Birth Right: Does a Lack of Access to Health Coverage for Fertility Treatment for Single Individuals and Same-Sex Couples Constitute Discrimination?

Quinn Kobrin

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ABSTRACT. There are often great costs associated with receiving fertility treatments such as IVF. Those who wish to overcome infertility and conceive may turn to their health insurance providers to find coverage for such treatments. Currently, many health insurance providers’ policies require that those seeking coverage show infertility either by (1) failing to conceive after six to twelve months of unprotected sexual intercourse; or (2) failing to conceive after six to twelve months of receiving fertility treatment. Advocates argue that such policies are discriminatory because classes of people such as same-sex couples and single individuals who wish to conceive cannot do so without the aid of fertility treatment, and therefore are only able to receive coverage for treatment after paying for treatment out-of-pocket for twelve months. Meanwhile, heterosexual couples can show infertility by failing to conceive through sexual intercourse over a period of time without paying anything out of pocket.

This Note analyzes the alleged discrimination toward same-sex couples and single individuals, discussing the current challenges of paying for infertility treatment, explaining the landscape of insurance in the United States, and examining the status of the law as it relates to protections against discrimination in health care coverage and recommended courses of action that may prevent the discrimination alleged herein from occurring in the future.

AUTHOR. Quinn Kobrin is a J.D. candidate at the University of New Hampshire Franklin Pierce School of Law. He is pursuing a Health Law and Policy certificate. He would like to thank Professor Lucy Hodder (UNH Law, Director of Health Law and Policy) for her help and support in the drafting and accuracy of this note. He would also like to thank Dr. Kate Schoyer (Medical College of Wisconsin, Director, Division of Reproductive Endocrinology and Infertility) for helping to inform him about reproductive medicine/fertility treatment. Lastly, he would like to thank his family, his classmates, and his significant other, Jessica, for supporting and encouraging him throughout the writing process.

1 This note is intended to be inclusive and avoid any discriminating, offensive, or excluding language. All efforts have been made to use inclusive language to describe the individuals impacted by the alleged discrimination.
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INTRODUCTION

Fertility treatments have been used for decades to help people overcome the inability to have children. Access to fertility treatment is a challenge for many different groups in the United States. One of the main obstacles to receiving treatment is the lack of coverage to pay for the costly process. In vitro fertilization (IVF) can often end up costing between $15,000–20,000. Many people cannot afford to pay these costs. While some insurers have taken strides to offer coverage for services such as in vitro fertilization to their policyholders, there are some people covered by insurance who feel they are unfairly discriminated against when it comes to qualifying for this coverage. The plaintiffs in an ongoing New York case argue that the language of such policies is discriminatory exclusively against people because of “their sexual orientation or gender identity.” However, this argument leaves out other classes of people, such as single individuals without partners capable of producing sperm who may wish to conceive on their own. It is arguable that if such a policy is discriminatory at all, then it is likely discriminatory to all who seek fertility coverage and are not part of a heterosexual relationship.

Using the complaint of a case currently in litigation called *Goidel v. Aetna Life Insurance Co.* as a vehicle, this Note describes and examines the overarching issue.

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6 See id. (noting “[a]t best, this price tag is daunting. For many of us, it sounds entirely out of reach, especially considering that many patients go through several cycles of IVF before conceiving or attempting other options”); see also *Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion*, 116 AM. SOCIETY FOR REPRODUCTIVE MED.: FERTILITY AND STERILITY 54, 55 (2021), [https://doi.org/10.1016/j.fertnstert.2021.02.019](https://perma.cc/8NAX-5BV6) (stating that “[c]ost pressures influence whether patients seek treatment and the decisions they make during treatment”).


9 See id. at 2.

10 See Gabriela Weigel et al., *supra* note 3.
of discrimination in accessing insurance coverage for fertility treatment as it relates to all people who are not part of a heterosexual couple. Additionally, the Note navigates the anti-discrimination provision of the Affordable Care Act, Section 1557, analyzing the evolution of how it has been interpreted and how it will likely be interpreted moving forward. The Note then reviews state action related to health coverage for fertility treatment, including what is and what is not required for insurers by state law. Finally, this Note recommends actions that should be taken on the state and federal level to mitigate future discrimination.

I. PART 1: WHY DO PEOPLE CARE ABOUT COVERAGE FOR FERTILITY TREATMENT?

A. Goidel v. Aetna & the Allegations of Discrimination

In Goidel v. Aetna, Life Insurance Co., a class action lawsuit against the health insurance company, Aetna, the plaintiffs contend that the provider illegally discriminates against them because it requires that couples who are unable to conceive through unprotected sexual intercourse pay out-of-pocket for a span of time ranging from six to twelve months before coverage will begin.11 One main reason for this argument stems from the fact that, according to Aetna’s plan, heterosexual couples, or those traditionally able to conceive through intercourse, only have to show they have been attempting to conceive through intercourse over the same period of time.12 This case appears to be the first sign of litigation asserting that such a discrepancy in coverage constitutes discrimination.

The plaintiff in Goidel, Emma Goidel, is a woman in a same-sex marriage.13 At the time she sought coverage for fertility treatment, she and her wife were enrolled in Aetna’s health plan through Columbia University.14 The Goidels decided that they wanted to have children, which meant they would have to utilize a fertility treatment such as intrauterine insemination (IUI) or in vitro fertilization (IVF).15 The couple submitted a claim to Aetna to cover six cycles of IUI.16 Aetna denied this claim,17 and referred the couple to their Clinical Policy Bulletin (CPB), which requires, “donor insemination if there is no male partner for at least (a) one year at any age, or (b) six months if older than 35.”18 As a result, Goidel would end up

