).
\textsuperscript{265} See \textit{id.} at 677. This reasoning was criticized by the \textit{Erickson} court, which stated: "[T]he major life activity of working applies only when no other major life activity is substantially limited. In other words the major life activity of working does not inform the inquiry of whether reproduction is a major life activity." \textit{Erickson}, 1997 WL 548030, at *4 (citation omitted).
\textsuperscript{266} 881 F. Supp. 240 (E.D. La. 1995).
\textsuperscript{267} \textit{Id.} at 243 (citations omitted).
\textsuperscript{268} 916 F. Supp. 797 (N.D. Ill. 1996).
\textsuperscript{269} See \textit{id.} at 801.
sense to include the reproductive system among the systems that can have an ADA physical impairment." The court also rejected the reasoning employed in Zatarain that because reproduction is not carried out on a daily basis it is not a "major life activity." The court found this interpretation of the ADA to be too narrow, and pointed out that a "major life activity" should not be defined by the "quantity" of its performance, but rather by how the absence of the ability to perform the activity can affect the "quality" of life.

According to the EEOC's Regulations, the ADA's non-discrimination mandate includes "[f]ringe benefits available by virtue of employment, whether or not administered by the [employer]." This includes employee-benefits packages. However, there is a special insurance provision that indicates that the ADA does not prohibit insurers from classifying risks in accordance with state law, so long as such classifications are not a "subterfuge to evade the purposes [of the ADA]." The statute "specifically permits the use of disability-based distinctions for insurance purposes so long as the distinction is based on traditional risk management practices and can be supported by actuarial data." This means that employers may price-discriminate in order to reflect the increased risk and higher expected costs of covering people with conditions that are expensive to treat. It is also permissible for the employer to exclude or put coverage caps on certain conditions.

This provision means that even if infertility is accepted as a disability under the ADA, it will still be permissible for employers to exclude infertility treatments from their employee benefits packages simply because of the potentially high costs of treating such conditions. While this seems to be blatant discrimination, it is not a violation of the statute so long as it is based on sound actuarial principles. In order to defeat this claim, the insured would have to argue that the

\[270\] Id.
\[271\] See id.
\[272\] See id. at 804 ("[N]either the ADA nor its implementing regulations either explicitly or impliedly defines 'major life activities' by the frequency with which they occur . . . [but rather as] those basic activities that the average person in the general population can perform with little or no difficulty.").
\[274\] See Anderson v. Gus Mayer Boston Store, 924 F. Supp. 763, 781 (E.D. Tex. 1996) (holding that under the ADA an employer is required to provide equal access to insurance coverage to employees with disabilities).
\[277\] See id.
\[278\] See id.
average cost of treating infertility is low, and that when spread across the employee population, the increase in policy price is not very high. Considering the ADA's liberal acceptance of traditional insurance practices these arguments would probably be rejected, and the ADA is unlikely to offer much support for protecting the provision of infertility services.

E. Employer Choice

Another way to avoid the ERISA problem is to encourage employers to choose HMOs that provide infertility services as a means of attracting and maintaining employees. This added benefit could improve employee morale and help retain employees. Last year, the percentage of large employers who chose HMO plans that cover IVF rose from 19% to 22%. The added costs of these plans are relatively inexpensive, and if the insurance benefits do successfully attract more qualified and productive employees while helping to retain employees, the employer would be benefited by having a more productive work force and by saving time and money that would otherwise be spent on training new individuals. Also, as more employers offer this option, it will become a necessary tool for attracting the best employees.