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11 Amended Complaint, supra note 8, at 2.
12 Id. at 5–6.
13 Id. at 7–8.
14 Id. at 7.
15 See id. at 8.
16 Id. at 9.
17 Id.
18 Id. (emphasis omitted).
undergoing five cycles of IUI which she and her partner paid for out-of-pocket.\textsuperscript{19} None of these resulted in a pregnancy.\textsuperscript{20} She went on to attempt IVF, which resulted in a pregnancy, then a miscarriage.\textsuperscript{21} It was not until the sixth attempt at IUI that Goidel was able to successfully conceive again.\textsuperscript{22} Aetna consistently denied coverage throughout all of this.\textsuperscript{23} The couple asserts in their complaint that the treatments cost them close to $45,000.\textsuperscript{24} Other named members of the class shared similar accounts in the complaint.\textsuperscript{25} They additionally contend that, in denying them coverage for the treatment, Aetna violated Section 1557 of the Affordable Care Act, Section 296(2)(a) of the New York State Human Rights Law and Section 8-107(4) of the New York City Human Rights Law.\textsuperscript{26} The complaint concludes its preliminary statement by claiming to bring the case “on behalf of themselves and all others who are unable to conceive through intercourse due to their sexual orientation or gender identity.”\textsuperscript{27}

\textbf{B. The Hurdles to Overcoming Infertility}

People who wish to have children but are unable to conceive often turn to fertility treatment for a solution.\textsuperscript{28} There are a variety of fertility treatments available, including IUI and IVF.\textsuperscript{29} IVF, in particular, falls into the category of “assisted reproductive technology” (ART), and is “by far the most common ART procedure performed.”\textsuperscript{30} In 2019, there were 330,773 ART cycles performed in the United States.\textsuperscript{31} There is, to date, very little data about how many same-sex couples

\begin{itemize}
\item \textsuperscript{19} Id. at 9–11.
\item \textsuperscript{20} Id.
\item \textsuperscript{21} Id. at 13.
\item \textsuperscript{22} Id.
\item \textsuperscript{23} Id. at 9–13.
\item \textsuperscript{24} Id. at 2.
\item \textsuperscript{25} See id. at 14, 19.
\item \textsuperscript{26} Id. at 2.
\item \textsuperscript{27} Id. at 3.
\item \textsuperscript{29} See id.
\item \textsuperscript{31} ART Success Rates, CENTERS FOR DISEASE CONTROL AND PREVENTION, \url{https://www.cdc.gov/art/artdata/index.html#} [https://perma.cc/20on20CDC’s%202019%20Fertility Rates].
\end{itemize}
or single individuals utilize these services. However, it is clear that the cost of IVF is a large factor in people’s decision to use it, regardless of their relationship status or sexual orientation.\textsuperscript{32} As evidenced by a study analyzing the use of IVF before and after it was covered by the University of Michigan’s health insurance plan, the use of expensive treatments like IVF increases substantially when people do not have to pay out-of-pocket for it.\textsuperscript{33} This is because the expense of fertility treatment tends to be cost-prohibitive.

On average, the cost of IVF is around $19,200.\textsuperscript{34} A single IVF cycle can range from $15,000–$30,000.\textsuperscript{35} However, many patients often have to go through multiple full cycles of IVF before they are able to successfully conceive.\textsuperscript{36} This makes sense, considering the success rate for IVFs in women under 35 in 2020 was approximately fifty-five percent.\textsuperscript{37} Whether due to the cost of a single cycle of IVF or the need to undergo multiple rounds, a 2015 study showed that seventy percent of women who underwent IVF treatment went into debt.\textsuperscript{38} The cost of IUI can range from a few hundred to almost $4000 per attempt.\textsuperscript{39} While this amount is significantly lower than the cost for a cycle of IVF, the rate of success is not better, generally ranging from 5%–15%.\textsuperscript{40} With this in mind, there is a considerable likelihood that most people who seek fertility treatment will end up spending at least a few hundred—if not several thousand—dollars, just as the plaintiffs in \textit{Goidel} are purported to have done.\textsuperscript{41} It is therefore reasonable to understand why people are arguing that insurance policies should expand their scope of coverage to be as inclusive as possible. For example, the Ethics Committee of the American Society

\textsuperscript{32} See Carroll, supra note 4.
\textsuperscript{33} See id. (showing that the use of IVF treatment “nearly tripled overall and increased more than nine-fold among employees and dependents in lower-salary brackets”).
\textsuperscript{34} \textit{Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion}, supra note 6.
\textsuperscript{35} Conrad, supra note 5.
\textsuperscript{36} Id.
\textsuperscript{38} \textit{Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion}, supra note 6.
\textsuperscript{41} See Amended Complaint, supra note 8, at 2.
for Reproductive Medicine (ASRM) asserts that “[i]t is important for [‘diverse sexuality and gender (DSG) individuals and couples’] to have the same access to infertility care as cisgender heterosexual married couples.”

As in many legal issues, language plays a very integral role in understanding the conflict at hand. The vast disparity in coverage of fertility treatment for heterosexual couples and coverage of treatment for same-sex couples and single individuals seeking to have children can be traced to the use and definition of the word infertility. According to the CDC, “infertility is defined as not being able to get pregnant (conceive) after one year (or longer) of unprotected sex.” Similarly, it is defined by the ASRM as being “the result of a disease . . . of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.” These definitions exclude otherwise healthy individuals in same-sex relationships or who wish to become pregnant but do not have a partner capable of producing sperm. Neither category of people can meet the definition of infertility because there is no possibility of insemination. The question of language is at the very heart of the issue when it comes to access to coverage for fertility treatment, and will be reviewed at length in the discussion about the current landscape of the law.

C. The Legal Implications of Health Insurance in the United States

Before moving into the law as it relates to discrimination in health care, it is necessary to break down the role of health insurance in the United States. There are several sources of insurance available to individuals depending on their personal (and often financial) circumstances. These include employer-sponsored coverage, individual marketplace plans, and Medicaid, among others. It is essential to

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45 See generally Weigel et al., supra note 3.

46 Health Insurance Coverage of the Total Population, KFF: STATE HEALTH FACTS, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22collId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%2C%22%7D [https://perma.cc/Y7E-H8JX] (last visited Feb. 24, 2023).
understand what types of health insurance coverage are available and which laws apply to each type in order to recognize how many people will be impacted by the various laws passed by various entities.

In the United States, 48.5% of the population receives health insurance through their employer.\textsuperscript{47} Employer-sponsored coverage can be broken down into two main categories: fully-insured plans and self-insured plans. A fully-insured plan is one in which an employer pays a premium to an insurance company to insure its employees.\textsuperscript{48} In a self-insured (or self-funded) plan, an employer provides health benefits directly to its employees.\textsuperscript{49} This means that employers, rather than insurance companies, bear the risk of covering medical costs of employees.\textsuperscript{50} However, employers often contract with insurance companies to act as third party administrators (TPAs) to assist in appropriately carrying out the plan and providing benefits.\textsuperscript{51}

An important aspect of employer-provided insurance, particularly when considering laws that could affect insurance, is The Federal Employee Retirement Income Security Act (ERISA). ERISA applies to self-insured plans.\textsuperscript{52} Specifically, § 514(a) of the statute provides that ERISA supersedes any state law that relates to employee benefit plans.\textsuperscript{53} A state law that “directly affects the relationship among traditional ERISA entities . . . [i]nterferes with plan administration; or . . . [u]ndercuts ERISA’s purpose” makes an impermissible reference or impermissibly relates to employee benefit plans.\textsuperscript{54} Self-insured plans fall under the umbrella of employee benefit plans.\textsuperscript{55} Because of this law, self-insured plans are not required to comply with state laws governing insurance. This means that “state law[s] requiring insurance companies to cover infertility treatment cannot apply to companies that

\begin{itemize}
  \item \textsuperscript{47} Id.
  \item \textsuperscript{49} Id.
  \item \textsuperscript{50} See id.
  \item \textsuperscript{51} See id.
  \item \textsuperscript{53} 29 U.S.C. § 1144 (2006).
  \item \textsuperscript{54} Thorne et al., \textit{Novel ERISA Preemption Questions Presented by U.S. Supreme Court’s Dobbs Decision}, JACKSON LEWIS (June 30, 2022), https://www.jacksonlewis.com/publication/novel-erisa-preemption-questions-presented-us-supreme-court-s-dobbs-decision#:~:text=Breaking%20these%20categories%20down%2C%20a%2C%20order%20to%20resolve%20the%20claim [https://perma.cc/5DV3-76JA].
\end{itemize}
‘self-insure their employees. . . .’\textsuperscript{56} Therefore, only federal law can mandate if and how fertility treatment is covered by self-insured entities.

The other main way that people get private insurance is through the health insurance marketplace.\textsuperscript{57} Roughly six percent of Americans with health insurance are insured in these “non-group” plans.\textsuperscript{58} The health insurance marketplace allows people to purchase ACA-compliant plans and potentially “receive income-based subsidies.”\textsuperscript{59} These plans, like fully-insured plans, are not preempted by ERISA.\textsuperscript{60} This is because ERISA’s “savings clause” provides that state laws relating to insurance, among other things, shall not be preempted.\textsuperscript{61} The savings clause does not include or apply to self-insured plans because of the “deemer” clause, which states that entities offering employee benefit plans shall not be deemed insurers subject to the savings clause.\textsuperscript{62} Thus, fully-insured plans are subject to state insurance laws.

Finally, people who meet financial or age thresholds or have certain disabilities may qualify for coverage under Medicaid or Medicare.\textsuperscript{63} Nearly thirty-five percent of the U.S. population is covered by either Medicaid or Medicare.\textsuperscript{64} According to the Department of Labor, “ERISA does not cover group health plans established or maintained by governmental entities.”\textsuperscript{65} Thus, like fully-insured employer-provided coverage and marketplace plans, coverage offered under Medicaid and Medicare is not preempted by ERISA, but rather is subject to state insurance laws.

\textsuperscript{56} Health Insurance 101, supra note 52.


\textsuperscript{58} KFF: STATE HEALTH FACTS, supra note 46 (defining non-group insurance as coverage “by a policy purchased directly from an insurance company,” as opposed to group plans sponsored by employers).


\textsuperscript{61} See id.


\textsuperscript{63} Finding Health Insurance, supra note 57.

\textsuperscript{64} See KFF: STATE HEALTH FACTS, supra note 46.

II.  PART 2: THE LANDSCAPE OF THE LAW SURROUNDING DISCRIMINATION IN HEALTH CARE

A.  Section 1557: History & Enforcement of the Federal Anti-Discrimination ACA Provision

Section 1557 is a provision of the Patient Protection and Affordable Care Act of 2010.66 The section is considered to be the “first federal anti-discrimination provision directly focused on health care services . . .”67 Section 1557 prohibits discrimination on the basis of several factors, including age, race, disability, and sex.68 This prohibition applies to many entities, including “any health program or activity, any part of which receives Federal financial assistance . . .”69 If any such entity is alleged to have illegally discriminated against an individual, the Office of Civil Rights (OCR) under the Department of Health and Human Services (HHS) investigates to determine if there was a violation or compliance issue.70 This can result in the OCR issuing letters to the offending entity and seeking out voluntary compliance.71 If the entity in question refuses to comply voluntarily, the OCR can refer the case to the Department of Justice or revoke federal funding from the entity.72 Additionally, “[i]ndividuals can . . . file lawsuits under Section 1557.”73

Taking the language of the statute at face value, it may be difficult to discern how Section 1557 protects against discrimination on the basis of sex. In the first paragraph of the provision, there are references to Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and the Age Discrimination Act of 1975.74 Additionally, in the second paragraph, the provision makes reference to Title VII of the Civil Rights Act of 1964, stating that Section 1557 “shall not be construed to invalidate or limit the rights, remedies, procedures, or legal standards available” under Title VII.75 Multiple courts have held that, by making the reference

67  Id.
68  Id.
71  See id.
72  Id.
75  Id.
at all, Section 1557 incorporates these statutes.\textsuperscript{76} In fact, the court in \textit{Panama Railroad Co. v. Johnson} approved of this method of adopting statutes by reference, stating that “[t]his is a recognized mode of incorporating one statute or system of statutes into another, and serves to bring into the latter all that is fairly covered by the reference.”\textsuperscript{77} Thus, Title VII, which prohibits discrimination on the basis of sex, is incorporated into Section 1557. This now begs the following question: What constitutes “discrimination on the basis of sex” for the purposes of Section 1557? The answer to this question lies within the volatile and ever-changing interpretation of Section 1557.