F. Voluntary Coverage by HMOs

Another alternative is to encourage HMOs to provide these services on their own, without any prodding by the state or local government. As has been demonstrated in states where infertility laws have been passed, the costs of implementing such services are not as great as expected. Furthermore, as competition between provider organizations grows, the ones that offer the most services at competitive costs will become the most popular. Because the average cost of treating infertility is low, this will not be an expensive measure for a HMO to undertake. If a HMO provides infertility services in every contract it sells, the costs will be so widely distributed across the population that the costs shifted to each consumer will also be negli-

---

279 See supra notes 229-32 and accompanying text (providing examples of how mandated infertility coverage increased insurance premiums only slightly).
280 See Greenwald, supra note 4, at 3 ("[O]n a per employee basis, the cost is not significant because of the relatively few employees who use these treatments.").
281 See O'Rourke, supra note 6, at 385.
283 See Ornstein, supra note 1, at D6 (citing a study by William M. Mercer, a benefits consulting firm).
284 See O'Rourke, supra note 6, at 383 n.394.
gible. In addition, infertility patients usually have short hospital stays, so there would not be any significant inpatient bills. Infertility patients tend to pay their bills, so by extension they will most likely make their co-payments in a timely fashion. And finally, the number of couples who actually undertake these procedures is limited to those afflicted with infertility.

1. Proposed Contract Clause

The proposed contract clause outlined below maintains some limits on infertility treatments, and yet offers a comprehensive package. HMOs that voluntarily adopt such a clause would have the potential to reap the benefits outlined in the previous sections.

Infertility Coverage

Benefits will be provided for diagnosis and treatment of infertility, including but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and low tubal ovum transfer performed on the subscriber or the subscriber’s dependent spouse, subject to the following conditions:

1. in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer shall only be required if the covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate treatments;
2. the covered individual has not undergone 4 completed oocyte retrievals, unless a live birth follows an oocyte retrieval, in which case 2 more oocyte retrievals shall be covered; and
3. the treatments are procedures consistent with the medical practice in the treatment of infertility by licensed physicians and are performed at licensed medical facilities.

---

285 See Rinehart, supra note 13, at 90 (noting that infertility patients tend to require short hospital stays, thereby minimizing staffing requirements, materials and overhead costs).
286 See id.
“Infertility” means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth, after one year or more of unprotected regular sexual intercourse.\(^\text{287}\)

Ideally, this contract clause would be included in all HMO contracts. If the HMO decides to merely offer policyholders the option for infertility services, which would be better than not giving them the option at all to have these services included, a refusal of additional coverage could be obtained in writing.\(^\text{288}\) This would protect both the HMO, by demonstrating that the subscriber was offered the option of purchasing coverage for infertility treatments and opted not to take it, as well as the subscriber, by ensuring that they were made aware that such coverage was not part of the standard policy and that it was available.

2. Protection for the Insured

This proposed contract clause would provide adequate infertility coverage. It allows the subscriber to utilize all of the technology currently available to achieve pregnancy. The success rates of IVF, GIFT and ZIFT have demonstrated that these are acceptable and useful means of attaining pregnancy,\(^\text{289}\) and therefore deserving of coverage under HMO policies. The list of covered procedures is not exclusive. It allows new techniques to be covered by the HMO contract once those techniques have gained medical acceptance. The policy also does not limit these procedures to married couples by requiring the eggs to be fertilized only by the sperm of the patient’s spouse. This is an important provision because there are single women who suffer from infertility as well as married couples whose infertility stems from a problem with the husband’s sperm.

The contract also does not require a prolonged period of infertility absent a specific, definable defect. This is also important because many couples do not have one of the easily identifiable infertility problems, such as endometriosis, in utero exposure to DES, oligo-

\(^\text{287}\) Portions of this clause are modeled after provisions from the California statute, see CAL. INS. CODE § 10119.6 (West 1993), and the Illinois statute, see 215 ILL. COMP. STAT. ANN. § 5/356m (West 1993 & Supp. 1998).

\(^\text{288}\) This requirement is incorporated in the Texas statute. See TEX. INS. CODE ANN. art. 3.51-6 § 3A(c) (West 1991 & Supp. 1999).