1. The 2016 Rule

The first relevant interpretation of the statute was made by the Obama administration on May 18, 2016.\textsuperscript{78} On that date, the HHS Office of Civil Rights issued a final rule interpreting Section 1557.\textsuperscript{79} In this rule, the OCR clarified what qualified as “Federal financial assistance” under the provision.\textsuperscript{80} Notably, the rule states that assistance includes both “funding received directly by covered entities” and “premium and cost-sharing subsidies provided . . . for coverage through Federally-facilitated or State-based Marketplaces.”\textsuperscript{81} This means Section 1557 applies to insurance providers that offer Marketplace plans to consumers.\textsuperscript{82} Furthermore, the OCR argued that Section 1557 applies to all plans provided by such providers, not just those that were offered on the Marketplace, because the language of the provision “prohibits discrimination under ‘any health program or activity, any part of which is receiving Federal financial assistance . . . .’”\textsuperscript{83} Other providers that may be considered covered entities that receive federal financial assistance are health insurance issuers and TPAs, state agencies such as Medicaid, and employers who offer employee health benefit programs (in specific situations).\textsuperscript{84}

In the same rule, the OCR implemented language intended to protect against discrimination based on sex in health care and health care coverage.\textsuperscript{85} Specifically,

\begin{itemize}
\item[76] Doe v. BlueCross BlueShield of Tenn., Inc., 926 F.3d 235, 239 (6th Cir. 2019).
\item[77] Panama R. Co. v. Johnson, 264 U.S. 375, 392 (1924).
\item[79] Id.
\item[80] Id.
\item[81] Id.
\item[82] Id.
\item[84] Cornachione et al., \textit{supra} note 78.
\item[85] Nondiscrimination in Health Programs and Activities, \textit{supra} note 83, at 31387.
\end{itemize}
the OCR put out a definition for “on the basis of sex,” which included “discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.”\textsuperscript{86} In its response to comments on the proposed 2016 rulemaking, the OCR concluded “Section 1557’s prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual’s sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes.”\textsuperscript{87}

The OCR’s inclusion of gender and sex stereotyping was of particular importance because it expanded the scope of protection against discrimination on the basis of sex. Elsewhere in its summary of regulatory changes, the OCR stated, “that sex stereotypes can be based on expectations about gender roles.”\textsuperscript{88} One could argue that this more inclusive language includes discrimination based on the failure to provide equal coverage to same-sex couples (and even single individuals) seeking fertility coverage. Support for the inclusion of the language was found in a recent Equal Employment Opportunity Commission (EEOC) decision called \textit{Baldwin v. Foxx}.\textsuperscript{89} In this case, the EEOC concluded that Title VII’s prohibition against discrimination on the basis of sex also included sexual orientation because sexual orientation involved “sex-based preferences, assumptions, expectations, stereotypes, [and] norms.”\textsuperscript{90} The decision went on to say that “‘sexual orientation’ as a concept cannot be defined or understood without reference to sex.”\textsuperscript{91} Following this logic, arguments could have been made by same-sex couples that discrimination on the basis of sex includes the refusal by coverage providers to offer the same coverage to same-sex couples as is provided to heterosexual couples, simply because it is the norm for heterosexual couples to be able to conceive, and it is not the norm for couples of the same sex to be able to conceive. Similarly, single individuals might be able to argue that current fertility coverage policies wrongfully partake in sex stereotyping because such policies anticipate that all people who need fertility treatment will be in a committed relationship with a person who has the capability of producing sperm.

Such arguments might have faced resistance because of the holding in a Title VII case called \textit{Price Waterhouse v. Hopkins}.

\textsuperscript{92} In this case, the Supreme Court held that the only way an employer could avoid liability for making an employment decision motivated in part by gender was by showing the same decision would have been made regardless of the plaintiff’s gender.\textsuperscript{93}

\textsuperscript{86} \textit{Id.} (emphasis added); Cornachione et al., \textit{supra} note 78.

\textsuperscript{87} Nondiscrimination in Health Programs and Activities, \textit{supra} note 83, at 31390.

\textsuperscript{88} \textit{Id.} at 31392.

\textsuperscript{89} Baldwin v. Foxx, EEOC Appeal No. 0120133080, 25 WL 4397641, at *5–6 (July 15, 2015).

\textsuperscript{90} \textit{Id.} at *5.

\textsuperscript{91} \textit{Id.}

\textsuperscript{92} \textit{Price Waterhouse v. Hopkins}, 490 U.S. 228, 228 (1989).

\textsuperscript{93} \textit{Id.} at 258.
*Waterhouse* is applied to cases where single individuals and same-sex couples are denied fertility coverage, it might be argued that these denials would have occurred regardless of gender because, at least in cases like *Goidel*, the denial is, on its face, not based on gender. The Aetna policy referred to in *Goidel* gives two options for when it will start covering fertility treatment: (1) after six to twelve months of “regular, unprotected sexual intercourse” or (2) after six to twelve months of “therapeutic donor insemination.” However, when looking below the surface, it is reasonable to conclude that the only people who would need to utilize therapeutic donor insemination rather than sexual intercourse to demonstrate an inability to conceive are same-sex couples or individuals who do not have a partner capable of producing sperm.

Under the language adopted by the 2016 rule promulgation, it is likely that an argument could have been made that failure to provide equal coverage for fertility treatment to people who never would have been able to conceive through regular, unprotected sexual intercourse constituted discrimination on the basis of sex. This is because, per the *Baldwin* holding which the rule relied on, there was discrimination on the basis of sexual orientation, which inescapably is discrimination on the basis of sex. Additionally, per the *Price Waterhouse* holding, there was likely no way for health insurance providers to show that the denial of coverage would have happened regardless of gender.

Before moving to the 2020 rule, it is necessary to look briefly at a case that almost immediately limited the scope of the 2016 rule’s protections against discrimination. In December of 2016, a district court in Texas issued a nationwide preliminary injunction to prevent HHS from enforcing the prohibition of “discrimination on the basis of ‘gender identity’ and ‘termination of pregnancy.’” The court reached this decision following the claims by plaintiffs that the expanded scope of the definition would compel them to provide coverage for and/or perform gender transitions, “regardless of their contrary religious beliefs or medical judgment.” The court found for the plaintiffs, concluding that HHS’s 2016 rule contradicted current law and exceeded statutory authority, thereby violating the Administrative Procedure Act (APA). Additionally, it held that the regulation likely violated the Religious Freedom Restoration Act with regard to private plaintiffs. In 2019, the court issued its final decision on the matter, and for the aforementioned reasons, vacated the portions of the rule related to prohibiting discrimination based on gender identity and pregnancy termination. While this decision was certainly

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94 *Aetna Student Health Plan Design and Benefits Summary*, *supra* note 7 at 23.
96 *Id.* at 670.
97 *Id.*
98 *Id.*
99 *See* *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 946–47 (N.D. Tex. 2019); *Musumeci et*
a setback to advocates against discrimination, it does not bear much weight on the issue of discrimination when it comes to access to fertility care. Much of the previously mentioned and forthcoming sources of law tend to utilize language that protects against discrimination due to sex stereotyping (rather than gender identity), under which discrimination against same-sex couples and single individuals seeking fertility treatment may be argued to be prohibited. Thus, even with the court’s holding that this part of the rule violated the APA, other parts of the rule that protect against discrimination based on sex stereotyping were left in place.

2. The 2020 Rule

On June 19, 2020, the Trump administration directed HHS to reinterpret Section 1557. In its final rule, HHS eliminated Section 1557’s definition of sex discrimination as defined by the 2016 rule. This included the removal of “gender identity” and “sex stereotyping” from the definition of discrimination on the basis of sex. HHS instead reverted its interpretation of discrimination on the basis of sex to conform with the “plain meaning of the term,” defining sex as “refer[ring] to the biological binary of male and female.” This is in stark contrast to the previous interpretation of the statute. When this rule came out, some argued that the new definition for discrimination on the basis of sex “could allow health care providers to refuse to serve individuals who . . . do not conform to traditional sex stereotypes.” Their concern was that, with this new interpretation, Section 1557 would not be able to prohibit insurance providers from denying coverage to same-sex couples and single individuals who failed to conform with gender norms and stereotypes.

Perhaps a more striking shift by HHS in the 2020 rule is the decision to exclude insurers from the definition of those who provide health care. In the codified language, the new interpretation states that entities “engaged in the business of

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100 See, e.g., Nondiscrimination in Health Programs and Activities, supra note 83, at 31390.
101 See id.
102 Musumeci et al., supra note 99.
103 Id.
104 Id.
105 Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 36995, 37178 (June 19, 2020).
106 Musumeci et al., supra note 99.
107 Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, supra note 105, at 37172.
providing health insurance shall not . . . be considered to be principally engaged in
the business of providing healthcare.”

The explanation given in response to comments by those concerned about the change in definition stated that support could be found in the Civil Rights Restoration Act of 1987, among other laws, for the premise that health care providers and health insurance providers are two distinct entities. This distinction is an important one because it excludes insurers from the category of “health program or activity,” and thus displaces them from the umbrella of Section 1557. Critics of this change assert that this narrowing of the definition of health program or activity could lead to insurers “denying or limiting coverage of a health insurance claim” on the basis of sex, among other things. Under this interpretation, Section 1557 claims brought by single individuals and same-sex couples relating to discrimination in seeking coverage for fertility treatment would lack standing entirely.

It is likely, however, that the interpretation of Section 1557 will see another shift with the Biden administration’s control over HHS. Notice and comment has already begun to promulgate a new rule. However, before analyzing the likely changes that will result from the proposed rulemaking, it is necessary to look at relevant cases which have further developed the law leading up to and directly following the 2020 rule.

3. Expanding the Meaning of Discrimination on the Basis of Sex: Bostock v. Clayton County

Just four days after the regulation was published, a Supreme Court case called Bostock v. Clayton County was decided. Bostock contributed to the line of cases comprising the ever-evolving definition of discrimination on the basis of sex. Bostock looks at three cases in which employees were fired by long-term employers shortly after revealing that they were either homosexual or transgender. Importantly, in each case, there appeared to be no other reason for the termination. The Bostock Court set out to determine, once and for all, whether Title VII prohibited employment discrimination on the basis of sexual orientation or

108 45 C.F.R. § 92.3 (2020).
109 Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, supra note 105, at 31372–73.
110 See id. at 37171–72.
111 See Musumeci et al., supra note 99.
113 140 S. Ct. 1731, 1731 (2020); Musumeci et al., supra note 99.
114 See Musumeci et al., supra note 99.
115 Bostock, 140 S. Ct. at 1737.
116 Id.
gender identity.\textsuperscript{117} It concluded that “it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex.”\textsuperscript{118} It insisted that neither homosexuality nor being transgender is merely vaguely related to sex, stating instead that any discrimination “on these grounds requires an employer to intentionally treat individual employees differently because of their sex.”\textsuperscript{119} With this holding from the Supreme Court, Title VII (incorporated, as aforementioned, in Section 1557) now includes sexual orientation and gender identity among those things protected against discrimination on the basis of sex.\textsuperscript{120} Notwithstanding the issue of insurers no longer falling under the purview of Section 1557, this decision could advance the cause of advocates for fertility coverage for same-sex couples and single individuals.