\(^\text{289}\) See supra notes 53-59 and accompanying text (discussing the success rates of assisted reproductive technologies).
spermia, or blocked or damaged fallopian tubes. Forcing these couples to wait for longer than the typically defined one-year period is counterproductive. Infertility treatments can take multiple attempts before they are successful, while in the meantime, the likelihood of a woman achieving pregnancy declines with age.

3. Protection for HMOs

This proposed contract clause also protects HMOs. It provides that the more expensive, assisted reproduction techniques do not have to be employed until other less costly treatments have failed. This effectively limits the number of policyholders who will actually undergo IVF, GIFT or ZIFT because often counseling, diagnosis and drug therapies are successful in achieving pregnancy. It also limits the number of oocyte retrievals to four. This number is fair, because the success of the procedure declines with each attempt, and thus the insured is precluded from undergoing countless unsuccessful attempts. However, it is an adequate number of attempts to give a policyholder a reasonable chance of becoming pregnant. Finally, the proposed clause also limits covered procedures to those that are deemed accepted by licensed physicians and performed at licensed medical facilities. This protects the HMO from paying for treatments that are truly "experimental." In addition, "[c]omprehensive 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.’" The proposed contract clause strikes a reasonable balance between the interests of the infertile policyholder and the HMO concerned about containing costs. It offers an adequate health care package at a reasonable price.

CONCLUSION

In a nation trying to control health care expenditures and provide universal health care, arguing for the inclusion of a medical service that is potentially expensive and of questionable necessity to many Americans may seem preposterous. Obviously, we do not have the resources to fund every conceivable or desired health service, and

---

290 See Peter J. Neumann, The Cost of a Successful Delivery with In Vitro Fertilization, 331 NEW ENG. J. MED. 239, 239 (1994) (reporting the results of a 1994 study that estimated the probability of success for the first IVF cycle was 12%, and that by the sixth attempt it declined to 7%).

291 Linn, supra note 238, at G2 (quoting a study by William M. Mercer, a benefits consulting firm).
coverage for infertility services is likely to come at the expense of excluding other equally important services. However, while HMO coverage of infertility services will increase access to these services and in turn increase the price of a HMO contract, the increase in price will be insignificant when spread across the pool of policyholders. In addition, comprehensive coverage by HMOs will enable companies to more closely monitor the course of infertility treatments and control costs by eliminating unnecessary, repetitive and low-probability treatments. With this kind of supervision, costs will be effectively contained and valuable health care dollars will still be available for other services.

It is important that we take steps to insure that access to infertility services continues to exist and becomes more widely available to all Americans, not just the wealthy, because procreative liberty is a fundamental right in the United States. One way to do this would be to pass federal legislation requiring HMOs to provide health insurance. As this is unlikely, it will be up to employers and HMOs to offer or provide these services. Another solution may be to invoke the ADA to argue that not providing insurance coverage for infertility services discriminates against infertile employees. This argument may also be unsuccessful because it is not clear whether or not employers can discriminate on the basis of disability when the costs are great.

The best solution is to urge employers and HMOs to voluntarily provide these services. Instead of viewing health insurance plans that provide infertility services as an increased cost, employers should view them as an added benefit, a means of attracting and retaining quality employees. HMOs in turn should provide, or at the very least offer, infertility services in their policies. The costs associated with providing these benefits are minimal. Such plans will also provide a competitive edge in the maturing HMO market, where the most successful plan will be the one that offers the most services at the lowest costs.

A policy that provides coverage for a whole range of infertility services, from diagnosis to drugs to IVF, seems to be the ideal solution. To be truly protective of procreative freedom the policy can not discriminate between married and unmarried individuals. It should also apply the standard definition of infertility, which uses a one year period, rather than requiring some specific medical condition or a long history of infertility. Finally, some restriction, such as a limit on the number of trials, or on the types of procedures that can be performed, may be acceptable. The proposed contract clause discussed above is an example of fair coverage for infertility services. HMOs should work with infertile individuals in order to create an adequate
package of health care services, which meets their needs and allows them to pursue happiness to the same extent as their fertile counterparts.

Lisa M. Kerr