Following this decision, there were two cases that set out to challenge the Trump Administration’s 2020 rule interpreting Section 1557. The cases, \textit{Walker v. Azar} and \textit{Whitman-Walker Clinic, Inc. v. U.S. Department of Health and Human Services}, originated out of New York and Washington, D.C., respectively.\textsuperscript{121} In both cases, federal courts issued preliminary injunctions, staying the Trump Administration’s repeal of the 2016 definition of discrimination on the basis of sex.\textsuperscript{122} Both cases did so, at least in part, because HHS’s rule was arbitrary and capricious.\textsuperscript{123} They argued that the rule failed to take into account the holding from \textit{Bostock}, which is largely contrary to the portion of the rule that sought to repeal the 2016 definition.\textsuperscript{124} The court in \textit{Whitman-Walker Clinic, Inc.} looked to the preamble to the 2020 rule, where it was made clear that HHS wanted to bring the interpretations of Section 1557 “into compliance with the underlying statutes,” including Title IX and Title VII.\textsuperscript{125} Based on this reasoning by the HHS, the court claimed that the agency “plowed ahead” with the implementation of its rule without regard to how the \textit{Bostock} holding might affect Section 1557 or its incorporated statutes.\textsuperscript{126} These nationwide preliminary injunctions are now in effect, and have

\begin{itemize}
\item \textsuperscript{117} \textit{Id.} at 1738.
\item \textsuperscript{118} \textit{Id.} at 1741.
\item \textsuperscript{119} \textit{Id.} at 1742.
\item \textsuperscript{120} \textit{See generally id.}
\item \textsuperscript{121} Musumeci et al., \textit{supra} note 99.
\item \textsuperscript{123} \textit{Walker}, 480 F. Supp. 3d at 429–30 (asserting that “[a]n agency action can be ‘arbitrary and capricious’” if it “has ‘entirely failed to consider an important aspect of the problem’”); \textit{Whitman-Walker Clinic, Inc.}, 485 F. Supp. 3d at *42 (concluding that “it was arbitrary and capricious for HHS to eliminate the 2016 Rule’s explication of that prohibition without even acknowledging . . . the Supreme Court’s reasoning or holding”).
\item \textsuperscript{124} \textit{See Walker}, 480 F. Supp. 3d at 429–30; \textit{see also Whitman-Walker Clinic, Inc.}, 485 F. Supp. 3d at *42.
\item \textsuperscript{125} \textit{See Whitman-Walker Clinic, Inc.}, 485 F. Supp. 3d at *39.
\item \textsuperscript{126} \textit{See id.} at *40.
\end{itemize}
momentarily reverted the interpretation of the law to the 2016 regulation defining discrimination on the basis of sex, less the inclusion of gender identity and pregnancy termination, per *Franciscan Alliance*.\(^{127}\)

4. The Likely Future of Section 1557

Most recently, in May of 2021, the HHS announced its intention to include gender identity and sexual orientation in the definition of “on the basis of sex” under Section 1557 once again.\(^ {128}\) This announcement was in response to an executive order by President Biden, which referenced *Bostock*, and ordered that “[t]he head of each agency shall . . . consider whether to revise, suspend, or rescind such agency actions, or promulgate new agency actions, as necessary to fully implement statutes that prohibit sex discrimination . . . .”\(^ {129}\) After more than a year, HHS officially put out its notice of proposed rulemaking (NPRM) in August of 2022.\(^ {130}\) In a summary of the proposed rule, the Department stated that it intends “to address nondiscrimination on the basis of sex . . . consistent with *Bostock* . . . .”\(^ {131}\) This change, should it survive the notice and comment process, would restore the interpretation of Section 1557 to the 2016 definition. This restoration would likely result in a victory for same-sex couples seeking coverage, because it would mean that covered entities cannot discriminate based on sexual orientation. Importantly, HHS added that it intended to comply with “any applicable court orders that might have been issued” that related to Section 1557, including *Franciscan Alliance, Inc.*\(^ {132}\) Additionally, it confirmed that its interpretation will abide by the Religious Freedom Restoration Act.\(^ {133}\) Provided that it actually does so in the final rule, HHS’s expanded definition of discrimination on the basis of sex would most likely be less susceptible to challenge in the courts for ineffective notice and comment than the previous interpretation.

Moreover, the Department stated that it intended to “prohibit discrimination on the basis of sex related to marital, family, or parental status.”\(^ {134}\) This new

\(^{127}\) Musumeci et al., *supra* note 99.


\(^{131}\) *Id.* at 47828.

\(^{132}\) Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972, 86 Fed. Reg. 27984, 27985 (May 25, 2021).

\(^{133}\) *Id.*

\(^{134}\) Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. at 47828.
language is the most significant advancement for single individuals who wish to receive coverage for fertility treatment. Until now, the strongest argument for their inclusion in the prohibition against discrimination on the basis of sex was that single individuals who wish to have children may not conform to certain sex or gender stereotypes (specifically, those which assume that only couples, or people capable of giving birth who have access to an individual with the capability of producing sperm, are people who traditionally give birth). With this change, single individuals seeking coverage would likely have their own protection against discrimination when seeking fertility treatment.

Despite these changes, which appear to be favorable toward same-sex couples and single individuals seeking coverage for fertility treatment, all of these changes would appear to be moot, considering that HHS’s 2020 rule excluded insurance providers from its definition of health care providers. However, the 2022 proposed rule would expand the definition and include health insurance coverage, as well as other health-related coverage, in Section 1557’s prohibition against discrimination. The Department attributed this change in part to the confusion created by the exclusion of insurers from the list of health care providers and to the fact that Section 1557 was “less effective at combatting discrimination” which resulted in “less protection for people who need health care and are protected by Section 1557 . . . .”

Having concluded the comment period for its proposed rule, HHS is now in the process of finalizing and eventually publishing the rule with responses to comments. Provided there is not much change between the proposed rule and the final rule, this interpretation will be the most expansive interpretation of Section 1557 to date. Not only would it allow discrimination based on sexual orientation and gender identity to fall within the scope of discrimination on the basis of sex, but it would also include marital status as a factor which health care providers must not discriminate against. These protections against discrimination, coupled with the affirmative inclusion of insurers in the definition of “health care provider,” would likely result in Section 1557 protecting against discrimination toward same-sex couples and single individuals seeking coverage for fertility treatment from health care providers that receive Federal financial assistance.

B. State Insurance Laws Relating to Discrimination in Health Care

As expansive as the new protections under Section 1557 promise to be, it is still important to look at state laws currently in place that relate both to coverage in fertility treatment and discrimination in health care. Besides the volatile and ever-evolving nature of Section 1557, the statute still only applies to health care providers that receive Federal financial assistance. That means there may be entities that do

135 See id. at 47868.
136 See id.
137 See id. (specifying that comments must be submitted on or before October 3, 2022).
not receive any federal funding and are therefore not under the authority of Section 1557. Thus, it is necessary to look at some relevant state laws to see how they impact people who wish to conceive but are not in a heterosexual relationship.

State insurance laws related to fertility treatment coverage may come in two forms: mandates to cover treatment and mandates to offer treatment.138 A mandate to cover requires health insurance companies to cover fertility treatment as a benefit in every policy.139 A mandate to offer requires such companies to make policies available for purchase that offer coverage of fertility treatment.140 Currently, only twenty-one states have any requirements at all regarding coverage of fertility treatment.141 Of those twenty, eighteen have mandates to cover some amount of fertility treatment.142 Texas and California have mandates to offer coverage to employers who wish to provide certain benefits to their employees.143 Each state’s mandate ranges in what it requires, including what kinds of fertility treatment may be required or offered, and who the recipients of the coverage can be.144 Before looking at state laws that represent the spectrum of mandates, it is important to determine who the laws apply to.

As was addressed previously, self-insured plans provided by employers are preempted by ERISA, and are not required to comply with state insurance laws.145 Thus, none of these state mandates to cover or offer coverage for fertility treatments apply to self-insured plans. On the other hand, fully-insured plans offered by employers, individual plans purchased from the marketplace, and public coverage like Medicaid and Medicare are saved from ERISA preemption and therefore subject to state insurance laws.146 These plans are subject to state law,
though different states may or may not include certain types of plans in their respective mandates. For example, Utah’s coverage mandates extend only to a health plan for public employees and to Medicaid patients. Other states, like New York, may limit their plans only to group insurance policies, which are policies generally offered by an employer. Each state law may, evidently, apply to different providers of coverage. With that said, it is now possible to examine the range of laws that are currently in place, and the extent to which they protect or limit access to fertility treatment. It is important to bear in mind that these laws may not all directly relate to discrimination in providing health insurance coverage to fertility treatment, but they often have implications for groups of people who tend to be discriminated against.

Among the state laws that are most adverse to same-sex couples and single individuals seeking coverage for fertility treatment is an insurance law out of Texas. The law requires that issuers of group health benefit plans (group insurance policies) who offer pregnancy-related services in their plans also offer coverage for IVF. However, this coverage is only required to be offered if, among other things, “the fertilization or attempted fertilization of the patient’s oocytes is made only with the sperm of the patient’s spouse.” This language excludes same-sex couples, like the Goidels, who do not have a spouse capable of producing sperm. Much in the same manner, it excludes single individuals and people in a relationship who are not married. Similarly, Arkansas requires “all individual and group insurance policies that provide maternity benefits” to also cover IVF. Like the Texas law, Arkansas states in its patient requirements that this required coverage is limited to policyholders and their spouses, and that a spouse’s sperm is used for fertilization.

Conversely, a few states like New York have implemented mandates to cover with more inclusive language. In New York, group policies covering more than 100 employees must provide up to three cycles of IVF to patients. The law


147 See generally Insurance Coverage by State, supra note 141.
148 Id. (located under the “Utah” tab).
149 Id. (located under the “New York” tab).
151 See generally Insurance Coverage by State, supra note 141 (located under the “Texas” tab).
154 Insurance Coverage by State, supra note 141 (located under the “Arkansas” tab).
155 Id.
156 See generally id. (located under the “New York” tab).
157 Id.
prohibits insurers from discriminating “based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.” There is also a New York health insurance law that generally prohibits discrimination on the basis of sex or marital status, requiring that “[n]o individual or entity . . . refuse to issue any policy of insurance, or cancel or decline to renew the policy because of the sex or marital status of the applicant or policyholder or engage in sexual stereotyping.” Similarly, Maryland has language prohibiting insurers from requiring that same-sex couples use their spouse’s sperm for the treatment.

Unfortunately, despite their best efforts to be inclusive toward same-sex couples and unmarried individuals, even these states may not measure up to the Goidels’ expectations. While they may require that coverage for such groups be available, the consistent prerequisite appears to be a demonstration of a failure to achieve pregnancy after undergoing a period of uncovered fertility treatment. Each law anticipates that same-sex or single patients will demonstrate an inability to conceive by undergoing therapeutic donor insemination for six to twelve months, depending on the age of the patient. It is thus apparent that Aetna’s policy is no anomaly; even those states with laws that openly protect against the discrimination that Section 1557 has (with great fluctuation) sought to prohibit do not provide an avenue that is free and equal to that of heterosexual couples. This is where the definition of infertility resurfaces. As defined above, the language surrounding infertility focuses exclusively on people who wish to conceive through historically traditional sexual intercourse. Infertility is considered a disease, and does not extend to the general inability to conceive. With that in mind, it would appear that the current policy offered by Aetna is consistent with New York’s laws prohibiting discrimination. As such, the Goidels and other members of their class may have a difficult time demonstrating that the requirement to pay out-of-pocket before receiving treatment constitutes discrimination. With that said, it is now necessary to look toward the possible future of state laws that could one day expand the scope of discrimination on the basis of sex in health insurance coverage, as well as the potential implications of requiring that all health insurance providers cover the cost of fertility treatment.

158 N.Y. INS. LAW § 3221(k)(6)(C)(viii) (McKinney 2023); see also Insurance Coverage by State, supra note 141 (located under the “New York” tab).
159 N.Y. INS. LAW § 2607(a) (McKinney 2020).
162 Id.
163 See ASRM, supra note 44.
164 See id.
III. PART 3: A COURSE FORWARD TO MITIGATE DISCRIMINATION IN ACCESSING COVERAGE FOR FERTILITY TREATMENT

At this time, there is only one state law which does provide an avenue consistent with that sought by the Goidels and similarly situated advocates. Illinois’s insurance law pertaining to infertility defines infertility as “a disease, condition, or status” resulting from

(1) a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age . . . [or]

(2) a person’s inability to reproduce either as a single individual or with a partner without medical intervention . . .

Described by Bloomberg Law as the Illinois Model, this definition of infertility would be exactly what advocates like the Goidels have been hoping for. In the bill synopsis for the statute, it is asserted “that coverage for the diagnosis and treatment of infertility shall be provided without discrimination on the basis of . . . domestic partner status, gender, gender expression, gender identity . . . marital status . . . sex, or sexual orientation.” In a press release following the passage of the bill by the state legislature, bill sponsor State Representative Margaret Croke stated that “‘[e]veryone looking to start or grow a family should have access to the same insurance coverage, regardless of gender, sexuality, age, relationship status or medical history.’”

This Illinois law could have powerful implications for the future legal landscape surrounding coverage for infertility treatment. By including same-sex couples and single individuals in its definition of infertility, it takes into consideration the notion that some people are precluded from being able to conceive given the nature of their relationship and/or sexual orientation. This inclusion would save people like the Goidels from having to pay tens of thousands of dollars out-of-pocket simply to be able to conceive. Therefore, I propose that every state should seek to adopt this definition, or a definition similar to this, that expands the definition of infertility and makes it clear under the law that requiring same-sex couples and single individuals

165 See Insurance Coverage by State, supra note 141 (located under the “Illinois” tab).


to pay out of pocket for treatment while not requiring the same from heterosexual couples is discrimination.

In addition, I make two proposals to actors on the federal level. First, the CDC should expand the definition of infertility to include the language provided by the Illinois Model. Second, Congress should amend Section 1557 of the Affordable Care Act to affirmatively include sexual orientation, sex stereotyping, and gender identity within the definition of discrimination on the basis of sex.

As was previously noted, many states base their laws relating to fertility coverage off of the CDC’s definition of infertility. Although they would not be required to change their laws if it changed its definition, I believe that many more states would feel supported and perhaps compelled to match the CDC’s definition. Additionally, changing the definition would give more strength to plaintiffs like the Goidels who bring challenges under Section 1557.

On that note, Congress should amend Section 1557 to ensure that people cannot be discriminated against on the basis of sexual orientation, sex, stereotyping, and gender identity to prevent any additional whiplash of interpretations. The *Bostock* opinion was helpful to the cause, but it is clear from the constant challenges in courts and injunctions following every interpretation of the Section by HHS since the Obama administration that the only way to maintain a consistent, unwavering definition of what constitutes discrimination on the basis of sex is to pass a law defining as much.

It is this author’s belief that if these changes are made, the result would conform with what many health advocates are already arguing for. As the above American Society for Reproductive Medicine stated, “[i]t is important for [‘diverse sexuality and gender (DSG) individuals and couples’] to have the same access to infertility care as cisgender heterosexual married couples.”170 Such changes would prevent couples and individuals from having to go into debt simply to be able to conceive, and would help to eliminate perceptions of discrimination in accessing health coverage for fertility treatments.

**CONCLUSION**

At this point, the future of what constitutes discrimination in health insurance coverage for fertility treatment is volatile and murky, but there remains some hope for people like the Goidels. Section 1557, the anti-discrimination provision of the ACA, has had a fairly labile existence thus far, but the latest interpretation by HHS will likely expand protections against discrimination on the basis of sex to their broadest scope to date. It appears that the definition will be expanded by the Biden administration to once again include protections against discrimination based on sexual orientation, gender identity, and sex stereotyping, relying on case law like *Bostock*. The interpretation acknowledges the current status of the law, which the

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170 Access to fertility treatment irrespective of marital status, sexual orientation, or gender identity: an Ethics Committee opinion, supra note 42.
2020 interpretation failed to do, likely making this interpretation less susceptible to challenges in the courts. If this latest interpretation is successfully promulgated, it will prohibit health insurers who receive Federal financial assistance from creating policies that have different requirements for heterosexual couples, same-sex couples, and single individuals to qualify for coverage of fertility treatment.

Most states (including those that prohibit discrimination) allow for health insurers to have policies with differing requirements for patients to demonstrate a need for treatment based on sexual orientation or marital status, there remains a small ray of light for advocates against such policies. As of 2023, it appears that only Illinois has a state insurance law that sufficiently protects against discrimination in health insurance coverage for fertility treatment to the extent that Aetna’s policy would be illegal. The law does so by expanding the definition to include people who are unable to reproduce without medical intervention. If this definition were to be adopted by other states or the CDC, advocates like the Goidels would have more solid ground to stand on in arguing that policies like Aetna’s are discriminatory. Moreover, if Congress were to pass a law to amend Section 1557 to permanently include sexual orientation, sex stereotyping, and gender identity within the definition of discrimination on the basis of sex, Section 1557 would likely face less challenges in the court for its rule interpretation of discrimination on the basis of sex.

At the time of the writing of this Note, Goidel v. Aetna, Life Ins. Co. is still unresolved. The results of this case will undoubtedly have a profound impact on how we interpret what constitutes discrimination in health coverage of fertility treatment, and whether or not the requirement that people who cannot conceive through unprotected sexual intercourse pay out-of-pocket before they can qualify for coverage of fertility treatment is discriminatory.

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171 See 215 ILL. COMP. STAT. 5/356m(c)(2) (2022) (formerly ILL. REV. STAT. Ch. 73, par. 968m (1991)) (emphasis added).